Mental health: Therapeutic prevention

NICE has missed an opportunity to reinforce health visitors' ability to prevent problems while offering effective low-level interventions, says Professor Dame Sarah Cowley.

Health visiting starts from a position of health. That is not to dismiss the importance of disease or pathology—but it is to acknowledge that suffering, distress and risks to health come from multiple sources, of which a diagnosed disorder is only one. One of my earliest academic papers (Cowley, 1995) aimed to illuminate the processes involved in health visiting practice. It explained the intricacies of working with situations that featured both suffering and risk. The situations were deemed complex, because they involved more than one family member and more than one difficulty—for example, a crying baby affects the whole family, not just the infant.

Sometimes the suffering might be 'normal distress', in that it would be expected (the pain of bereavement, for example) or may stem from a mismatch between what is expected and what is experienced. Many mental health problems in pregnancy and postnatally are experienced as unexpected, as well as having multiple causes and effects. 'Risk' also occurs in two forms in these complex situations. First, the risk may be hidden, waiting to be identified—perhaps an infant's feeding problems stem from undiagnosed maternal depression, for example—so it can be formally diagnosed and treated. Alternatively, risks within a situation may cause a health problem, unless they can be ameliorated. The new National Institute for Health and Care Excellence (NICE, 2014) guideline on antenatal and postnatal mental health lists matters such as housing, history of mental health problems, domestic violence and abuse and other factors that might predispose a woman to developing a mental health problem.

The challenge for health visiting is to demonstrate the profession's worth in preventing a difficulty from arising, as well as identifying or treating it. Simply counting the number of diagnoses (e.g. the number of women identified with postnatal depression) fails to acknowledge the valuable work of prevention where risk has been identified and problems averted. My work (Cowley, 1995: 281) described how health visitors traditionally recognised the importance of 'offering human compassion and concern, perhaps aiming to give time, to listen or be with the person on their own terms'—activities based in mutual trust and relationships developed through routine home visiting. The aim was described as both therapeutic and preventive: to 'hold' the situation and avoid either deterioration or premature labelling, while potentially identifying other, contributory issues of concern that might be targeted for preventive purposes. The term 'therapeutic prevention' was coined to describe this complex and distinctive form of health visiting practice, which initially seemed impossible to research.

Morrell et al's (2009) intervention trial demonstrated the effectiveness of health visitors trained in psychological support and supportive listening visits—a form of 'low-intensity intervention' (NICE, 2014: 36). This intervention benefited women with an Edinburgh Postnatal Depression Scale score above 12. Further analysis of the data (Brugha et al, 2010) showed that women scoring below the threshold score at 6 weeks postnatally, were significantly less likely to develop depressive symptoms by 6 months, where their health visitors had this specific psychological training. This is therapeutic prevention set within in a rigorous, modern research frame, related to one particular matter of concern—antenatal and postnatal mental health. Unfortunately, the new NICE guideline mentions neither listening visits nor much in the way of prevention. The document has a lot to recommend it, but is clearly dominated by the starting point of treating established disease. Prevention is afforded far less attention, except to recognise that early contact may facilitate diagnosis. Perhaps health visitors need to shout louder about their ability to combine therapy and prevention, which must surely be more cost-effective than identification and referral to expensive hospital care? JHV

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