

The NICE guideline for antenatal and postnatal mental health : exploring the role of the health visitor.

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Abstract

When the NICE guideline for antenatal and postnatal mental health was updated in December 2014, the intervention delivered by health visitors, described as 'listening visits', was not included in the recommendations as one of a number of possible, evidence-based options of support. Maternal mental health is one of the six high impact areas designated as a fundamental component of health visiting practice. This review demonstrates how health visitors are uniquely placed to fulfill many of the recommendations in the updated NICE guideline and have a pivotal part to play in prevention, early identification, prompt treatment and improved outcomes for mothers, their partners and their babies. The review also highlights the challenges of delivering the recommended levels of perinatal mental health information, advice and support amidst budget cuts, reorganization of services and conflicting policy priorities.

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Introduction

The NICE guideline for antenatal and postnatal mental health was updated in December 2014. Health visitor-delivered 'listening visits' were included as a recommended intervention for mothers with mild to moderate depression in the previous version of the NICE guideline (NICE 2007) but were excluded from the updated version (NICE 2014a).

'Listening Visits' is the term used to describe the therapeutic package of care that health visitors offer to mothers with mild to moderate mental health problems during pregnancy or the year after delivery (the perinatal period). The package of care usually consists of 4 -8 weekly visits. The health visitor uses a range of different techniques to enable the mother to gain a better understanding of herself and her circumstances in order to explore interventions or support that will help her to feel better (Day 2014; Cummings and Whittaker 2016).

It is vital that commissioners, managers and practitioners understand that there are many reasons for the exclusion of 'listening visits' from the NICE guideline, some of which relate to the definitions and descriptions used and to the poor availability of appropriate research, or the way in which research findings have been interpreted (NCCMH 2014). The exclusion of 'listening visits' from the guideline should not mean the exclusion of health visitors from the pathway of care.

The purpose of this article is to explore the potential role of the health visitor in the context of the recommendations made in the updated guideline for antenatal and

postnatal mental health (NICE 2014a). It will illustrate the part that health visitors *could* play in preventing, assessing and managing maternal perinatal mental health problems. However, it must also be acknowledged that there are a number of contextual factors, such as changes in commissioning and organizational priorities, that mean that health visitors are not always able to fulfill this very important part of their role.

The role of the health visitor in prevention, early intervention and public health

Health visitors are key professionals in identifying and supporting mothers with mental health needs because of their background in nursing and/or midwifery and their public health expertise in prevention and early intervention. Some health visitors are qualified mental health nurses and many have undertaken extensive additional training in mental health.

Health visitors have the skills and qualities to work in partnership with families to explore and understand the contextual factors that impact on family health and well-being, and the ability to use a range of techniques to enable parents to find the actions and solutions that are right for them (Davis and Day, 2010). This means that in their everyday practice health visitors are already considering and addressing the multiple and varied determinants of health. Regardless of whether the issues identified relate to physical or mental health, or parenting, health visitors are in the process of building a therapeutic alliance using many of the common elements associated with effective psychological interventions such as empathy, warmth, genuineness and mutual respect (IAPT 2010a, IAPT 2010b).

Health visitors have a responsibility to contact all mothers during pregnancy and in the early years of a child's life (DoH/DCSF 2009, DoH 2014). This means that health visitors are ideally placed to make enquiries about maternal mental health, to undertake a comprehensive assessment of need and risk, and to facilitate access to a range of appropriate and effective options of support (DoH 2012). Maternal mental health is one of the six high impact areas that are considered to be a primary focus of health visiting practice. It could be argued that maternal mental health is of prime importance as any form of maternal distress can potentially have an adverse impact on maternal self-care; capacity to cope; capacity to access and engage with sources of help and support; and interactions with, and care of, other members of the family (DoH 2014).

The NICE guideline states that most women with additional mental health needs will be identified and treated in primary care (NCCMH 2014). As the greatest number of new episodes of postnatal depression occur 2-3 months after birth (Gavin et al 2015, O'Hara and McCabe 2013) the burden of this responsibility inevitably falls on health visitors as they are the only primary care health professionals who routinely see all mothers and babies beyond the first 6 weeks of a baby's life.

Mothers sometimes find it difficult to disclose how they are feeling during pregnancy and the year after delivery. There are many reasons for this including stigma, lack of information about perinatal mood disorders and the nature of the relationships

between mothers and health professionals (Dennis and Chung-Lee 2006).

As a home-based service, health visitors enjoy the benefit of being able to engage with mothers in the privacy and security of their own home, often for a longer period of time at each appointment, than is usually possible in health care facilities. A home environment also makes it easier for mothers to respond to infant needs, demands and feeding schedules. These circumstances can help to provide an environment in which mothers are more likely to feel at ease and health visitors are more likely to be able to get to know the family and share and explore sensitive information (Cowley et al 2013).

A narrative review of women's experiences of perinatal mental health care affirms that women value having the opportunity to get to know the people looking after them and are more likely to disclose mental health problems if they feel that they have a 'connection' with a single known health professional who is responsible for co-ordinating responsive, flexible and integrated care (NCCMH 2014). The fact that health visitors already know mothers from routine antenatal and new birth contacts may help to overcome any reticence or embarrassment possibly associated with talking about maternal mental health. As the role of health visitors includes providing information and anticipatory guidance about a range of health and childcare issues it should also be within their remit to provide information about perinatal mood disorders. (NICE 2014a, recommendation 1.4.1). Creating the right environment to facilitate disclosure is probably more difficult where corporate caseloads and skill mix teams mean that a mother might be seen by a different health visitor or team member at every visit, or where reductions in staff numbers and increases in caseloads mean that all women do not receive the mandated number of contacts.

The point is made in the guideline for antenatal and postnatal mental health that specific interventions to address mental health issues are more likely to be effective if they are offered within the context of a comprehensive treatment programme and include consideration of the needs of all family members (NICE 2014a, recommendation 1.3.4). This is particularly relevant to interventions offered by health visitors because these professionals have a responsibility not only to support mothers with mental health problems but also to assess and promote every aspect of family health and well-being. This includes an ability to acknowledge family strengths, needs and risks; consideration of the interactions and relationships between all family and household members; a responsibility to safeguard vulnerable adults and children; and a mandate to promote the optimal health, growth, development and safety of all children under 5 (Cowley et al 2013).

The role of the health visitor in psychosocial assessment

The purpose of psychosocial assessment is not just about identifying vulnerabilities but it is an opportunity to develop a "holistic, integrated, woman-centred approach to emotional health" (Milgrom and Gemmill 2013, p.5). This is compatible with the expectation in recommendations 1.3.6 and 1.4.3 of the NICE guideline (NICE 2014a) that health professionals should promote mental well-being and seek to prevent, as

well as treat, mental health problems.

It is common practice for health visitors to complete a family health needs assessment for every family on their caseload. This includes consideration of many of the factors that the updated NICE guideline (recommendation 5.4.8.5. NICE 2014a) recommends should be considered in the assessment and diagnosis of maternal mental ill-health. Risk factors for mental illness may be the same risk factors that also contribute to poor physical health, compromised relationships and social exclusion. By counteracting risk factors and reinforcing protective factors health visitors have the potential to make a significant contribution not only to the prevention and early identification of mental illness but also to contribute to better physical health, interpersonal relationships and socioeconomic outcomes (Hosman et al 2005).

Health visitors are expected to enquire about personal and family history of mental illness; parental experience of being parented, including recollections of childhood maltreatment; perceptions of personal safety including past or current exposure to intimate partner violence; personal or partner alcohol or substance misuse; and any other stressful events or traumatic experiences. Enquiries of this nature require great sensitivity and skill as well as knowledge and awareness of the implications of disclosure, or when urgent or immediate referral or help is needed. The key point here is that health visitors (if sufficiently resourced to allow them to deliver the mandated number of universal visits to all families) can take action to address these factors at the earliest possible opportunity and are able to identify, monitor and support mothers who may be at increased risk of suffering from a mental illness.

The role of the health visitor in assessing and managing physical and mental health

Health visitors are able to identify sub-clinical symptoms such as disturbances in sleep, appetite and concentration and to understand the interplay between symptoms identified and the biopsychosocial consequences of motherhood. For example, fatigue may be a symptom of depression but it may also be a sign of poor thyroid function or anaemia or disrupted sleep associated with infant feeding. Somatic symptoms such as back pain, headaches or nausea could indicate physical or psychological problems (Webb et al 2008, Harran et al 2014) or culturally acceptable ways of expressing emotional distress (Evagorou et al 2016).

Perinatal mental health problems may also be associated with risky behaviours such as smoking, drinking or taking drugs or compromised self-care such as poor nutrition and reluctance to engage with local services (Cinciripini et al 2010, Cha and Masho 2013, Alhusen, Ayres and DePreist 2016). In the light of their professional knowledge and experience, health visitors are able to appreciate this diversity of aetiology and expression. If adequately resourced to provide ongoing support to families, health visitors are able to continuously appraise the changing dynamics of circumstances, relationships and risk; explore and respond to readiness to change; provide anticipatory guidance to ameliorate the impact of symptoms on maternal functioning and well-being; or provide advice about behaviours, interventions and

support that can help to modify the symptoms or prevent them from occurring in the first place.

The role of the health visitor in assessing the level of contact and support needed.

Health visitors are trained not only to ask the relevant questions but also have the professional knowledge and clinical integrity to be able to deal with the responses given and the issues raised. This is particularly important with regard to the necessity of identifying mothers with serious mental health problems, or complex presentations, that require specialist intervention. The NICE guideline advocates a simplistic approach to initial assessment in the form of depression and anxiety identification questions, based on the logic that anxiety and depression are the most prevalent mental health problems in the perinatal period (NCCMH 2014). It is expected that every practitioner at every antenatal and postnatal contact will ask these questions (NICE 2014a). However, these questions alone will not help to reveal those women who are experiencing depression, anxiety, Obsessive Compulsive Disorder (OCD), Post Traumatic Stress Disorder (PTSD) or phobias, or who are experiencing other symptoms not usually indicative of anxiety or depression (Coates et al 2014; Highet et al 2014; Williamson et al 2015). Challenges may also arise from the difficulties of disentangling symptoms reflecting multiple co-morbidities (Brockington et al 2006).

Health visitors who have received training in differential presentations can use additional tools of assessment to help them to sensitively explore the breadth, depth and impact of the symptoms experienced in order to know the kinds of interventions that might be appropriate and when and to whom a referral is required. This is very important considering that the updated NICE guideline (2014a, recommendation 1.5.3) highlights that the “range and prevalence of anxiety disorders and depression are under-recognised” during the perinatal period and that all healthcare professionals working in universal services should “assess the level of contact and support needed by women with a mental health problem (current or past) and those at risk of developing one” (NICE 2014a, recommendation 1.4.8)

The role of the health visitor in facilitating access to integrated and collaborative care

NICE guidelines are clear in their expectation that all professionals should make decisions in collaboration with patients taking into account their unique circumstances, preferences, needs, values and beliefs (NCCMH 2014). This is of particular relevance for antenatal and postnatal mothers who may be experiencing symptoms that could be attributed to the unique context of motherhood, transient psychological distress or that may signify the onset of mental illness. The health visitor has the skills and opportunity to monitor changes in maternal health and well-being over time; to explore explanatory models of mental illness and motherhood; and to provide timely information and support. In situations where mothers are reluctant, or unable, to access additional services health visitors may be the only professional who is able to maintain contact.

Despite the fact that, according to the NICE (2014a) guideline for antenatal and postnatal mental health, 'listening visits' are no longer recommended as a therapeutic intervention, other guidance suggests (for example, NICE 2011, NICE 2012, DoH 2012, DoH 2014) that health visitors are expected to offer a series of supportive visits to mothers experiencing mild to moderate depression, as one of a range of possible options of support.

According to the updated guideline (NICE 2014a) 'Facilitated self-help' is the only suggested option for women experiencing mild to moderate or subthreshold depression. However it is important to realise that the strength of the recommendation is reflected in the words that are used (NICE 2014b). For example, the word 'consider' indicates that the evidence of benefit from the intervention is less than certain. If the NICE recommendation invites the reader to 'consider' a particular intervention the implication is that this intervention should only be considered as one of many possible options. Whilst, the option of facilitated self-help should be explored, any intervention is only likely to be effective if it is acceptable to the recipient and if they believe that it is likely to help them to feel better.

Although the definition of facilitated self-help referred to in the NICE guideline recommendation has very specific characteristics and implications, it could also be argued that any intervention offered by health visitors falls into this category. Many of the self-help strategies that health visitors might suggest or explore to ameliorate common mental health problems are those that are endorsed by both consumers and professionals as most likely to be helpful, such as behavioural activation, relaxation techniques and structured problem-solving (Morgan and Jorm 2009). Many of these techniques are included in what are currently described as 'listening visits' (Day 2014, Cummings and Whittaker 2016).

Specialist knowledge and advanced skills are required to ensure that prompt and appropriate action is taken when there is a sudden deterioration in maternal mental state or indications of increased risk of harm to either the mother or the baby. Health visitors are therefore often involved in organising emergency care or additional support from other agencies and may act as the intermediary between those agencies and the family. In some cases, as a result of delays in accessing treatment, lack of services for certain categories of illness or disability, restrictive referral thresholds or long waiting lists, health visitors may be required to temporarily monitor, manage and advocate for mothers exhibiting acute symptoms of severe mental illness, comorbid presentations including perhaps anxiety, depression and PTSD or mothers with mental illnesses superimposed on learning disabilities, personality disorders, domestic violence or substance misuse (Apter et al 2012, Austin et al 2015, Cummings and Whittaker 2016).

Even when mothers are receiving support from other professionals, health visitors may have a key role to play in encouraging sustained engagement with other therapists and ensuring that the health and well-being needs of all family members are considered and addressed (DoH/DCSF 2009). Health visitors may be instrumental

in exploring with the family ways of engaging with local communities and services and mobilising networks of support in order to foster resilience and reduce risk. In this respect, the role of the health visitor is similar, in many ways, to the role of the 'case manager' in other community services (Ross, Curry and Goodwin, 2011). Of course, health visitors can only fulfil this role if they are sufficiently resourced to do so.

The role of the health visitor in promoting infant well-being

The updated NICE guideline for antenatal and postnatal mental health (NICE 2014a) specifies that practitioners should recognise that some mothers might experience difficulties with the mother-baby relationship and requires that health professionals should assess the nature of this relationship at every postnatal contact (NICE 2014a, recommendation 1.9.12). It is expected that suitably qualified health professionals should be available to discuss any concerns the mother may have and consider further interventions to improve the mother-baby relationship if needed (NICE 2014a, recommendation 1.9.13).

As has been stated previously, health visitors are the only primary health care professional, with the appropriate skills and knowledge, who routinely see all mothers and babies between 6 weeks and 1 year after birth. Seventy-two percent of the additional economic burden imposed on society, as a result of failing to treat maternal mental ill-health appropriately, arises from the cost of dealing with the adverse consequences for the child (Bauer et al 2014). Assessing the impact of mental ill-health on the mother's capacity to interpret and respond to her child's needs must therefore be a fundamental component of a perinatal mental health pathway of care. For the mothers who do not need, or do not wish to access more specialist parent-infant mental health services, it is health visitors who have the knowledge, skills and opportunity to assess and nurture the mother-infant relationship.

In the full guideline, it is suggested that consideration of the practical demands of looking after a new baby are neglected because services prioritise "processes of assessment, monitoring, psychotherapeutic interventions and medication." (NCCMH 2014 p. 33). Whereas mental health professionals may not have the professional training and skills to be able to respond to maternity and childcare issues, health visitors can provide holistic, integrated packages of care that address the multiple needs of the mother and the health, growth, development and safety needs of the child. Health visitors should be aware of the many ways that maternal mental ill-health can impact on infant appearance and behaviour; infant growth and development; infant feeding and sleeping routines; clinic attendance; and childcare and safety practices (Stein et al 2014, Murray, Fearon and Cooper 2015, Balbierz et al 2015). At the same time, health visitors also know that there can be other reasons (besides maternal mental ill-health) that might have a bearing on these outcomes. Great sensitivity and skill is therefore needed to explore and understand the complexity of ideas, concerns and expectations that underpin maternal thoughts, feelings, actions, interactions and childcare practices and then to facilitate access to the most appropriate forms of help and support.

This is particularly relevant in the context of maternal mental ill-health when a mother may be feeling vulnerable, exhausted, isolated and depressed. Due to altered patterns of thinking (typical of mental illness) the mother may also harbour a belief that it is only a matter of time before someone else finds out that she is not the kind of mother she wanted to be. The fear of having the baby taken away is one of the main reasons why mothers do not want to risk sharing their feelings with others (Dennis and Chung-Lee 2006, Dolman et al 2013). In order to facilitate disclosure it is recommended that health professionals should “rectify women’s misplaced but understandable concerns that disclosure of a mental disorder may lead to their baby being taken into care” (Howard et al 2014, p.33). Health visitors have an opportunity to do this when they are sharing information about common mental health problems that may affect women in the perinatal period, or preparing women for a health visitor led maternal mental health assessment visit.

On the other hand, health professionals have to keep in mind that maternal symptoms of mental illness may indeed influence the way the mother feels about, cares for, and interacts with, her baby. In some cases, this maternal lack of capacity to provide sensitive, responsive care may lead to delays in development or manifestations of child abuse or neglect (Hogg 2013). Findings from serious case reviews have indicated that professionals dealing with parents with complex mental health issues can lose sight of a child’s needs (Brandon 2011). Whilst this is a difficult call for all health professionals, health visitors are accustomed to considering the health and safety of children whilst at the same time providing sensitive, responsive, non-judgemental support to mothers.

Discussion

It is regrettable that the national initiative to increase the number of health visitors by 50% between 2011 and 2015 (DoH 2011), in recognition of the vital importance of the early years, is now being undermined by existing and anticipated cuts in funding for public health (Unite the union/CPHVA 2016; Ford 2016; Stephenson 2016). The expectation was that the increase in numbers would reduce the size of health visiting caseloads and free up health visiting time to provide more intensive support for families who have been identified with additional needs (including those related to maternal and infant mental health). It is difficult to understand how the current erosion of health visitor numbers is compatible with the statement in the *NHS Five Year Forward View* ‘that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health’ (NHS England 2014b, p.3) and the Public Health England (PHE) priority to ensure that ‘every child has the best start in life’ (PHE 2016a).

Although health visitors may appear more expensive than, for example, early years workers in Children’s Centres or psychological well-being practitioners in ‘Improving Access to Psychological Therapy teams’ (IAPT), they represent added value because they can provide interventions that can concurrently address the emotional, social and physical health needs of all family members. Moreover, health visitors may be

the most appropriate health professionals to fulfil some of the newly added recommendations in the updated guideline such as providing new parents with “culturally relevant information on mental health problems” (recommendation 1.4.1, Nice 2014a) and monitoring women regularly “for symptoms throughout pregnancy and the postnatal period, particularly in the first few weeks after childbirth”(recommendation 1.4.8, Nice 2014a). However, It takes time and trust to explore maternal thoughts, feelings and relationships especially when variations in maternal perceptions and expectations might influence the readiness of women to divulge how they feel or engage in services.

One of the biggest barriers to reducing the impact of maternal mental ill-health on mothers and babies is the failure to identify mothers who would benefit from a therapeutic intervention (Khan 2015, Howard et al 2014). Given the assumption that “the large majority of women (over 90%) with mental health problems in pregnancy and the postnatal period are treated in primary care,” (NCCMH 2014, p.32) it is not clear which professionals in primary care will have the capacity to fulfil this expectation. If health visitors are not being commissioned to offer universal 6-8 week and 3-4 month assessments of maternal mental health then it is inevitable that less mothers will have their mental health needs identified and met (iHV 2015).

Assessment is not just a matter of asking a clutch of identification questions and then referring mothers, who say ‘yes’ to any of the questions, to another service. Comprehensive assessment involves the exploration of a much greater range of issues and symptom clusters, as well as consideration of the impact of maternal mental ill-health on other members of the family, especially the baby. When it comes to treatment, It is unlikely that the version of ‘facilitated self-help,’ advocated for women with sub-threshold symptoms or mild to moderate perinatal depression based on the intervention described in the NICE guideline for depression in adults, will address the impact of maternal depressive symptoms on all members of the family.

Another of the recommendations added to the updated guideline specifies that “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.”(NICE 2014a, recommendation 1.7.1). This means that although depression and anxiety might be the most common mental health problems likely to occur in the perinatal period, it is not sufficient just to know about these two conditions. It is worrying that in some areas there has been an assumption that if mental health assessment just involves asking a limited number of simple questions about depression and anxiety then anybody can ask them (unpublished health visitor survey 2016). The reality is that positive responses to these questions are just the tip of the iceberg in terms of assessing the aetiology, range, severity, duration and impact of symptoms.

Immediate referral of women who respond positively to the identification questions not only risks overwhelming follow on services thereby increasing waiting times and

delaying further assessment and treatment, but also fails to consider and address potential underlying causes of psychological distress. It takes time, knowledge, sensitivity and skill to undertake a comprehensive assessment of symptoms, need, resilience and risk. Primarily, it is vital that health visitors are funded to offer at least the designated minimum number of face-to-face contacts recommended by the universal healthy child programme (HCP) (DoH/DCSF 2009) but they must also be allocated sufficient time and capacity to build relationships, undertake maternal mental health assessments, provide support, and co-ordinate integrated care in collaboration with families and other services.

In order to share sensitive information mothers have to feel confident that the person that they are sharing the information with is consistent, knowledgeable and reliable. Although health visitors do already have many of the skills and qualities needed to work with families with children under 5, if they are to be effective in improving maternal mental health outcomes due regard must be given to recommendation 1.7.2 of the NICE guideline with respect to competency, efficacy, outcomes and supervision. All health visitors must not only have access to evidence-based training and regular updates, they must also have opportunities for observing the practice of others, reflection and supervision. Systems must be in place to regularly assess health visitor competence in delivering effective and acceptable interventions as well as regular audits of outcome measures that measure impact and satisfaction as well as the number of women who have been offered a specific maternal mental health assessment.

It is to be hoped that the identification of perinatal mental health as a government priority (Public Health England 2016a, 2016b) and the commitment to increase funding and improve services over the next five years will specify how some of that funding will be allocated to support the work of health visitors, who are likely to be one of the first points of contact between mothers and health services. The concern is that whilst investment in specialist community services and in-patient care is to be applauded, the failure to specifically mention the importance of continuing to fund front-line services means that commissioners may not appreciate, and therefore fund, the very important contribution that health visitors make to the perinatal mental health pathway of care.

The government report *'Future in Mind'* identified prevention and early identification as a key priority in the quest to reduce the number of children and young people experiencing mental health problems (DoH 2015). A fundamental premise of early intervention is the understanding that "the later we wait to support families with children who are at greatest risk, the more difficult (and more costly) it will be to achieve positive outcomes" (Center on the Developing Child 2016, p.5). However, it is not clear whether funding the important work that health visitors do in identifying and supporting mothers with mental health problems has been included in the budget allocation for early intervention services to reduce child and adolescent mental ill-health. This is despite the fact that the majority of the estimated cost of perinatal mental health problems is a consequence of the adverse

impact of maternal mental ill-health on the child's future health and well-being (Bauer et al 2014).

Conclusions

The focus of the updated NICE guideline (2014a) on specific symptoms and diagnoses does not adequately acknowledge the challenges inherent in providing a continuum of perinatal mental health care that is responsive to the multiple and dynamic aspects of health, need and risk for all the family. Despite the fact that 'listening visits' have been excluded from the updated guideline, this article has demonstrated that health visitors have a key role to play in the prevention, assessment and management of maternal mental health problems during pregnancy and the first postnatal year.

The health visiting profession has acknowledged that a range of models and techniques can be used to support mothers with mental health problems (Day 2014, iHV 2014). This may be because the help that health visitors provide to address mental health issues is delivered across a continuum of need and may be blended in with other aspects of support. Rather than waiting until symptoms fulfil diagnostic criteria in order to trigger an intervention, health visitors are often able to identify and ameliorate the factors that might contribute to mental illness, or offer support to mothers who are experiencing stress or psychological distress before a diagnostic threshold is reached. Unlike many other professions and services, access to health visiting support is not based on 'caseness' so health visitors are available to support women and their families before, during, after, or instead of, mental health care from other services.

If health visitors are allowed to fulfil their remit to provide a minimum number of contacts to all families and are funded, trained and supported to provide additional help to those families who need it, they are ideally placed to co-ordinate an integrated, family-oriented programme of perinatal mental health prevention, promotion and care. Whilst the debate continues about the format and content of a health visitor led therapeutic intervention for mild to moderate maternal depression or anxiety, it is clear that health visitors have the potential to help to deliver many of the recommendations included in the updated NICE guideline for antenatal and postnatal mental health.

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