

© 2016. This manuscript version is made available under the CC-BY-NC-ND 4.0 license <http://creativecommons.org/licenses/by-nc-nd/4.0/>

Please note this manuscript is a pre-submission version of a paper published in the Journal of Health Visiting

It should be cited as:

Cummings, E., Whittaker, K. (2016) An exploration into the experiences of health visitors delivering listening visits to women as an intervention for mild to moderate postnatal depression or anxiety. *Journal of Health Visiting*. 4(5): 264-270. DOI: <http://dx.doi.org/10.12968/johv.2016.4.5.264>

Published Online: May 16, 2016

Title:

An exploration into the experiences of health visitors delivering listening visits to women as an intervention for mild to moderate postnatal depression or anxiety.

Authors:

Emma Cummings: Health Visitor Lancashire Care NHS Foundation Trust and CLAHRC internship student at University of Central Lancashire.

Dr Karen Whittaker: Senior Lecturer, College of Health and Wellbeing, University of Central Lancashire.

Correspondence: kwhittaker1@uclan.ac.uk

An exploration into the experiences of health visitors delivering listening visits to women as an intervention for mild to moderate postnatal depression or anxiety.

Abstract

Background

This study explored the experiences of health visitors carrying out listening visits, an intervention used to support women suffering from mild to moderate depression and anxiety in the postnatal period.

Methods

Thirty three health visitors from one single trust were surveyed using an online questionnaire. Follow up interviews were also carried out. Quantitative data from the questionnaires was analysed using descriptive statistics, answers to semi-structured questions within the survey were analysed using content analysis. Interview recordings were transcribed verbatim and analysed using the constant comparative method.

Results

The health visitors participating in this study value this widely used intervention but report that training in the use of therapeutic tools and wider knowledge of mental disorders would improve delivery. Health visitors identified that they carry out a range of responsive activities during a listening visit, including, but not exclusively, non-directive listening. They focus on the whole family, supporting women to deal with complex bio-psycho-social issues. Concern is raised around health visitors supporting women whose needs have escalated beyond the scope of listening visits due to lengthy waiting lists for mental health services. They raise concerns about whether they are equipped to deal with such needs and suggest that preparation of the workforce in the use of therapeutic tools and wider knowledge of mental disorders would improve delivery.

Conclusion

Listening visits are valued by health visitors who report positive feedback from mothers. In order for health visitors to deliver this intervention effectively, they require appropriate training and supervision. Set standards may also support more effective outcome measuring.

Key words (up to 8)

Perinatal Mental Health, Listening Visits, Health Visitors, Training

Key Points

- **Perinatal mental illnesses are widespread life limiting conditions that are associated with great costs to mothers, families and the wider society.**
- **Listening visits are widely used by health visitors who value this intervention.**
- **Health Visitors with the appropriate skills can intervene early and provide essential support for families**
- **In order to provide an effective intervention, the workforce needs to be properly prepared and supported.**

Background

This paper reports a mixed methods research study exploring health visitor's experiences of providing listening visits as a means of supporting women with mild to moderate post-natal depression. In discussing the findings consideration will be given to current health visiting practice, workforce preparation and support for staff who are providing this intervention.

Perinatal mental illnesses affect between 10-20% of women during pregnancy and for the first year after delivery, translating to 144,000 babies under 1 year old living with a parent who has a mental health condition (Hogg, 2011). Suicide is one of the most common causes of maternal death in the first year post delivery in the developed world (World Health Organisation, 2013). These figures are alarming not least because of the resulting human distress, but also due to financial costs. Perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK; equivalent to around £10,000 per birth (Centre for Mental Health, 2014). In light of these issues, the Department of Health (DH) (2014) have included perinatal mental health as one of their six early year's high impact areas (see fig 1).

Health visitors routinely screen all mothers at key points during the perinatal period to identify changes in mood as per The Healthy Child Programme (DH, 2009), a public health plan with early intervention and prevention at its core. A service care model informed by progressive universalism principles, which support the provision of universal services that can be escalated to accommodate increasing need, enables health visitors to assess families and provide support under four categories. These are: 'Community', 'Universal' (offered to every family), 'Universal Plus' (additional support) or 'Universal Partnership Plus' (intensive support) (see fig 1). Postnatal mental health is the main reason for women accessing Universal Plus services in the UK (Department of Health (DH), 2009;

Cowley et al, 2013). Screening at five key contacts which are; antenatal contact, new baby visit, 6-8 week review, 8-12 month review and 2 year review (see fig 1) allows for early identification of a perinatal mental health problem. Upon identification, early support can be initiated; referral to appropriate professionals and supporting sensitive parenting and development in the infants first critical 1001 days (Leadsom et al, 2013) can reduce toxic stress and promote infant mental health (Garner, 2013). These early interventions may help to prevent attachment issues and their associated short and long term problems; poor cognition, delayed language development (Grace et al, 2003), mental illness, anti-social behaviour and poor physical health result in costs to the individual, the public sector and society as a whole (Centre for Mental Health, 2014).

Fig 1. *The 4-5-6 model of health visiting (Institute of Health Visiting, 2015) describes the national health visiting offer to families and provides a framework for the service.*

4 Level service model	5 Universal contacts	6 High Impact Areas
• Your community	• Antenatal health promoting visits	• Transition to parenthood and the early weeks
• Universal	• New baby review	• Maternal (perinatal) mental health
• Universal Plus	• 6-8 week assessment	• Breastfeeding
• Universal Partnership	• 1 year assessment	• Healthy weight, (healthy diet and being active)
	• 2 to 2 1/2 year review	• Managing minor illnesses & reducing accidents
		• Health, wellbeing & development at 2 years & support to be 'ready for school'

Where an assessment of mood indicates mild to moderate depression and/or anxiety, listening visits may be offered. National Institute for Health and Care Excellence (NICE) (2014) describe listening visits as a preventative, psychosocial intervention, based upon Rogers (1957) non-directive counselling theory, for the prevention of mental health problems. The guideline states that healthcare professionals delivering listening visits are '*trained to help clients gain a better understanding of their circumstances and themselves*'. This assumption that health visitors are specifically trained in this intervention may not always be reflected in practice. The evidence base for this intervention is limited but existing studies (Clement, 1995; Holden, Sagovsky and Cox, 1989; Shakespeare and Blake, 2006; Turner, Chew, Graham, Folkes, Sharp, 2010; Segre, Stasik, O'Hara, Arndt, 2010) have shown that health visitor led listening visits can be helpful in promoting recovery. Some studies have emphasised links between structured approaches to listening visits, where health visitors are trained in the use of specific therapeutic tools, and positive outcomes for women. For example, cognitive behavioural type therapies and counselling skills have been identified as useful tools to aid the delivery of listening visits (Yongmei et al. 2014; Ammerman et al. 2011; Brugha et al 2011; Morrell et al 2009; Slade, et al. 2010; Appleby et al. 2003, Holden, Sagovsky, Cox, 1989). Holden et al (1989) examined the efficacy of listening visits carried out by health visitors who were briefly trained in counselling skills. In a study by Turner et al (2009) women's experiences of listening visits were based upon those carried out by health visitors who received formal training from a clinical psychologist. Segre et al (2010) based their evidence on US home visitors who attended specific listening visits workshops. However, not all health visitors have specific training in the use of a therapeutic approach and so findings from previous studies may not fully reflect the potential value of listening visits in practice.

Nursing and Midwifery Council (NMC) Standards for Proficiency for SCPHN (NMC, 2004) set out the requirement for all practising Health Visitors to develop and expand their knowledge post-registration. In addition, the National Health Visiting Core Service Specification for Health Visitors 2015/16' (NHS England, 2014) requires providers to promote a workforce development plan based upon the learning needs analysis of the existing workforce. This will ensure the workforce is able to deliver the full service specification. Of particular interest is that of Early Years High Impact Area 2 – Maternal (Perinatal) Mental Health (DH, 2014) (see fig. 1). It is suggested that professional mobilisation will need to take place to ensure; effective identification of perinatal mental health issues, holistic integrated working, implemented perinatal mental health pathway's and recommends that CBT trained staff should be in place. The Institute of Health Visiting (iHV) (2015) have developed a framework for continuing professional development providing a set of standards for the commissioning of education and development for health visitors. The national standards

cover four key areas; working therapeutically to effect change with children and families, maintaining and developing prescribing practice, providing and developing intelligence to inform the Joint Strategic Needs Assessment Process and working in partnership with families and communities to build capacity and resilience. The first of these professional areas is particularly pertinent to the health visitor's role in supporting women with perinatal mental health issues. The iHV reports that in order for health visitors to confidently and effectively engage with their communities, they must continue to develop their skills around relationship building. It also suggests that health visitors should be trained in a strengths-based and solution-focused approach. As well as developing skills, it is thought that supporting health visitors through continuing professional development and supervision will build resilience (iHV, 2015). These efforts could also go some way towards helping health visitors keep in touch with their professional values and motives for practice; elements that have a crucial role to play in supporting workforce retention (Whittaker et al 2015).

Study Methods

This research was designed as a mixed methods study for breadth and depth.

Data Collection

A questionnaire consisting of 12 open and closed questions, designed to extract demographics such as; length of service, previous registration and training undertaken was emailed to all health visitors across the trust. The email also included an invitation to take part in an interview. Semi-structured follow up interviews were carried out in the following weeks to gain more qualitative insights into the role of the health visitor and their lived experiences. This provided a convenience sample with 33 health visitors completing the questionnaire and 3 health visitors taking part in interviews.

Ethical considerations

Permissions to proceed were gained through the Local NHS trust using the Integrated Research Application System (IRAS) and the University of Central Lancashire. It was made clear at the introduction to the research project and through study information sheets, that health visitors were under no obligation to participate in the research and that any data collected would be anonymised. Consent was implied by health visitors if they completed the online survey, but if they participated in an interview a consent form was signed. Access to a study information sheet was available to read in advance of participation.

Data Analysis

Quantitative data was analysed using SPSS to produce descriptive statistics. Answers to open questions within the survey were analysed using content analysis. Interview recordings were transcribed verbatim. The qualitative data analysis programme, NVivo 10[®], was used to support the constant comparative method, to identify patterns and relationships within the data. Open codes were created for each interview, and then clustered to each other in order to create broader categories. These categories were then grouped to develop themes.

Results

The following data derived from the questionnaire responses of 33 health visitors and the transcripts of three interviews. The respondents ranged from student health visitors to those with over 10 years of experience. Several themes emerged from the data which are discussed below and illustrated using excerpts from the interviews.

Supporting women with perinatal mental illness

During the month of August 2014, 56 women were receiving listening visits, carried out by the 33 respondents with a reported average of four visits delivered to each woman. Health visitors reported; patient need, severity of mental illness, resolving symptoms, available social support, and mothers coping mechanisms to be the factors effecting their decision making around the number of listening visits they offered to mothers. It was found that listening visits are offered both as a means to preventing referral into mental health services and to bridge a gap in service provision whilst awaiting mental health referral. Workload capacity, perceived benefit and local pathway/policy also impacted on decision making when offering listening visits.

A number of bio-psycho-social issues were identified as factors impacting upon a woman's mood in the post-natal period. Historic and present abuse, forced marriage, family members drug use, perceived pressure from family members and managing others expectations were issues health visitors discussed as being problematic for post-natal women. Health visitors also report that, if a woman requests, they may carry out a breastfeeding assessment at a listening visit.

When asked how they describe listening visits, respondents explain that listening visits are an opportunity to offer an early intervention for women, supporting and guiding through a range of activities. One health visitor discusses how she would describe a listening visit to a mother.

'To a mum, I'd say, I'll come to support you with how you're feeling and it's your opportunity to talk to me as an outsider...you might want to talk things through you that feel you can't with your family. I'm there to guide and support you. (Interview 2)

Another health visitor reports;

'Listening visits help a mother towards recovery and health visitors have the opportunity to provide early effective interventions' (survey no. 33)

It was found that weekly listening visits in the family home provide an opportunity for health visitors to continually assess any changes in the woman's presentation along with ongoing assessment of family dynamics. It was explained that building a therapeutic relationship can support ongoing assessment, particularly where parents fear the disclosure of mental illness may result in them losing their children. Health visitors describe the use of open conversation to be as important as the use of formal assessment tools in helping a woman disclose their thoughts and feelings.

'I don't use the formal assessment tool every week, I don't think there's much point in that. If you're clever you know what to tick.' (Interview 3)

'I think if you manage to develop a rapport with a mother and develop that relationship, I think you can be quite beneficial. And it's allowing them to offload without feeling threatened or guilty or fear the baby being taken off them' (Interview 2).

A very large proportion of participating health visitors (90%, n=27) were trained in The Solihull Approach (Solihull Approach, 2015). Some referred to the use of containment as a basis for their visits in supporting mothers and babies. Health visitors identified confidence building as an important component of listening visits and noted that they would offer explanations regarding infant brain development to mothers as a means of promoting sensitive parenting.

Workforce preparation

Confidence

It was found that 88% (n=29) of the respondents value the role of listening visits in supporting the recovery of women with postnatal anxiety and depression. 76% (n=25) of respondents reported feeling confident in their delivery of listening visits. Confidence was linked to experience and receipt of specialist training. Positive comments from mothers were also reported to build confidence.

'Having knowledge of simple CBT techniques and years of experience working with mothers with PND' (Survey no. 18)

'It is the positive comments from clients that has increased my confidence in the delivery of listening visits' (Survey no. 9).

Health visitors reported concerns regarding their role in the management of risk. For many, dealing with severe mental illnesses resulted in them feeling 'out of their depth'. Some health visitors feel they are bridging a gap in services with limited training or experience of managing risk in severe mental illness.

'I think it's scary working with people who self-harm because you don't want to stop seeing them in case something bad happens...it's that managing risk thing. (Interview 3)

'Listening visits are aimed as a brief intervention but for some clients a longer period is required...due to lengthy waiting lists [for mental health input] (I) sometimes can feel inadequately prepared for listening visits'. (Survey no. 11)

'I feel that Psychological Wellbeing Practitioners are best placed to deliver this, unfortunately there is a long wait'. (Survey no.1)

Training

Health visitors mainly responded that they found training helpful in their role as listeners and would welcome more specific training to enhance their skills toolbox. Training was related to increased confidence in practitioners and greater numbers of listening visits being offered. Respondents were asked if they had received any specific training to support their delivery of listening visits. Over 80% (n=27) of health visitors report that they have received some training to support their work with perinatal mental illness; but, health visitors do not always feel the training they have received adequately prepares them for listening visits.

'I have had Solihull training however I feel this has limited use in listening visits and CBT strategies would be of more use' (Survey no 6)

'I don't feel the level of training I have had prepares me to deliver these visits'. (Survey no. 19)

'(Health visitors) need more information on different conditions'. (Survey no. 20)

Only 30% (n=10) felt their health visitor training course provided them with sufficient learning opportunities around maternal mental health.

'We discussed postnatal depression (at university) but then again, listening visits aren't all about depression'. (Interview 1)

Practitioners who had received specific training felt they were able to offer an enhanced service to clients.

'I have been fortunate to have additional training and I feel having a choice of approaches to use as brief, early intervention is beneficial, as one approach may not always suit each client'. (Survey no. 33)

Training in Cognitive Behavioural Therapy was suggested by (n=11) of the participants who felt it would offer some structure to their visits and better support women.

'Would be good to have some basic CBT training' (Survey no. 3)

Supporting Staff

Only half of the health visitors surveyed felt they had appropriate support mechanisms in place to support them in their work with women suffering from perinatal mental illness. Health visitors do not report receiving any specific supervision for this particular intervention. It was felt that group supervision may not be an appropriate place to discuss personal issues or triggers raised during listening visits. A quarter of health visitors report using peer support but there are reports that perceived increased work related pressures are forming a threat to this form of support. Some participants report that they gain support from the wider multi-disciplinary team. It was felt that improved communication with mental health services would also be beneficial.

'This job can be extremely emotionally draining at times and if I'm feeling low my ability to support others is affected'. (Survey no. 4)

Health visitors report that it is difficult to measure the outcomes of listening visits and report that a lack of set standards makes it difficult to evaluate the quality of this intervention. Insufficient evidence to support practice is also discussed.

*'Not sure how effective they are, sometimes people just want to talk but how effective it is in helping depression or low mood is debatable and it's not been researched enough'
(respondent no 31)*

'I've been qualified nearly 15 years now so my listening visits will be different to somebody else's as there's no set standards, there's not been any training or anything its each individuals interpretation.... It's difficult to measure the outcome of your visits' (Interview 2)

Issues of time and capacity were raised in relation to ability to deliver quality visits.

'I feel it is an important part of the health visitor's role which needs appropriate time allocated'. (Survey no. 30)

'I am increasingly concerned that increasing workload and spending most of my time on the computer will affect the quality of my visits'. (Survey no. 3)

'Heavy workload prevents opportunity to deliver as many visits as I would like'. (Survey no. 3)

Discussion

Health visitors involved in this study have been found to value the use of listening visits in that they allow ongoing assessment of mothers, babies and the wider family allowing prompt referral to specialist services should a woman's presentation change. Health visitors explained that during a listening visit, they carry out a number of activities which are both directive and non-directive, to prevent, identify and treat postnatal mental illness. The visits are led by the needs of the mother and the health visitor works responsively to guide and support with a focus on mother, baby and the wider family. Activities described by health visitors can help to encourage sensitive parenting and offer containment.

Listening visits are intended as an early intervention to prevent decline in perinatal mental health, however, due to extensive waiting lists for specialist services, health visitors report that they are offering listening visits to women with more severe and enduring mental illness whilst they await referral; resulting in health visitors feeling 'out of their depth'. The need for more training in risk management and wider knowledge of mental illnesses outside of depression and anxiety are apparent. It is assumed that health visitors are 'trained to help clients gain a better understanding of their circumstances and themselves' (NICE 2014). In this study, a proportion of health visitors feel they require more specialist training and an increased knowledge base to enable them to deliver this intervention effectively. A quarter of respondents suggested training in CBT as an aid to support their visits. There is growing evidence that psychologically informed interventions such as CBT, delivered by health visitors, can be effective in decreasing depression in new mothers (Morell et al, 2009). NICE (2007) states, 'in meeting the mental health needs of women in the perinatal period, services should seek to provide the most effective and accessible treatments'. Upskilling health visitors to deliver psychologically informed therapies could lead to increased accessibility, more timely interventions and would give the health visitor increased structure to their listening visits (Ammerman, Putnam, Stevens, Bosse, Short, Bodley and Van Ginkel, 2010).

It was found that health visitors find it difficult to measure the outcomes of listening visits and that a lack of set standards makes it difficult to evaluate the quality of this intervention. It is suggested by

NICE (2014) that practitioners delivering psychosocial interventions for maternal mental health should routinely use outcome measures to ensure efficacy of treatment. This would also improve equity of service. Practitioners should be able to access regular high-quality supervision (NICE, 2014) but this has been highlighted as a gap in practice.

Conclusion

Perinatal mental illnesses are life limiting and are associated with great costs to mothers families and the wider society. This study found listening visits to be a commonly used intervention that is valued by health visitors and anecdotally well received by the women who accept them. Health visitors need to be skilled in order to allow conversation to be led by the mother's needs, but must also be able to know when to direct and advise due to the complex array of issues that arise during a visit. The activities that ensue are diverse, person centred and with a focus on mother and baby. Health visitors are in a prime position to be able to offer early interventions to prevent illness and support recovery, with an ultimate aim of reducing negative impact on women, children, families and the wider society. Health visitors, through their listening visits with mothers clearly demonstrate their role in prevention, identification and treatment of mental illness. Therefore, every health visitor should feel confident and properly equipped to deliver this intervention to effect a wide-reaching positive impact.

Health visitors report that more specialist training in the use of therapeutic tools would enhance the service they offer to women. Continuing professional development in this area would build upon the existing knowledge base to ensure that health visitors can effectively identify and support women with perinatal mental health conditions. NICE (2014) guidelines assume health visitors to be trained in non-directive counselling skills, however, in practice, this may not always be the case.

Concern is raised around onward referrals and health visitors report that long waiting times for mental health services mean they are continuing to support women whose needs have escalated beyond the scope of a listening visit. Health visitors require adequate supervision to ensure their wellbeing and to enable them to continue to offer effective listening visits to women.

Suggestions for further research

Further research around the effects of health visitor interventions to support perinatal mental health would add to the existing knowledge base.

References

Annerman, R.T., Putnam, F. W., Stevens, J. Bosse, N.R., Short, J.A., Bodley, A.L., Van Ginkel, J.B. (2011) An open trial of in home CBT for depressed mothers in home visitation. *Journal of Maternal Child Health*. 15, 1333-1341.

Appleby, L, Hirst, E, Marshall, S, Keeling, F, Briand, J, Butterworth, T, Lole, J (2003) The treatment of postnatal depression by health visitors: Impact of brief training on skills and clinical practice. *Journal of Affective Disorders*. 77 (2003) 261-266.

Bowlby, J. (1969). *Attachment and loss: Volume 1. Attachment*, New York: Basic Books

Brugha, TS, Morrell, GJ, Slade, P, Walters SJ (2011) Universal prevention of depression in women postnatally: cluster randomized trial evidence in primary care. *Psychol Med*. 2011 Apr; 41(4): 739–748. doi: 10.1017/S0033291710001467 PMID: PMC3042795

Centre for Mental Health and London School of Economics (2014). *The Cost of Perinatal Mental Health Problems*.

Centre for Mental Health. (2015) *Investing in children's mental health. A review on the costs and benefits of increased service provision*. London Centre for Mental Health

Clement S. (1995) 'Listening visits' in pregnancy: a strategy for preventing postnatal depression? *Midwifery*. (2):75-80.

Cowley, S. (2015). *Mental health: Therapeutic Prevention*. *Journal of Health Visiting*, Vol. 3, Iss. 1, 21 pp 58

Cowley S., Whittaker K.A., Grigulis A., Malone M., Donetto S., Wood H., Morrow E., Maben J. (2013). *Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families*. Department of Health Policy Research Programme. King's College, London, National Nursing Research Unit.

Department of Health (2014) *Commissioning of public health services for children Early Years High Impact Area 2 – Maternal (Perinatal) Mental Health*.

<https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children>

Department of Health. (2009). *Healthy Child Programme: pregnancy and the first five years of life*. London: DH

Garner, A. S. (2013). Home Visiting and the Biology of Toxic Stress: Opportunities to Address Early Childhood Adversity. *Pediatrics*, 132, Supplement 2, S65-S73.

Grace, S.L. Evindar, A. Stewart, D.E. (2003) The effect of postpartum depression on child cognitive development and behaviour: A review and critical analysis of the literature.

Arch.Women.Ment.Health 6(4):263-74.

Hogg, S. (2013). All Babies Count: Spotlight on Perinatal Mental Health. NSPCC.

Holden, J. M., Sagovsky, R. & Cox, J. L. (1989) Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. British Medical Journal, 298, 223–226

Institute of Health Visiting (2015) A National Framework for Continuing Professional Development for Health Visitors - Standards to support professional practice. iHV

Institute of Health Visiting (2015) 4-5-6 Model for Health Visiting
www.ihv.org.uk/uploads/iHV_A5_456_model_V7_WEB.pdf

Joint Commissioning Panel for Mental Health. (2012). Guidance for commissioners of perinatal mental health services. Joint Commissioning Panel.

Leadsom, A., Field F., Burstow, P., Lucas C. (2013). The 1001 Critical Days: The importance of the conception to age two period. www.andrealeadsom.com/downloads/1001cdmanifesto.pdf

Morrell, C.J., Warner, R., Slade, P., Dixon, S., Walters, S., Paley, G., Brugha, T. (2009)

Psychological interventions for postnatal depression: cluster randomised trial and economic evaluation. The PoNDER trial. Health Technology Assessment. Vol. 13: No. 30 DOI: 10.3310/hta13300

National Institute for Health and Clinical Excellence. (2007). CG45 Antenatal and Postnatal Mental Health. London: NICE.

National Institute for Health and Care Excellence (2014) Antenatal and postnatal mental health: clinical management and service guidance. NICE guidelines [CG192] London:NICE

NHS England (2014) National Health Visiting Core Service Specification 2015/2016. Available at:bit.ly/1qDcEWe (accessed 11.1.15).

Nursing and Midwifery Council (2004) Standards of proficiency for specialist community public health. Available from:bit.ly/150PzDa

Public Health England, NHS England, Health Education England and Early Intervention Foundation (2014) Early Years High Impact Area 2 – Maternal (Perinatal) Mental Health. DH

Rogers, C. R. (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.

Segre, L. S., Stasik, S.M., O'Hara, M.W., Arndt, S. (2010). Listening visits, an evaluation of the effectiveness and acceptability of a home-based depression treatment. *Psychotherapy Research*. 20 (6), 712-721

Shakespeare, J. Blake, F. (2006). How do women with postnatal depression experience listening visits in primary care? A qualitative interview study. *Journal of reproductive and infant psychology*.24 (2) 149-162.

Slade P, Morrell CJ, Rigby A, (2010) Postnatal women's experiences of management of depressive symptoms: a qualitative study. *Br J Gen Pract*. 2010 DOI: 10.3399/bjgp10X532611

Solihull Approach (2015) <http://www.solihullapproachparenting.com/> [accessed 5/10/2015]

Turner KM, Chew-Graham C, Folkes L, Sharp D. (2009) Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: a qualitative study. *Patient Educ Couns*. 2010 Feb;78(2):234-9. doi: 10.1016/j.pec.2009.05.022. Epub 2009 Jul 1.

Turner, K.M., Chew-Graham, C., Folkes, L. Sharp, D. (2010). Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: A qualitative study. *Patient Education and Counselling*, 78, 234-239.

Whittaker, K. A., Malone, M., Cowley, S., Grigulis, A., Nicholson, C., & Maben, J. (2015). Making a difference for children and families: an appreciative inquiry of health visitor values and why they start and stay in post. *Health & Social Care in the Community*, DOI: 10.1111/hsc.12307

World Health Organization. (2013, June). Maternal mental health. Retrieved 2013, from [www.who.int: http://www.who.int/mental_health/prevention/suicide/MaternalMH/en](http://www.who.int/mental_health/prevention/suicide/MaternalMH/en)

Yongmei Hou,¹ Peicheng Hu,² Yongmei Zhang,³ Qiaoyun Lu,¹ Dandan Wang,¹ Ling Yin,¹ Yaoqi Chen,¹ Xiaobo Zou⁴ (2014) Cognitive behavioral therapy in combination with systemic family therapy improves mild to moderate postpartum depression. *Revista Brasileira de Psiquiatria*. 2014;36:47–52 2014 Associação Brasileira de Psiquiatria doi:10.1590/1516-4446-2013-1170