



The Children and Young People's Mental Health Coalition (CYPMHC) is a unified campaigning voice aiming for policy change at the highest level. We have prioritised four key areas of focus and this policy briefing comes under The Early Years. The briefing presents one of our policy recommendations, the particular problem it is seeking to address and the evidence supporting our recommendation.

What are we asking?

To re-establish health visitors as trusted support figures for parents and children.

What is the problem?

1. Most parents want to do the best they can for their child, but find this very difficult, especially when there is an interplay of factors including poverty, mental ill health including post-natal depression, addiction and violence in the family.
2. Health visitors can be seen by some parents as being 'agents of the state' who cannot be trusted. They fear that having an open and honest discussion about their difficulties will result in their child being taken into care.
3. Health visitors need more training on building relationships with families, children's mental and emotional development and the importance of secure attachment.
4. Shortages of health visitors.

We welcome the Government's recent pledge to increase the number of health visitors by 4,200. However, for existing and new health visitors to have the most positive impact on the lives of infants and families they must be capable of supporting their mental health and wellbeing.

Action points

1. The Government should establish the promotion of infant and family mental health as a key priority for health visitors. This should be reflected in new infant and family outcome measures for health visitors, drawn up with the help of families.
2. Health visitors need training to help them build a trusting relationship with families and overcome the stigma surrounding their role. This requires continuity of care and manageable caseloads. The Government should establish an information and communication programme to clarify and confirm the role of health visitors as trusted support figures for families, to overcome their image as purely 'child protection agents of the state'.
3. Health visitors also need training in children's mental and emotional development and an understanding of attachment and know how to promote it, to ensure they can best meet the needs of infants and families; they should also be enabled to lead and deliver evidence-based services to families themselves.
4. Health visitors should work as part of an integrated team with other professionals working with families, including midwives, community and public health nurses, voluntary sector organisations, Family Nurse Partnerships, as well as mental health practitioners. This team will need to work with other professionals such as the perinatal and infant mental health team to ensure that families who have more significant problems are referred on.
5. The proposed Outcomes Framework for the NHS and the forthcoming framework for the Public Health Service need to cover infant and family mental health, citing the role that health visitors can play.

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The Children and Young People's Mental Health Coalition (CYPMHC) brings together leading children and young people and mental health charities to campaign with and on behalf of children and young people in relation to their mental health and wellbeing. With a unified voice, the CYPMHC aims to achieve policy changes at the highest level that will directly improve the mental health and wellbeing of children and young people across the UK. This is necessary because at any one time, one in ten children and young people have a diagnosed mental health problem and it is now well established that the antecedents of most adolescent and adult mental illness are in childhood. Addressing issues early will ensure better outcomes for individuals and for society.

The CYPMHC's 4 key areas of focus are:

- **The Early Years** – To have greater emphasis on the psychological aspects of parenting and providing parents/care givers with the knowledge and tools to improve their own and their children's mental health and wellbeing.
- **Building Emotional Resilience** – To support all children and young people to meet the challenges of growing up by equipping them with self-awareness and emotional resilience to achieve good mental health.
- **Reaching Adulthood** – To achieve greater recognition that development to adulthood continues to the mid-twenties and demands a responsive and flexible approach across all areas of health and social policy and practice.
- **Seldom Heard Voices** – To give all children and young people timely access to good quality mental health and well being support, with effective outcomes, regardless of their ethnicity, gender, sexual preference, disability or other personal experience.

What is the evidence for the problem?

1. Many parents want to do the best they can for their child, but find this very difficult, especially when there is an interplay of factors including poverty, mental ill health including post-natal depression, addiction and violence in the family.

Child development starts before birth, so the health and wellbeing of the mother and the wider family can impact on the baby before it is even born. Babies' early experiences and the relationships they form are known to have a long term impact on their brain development and mental health (Center on the Developing Child at Harvard University, 2010). Babies need to form secure attachment with their main carers. This develops best when caring adults respond in warm, stimulating and consistent ways. Secure attachment has been shown to be important in developing empathy, trust and wellbeing (Allen & Duncan Smith, 2009).

In contrast, when the environment is impoverished, neglectful, or abusive, children risk not developing empathy, nor learning how to regulate their emotions nor developing social skills (insecure attachment). This can lead to an increased risk of mental health problems, conduct disorder, aggression, anti-social behaviour and crime. This is a significant threat as about 40% of children are not securely attached (Van Ijzendoorn et al, 1992). Other studies have found that in middle-class families about 15% of children develop attachment problems, but this is likely to be twice or three times higher in more vulnerable families (Van Ijzendoorn et al, 1999).

The 2009/10 Children's Services Mapping exercise (Children's Services Mapping, 2010) covered perinatal and infant mental health (PIMH) services for the first time. With regard to infant mental health provision, they found that there is still a great deal of variability in the number of services that provide targeted infant mental health interventions. For instance 31 relevant services in the North West and 60 in London reported that they provided targeted infant mental health interventions, compared to only five relevant services in East Midlands. The type of service they provide is quite broad, but the most common intervention is 'early years and health visiting'.

2. Health visitors can be seen by some parents as being 'agents of the state' who cannot be trusted. They fear that having an open and honest discussion about their difficulties will result in their child being taken into care.

Health visitors are in an ideal position to work with all families, but their role needs to be re-established as trusted support figures for parents and children. For some time now, there have been concerns that even health visitors themselves are unable to define what health visiting is about and what health visitors should be doing. The profession seems lost and under pressure just when the issues on which health visitors can make a positive difference are higher on the public's mind and government policy than ever (Lowe, 2007). Prevailing pressures have led staff to concentrate on identifying children at risk (Hall & Hall, 2007).

Parents need to feel that they know and trust a practitioner before they share their concerns with them (Department of Health et al, 2009). To build a relationship there needs to be continuity of care, with staff having time to talk with families (Community Practitioners' and Health Visitors Association (CPHVA), 2009). Feelings of distrust prevent parents openly discussing their problems with the health visitor.

A report on Sure Start Local Programme Maternity Services (Kurtz et al, 2005) found that in some communities health visitors are seen as being the 'eyes and ears' of social services, so there is some reluctance to access health visitor-led services. Anecdotally, the CYPMHC has heard that because health visitors have a duty concerning safeguarding children, many parents view them with the suspicion that the health visitor might take their baby away.

Professionals have difficulty reaching some families in part because families have low levels of trust in, or respect for, the professionals they know; a perception of professionals as intrusive, unsympathetic, authoritarian and out of touch; and a fear of exposing poverty, poor quality child care, abuse or domestic violence to the 'prying eyes' of professionals (Hall & Hall, 2007).

3. Health visitors need more training on building relationships with families, children's mental and emotional development and the importance of secure attachment.

Health visitors are in an ideal position to offer advice about attachment issues, and the emotional development of children, as part of a wider package of support. Several guidelines from the National Institute for Health and Clinical Excellence (NICE, 2006, 2007, 2010) recommend that health visitors should be able to identify mental health problems in the mother or the family; identify mothers at risk of developing mental disorders; be able to assess and promote emotional attachment between mother and child; and promote emotional attachment and parenting skills through group-based parent-training programmes, and support for fathers. Promoting infant, child and family mental health has been cited as a priority for health visitors (Lowe, 2007).

However, health visitors need the relevant training and skills to enable them to provide this help and support, and we know that they do not at present always have such skills (CPHVA & Unite, 2007; Adams, 2008).

A review that sought to describe a renewed role for health visitors (Lowe, 2007) found that there is a need to update health visitors' knowledge especially in relation to neurological development, mental health promotion and parenting, and to build stronger relationships with midwives and to integrate their services. Health visitors themselves reported a mismatch between training and the service requirements.

Suitable training is available. For example, the Tavistock and Portman NHS Foundation Trust runs a *part-time, two-year* course on *Early Years Development: Infant Mental Health for professionals (including health visitors) working with infants, children under five or their families, in health or 'children, schools and families' settings*. It offers an experience-based and theoretical approach to understanding children's emotional, social and cognitive development. It may be a problem, however, for health visitors to find the time to attend such courses, given that around a quarter of all health visitors find access to training not easy or impossible, and health visitor education shows great variation in inclusion of mental health (Adams, 2008).

4. Shortages of health visitors.

The number of health visitors in England has been dropping at a time when the needs of infants and families have been increasing. In England, the numbers of full-time equivalent health visitors dropped from 10,137 to 9,056 between 2004 and 2007 (NHS Information Centre, 2007). Vacancies for health visitors have risen from 166 to 233 between 2008 and 2010 (NHS Information Centre, 2010), with London showing the highest vacancy rate of 6.2%.

In some places practitioners reported being under considerable pressure with high levels of need, unfilled vacancies and large workloads. Health visitors seem to be particularly vulnerable when organisations are faced with financial constraints (Lowe, 2007). Low recruitment and high attrition rates may be due to poor relationships between parents and staff (Barlow et al, 2008). Netmums, the UK online parenting organisation, has spoken of the problems posed by shortages of health visitors:

"If we are to support families at this most important stage in their lives, then the decimation of the health visiting service must be reversed. Health visitors are a vital service to families. They are a crucial frontline service and the support they can provide to families should not be undervalued.... We know from our research at Netmums that many mums would be much more likely to admit that they were struggling or not coping if they could turn to their health visitor who they knew and trusted" (Boots WebMD, 2010).

Caseloads can also pose a problem. Building trust takes time and effort that health visitors cannot spare if their caseload is too large or too complex (Barlow et al, 2008; Department of Health et al, 2009; Adams 1998, unpublished).

There can be a 'postcode lottery' in health visitor provision with many service cuts, or health visitors having to delegate interventions. Additionally, the focus for delivering many interventions can be on the children's centre workforce, rather than health visitors (Adams, 1998).

Failure to address the problem

If we fail to address the problems outlined above, some families will continue to be reluctant to engage with professional staff, and treat them with distrust. This means that they may miss out on valuable interventions and support, including a better understanding of the importance of attachment in their children's development. It also means that early signs of mental health problems – whether in the infant or the parent – may be missed, increasing the risk of serious mental disorders, which are costly both in financial and human terms.

Mental health problems during the perinatal period have been shown to have a significant impact on the baby, as well as the mother, and the rest of the family. Children with disorganised attachment seem to be least able to cope with the stress of

the separations and reunions because they lack a consistent strategy for dealing with negative emotions (Van Ijzendoorn et al, 1999). Without experiencing a safe and protective environment early in life, children cannot develop secure attachment. Those with mental health problems and conduct disorders/behavioural problems are more likely to go on to have conduct disorders in adult life. As it stands, up to 40% of pre-school children with problem behaviours go on to develop conduct disorder, including drug misuse, and criminal and violent behaviour (Coid, 2003). Early, severe and persistent anti-social behaviour has a profoundly negative impact on families, peers and communities. Costs associated with children with conduct disorder are estimated to be ten times higher than those for children without conduct disorder (Scott et al, 2001).

What is the evidence to support our recommendation?

The CYPMHC has welcomed the Government's pledge to increase the number of health visitors by 4,200. A number of existing policy documents have highlighted the importance of early intervention and of the role of health visitors (Department of Health, 2009; Department of Health, 2010a, 2010b; Institute for the Study of Children, Families and Social Issues, 2008; Barnes et al, 2000).

There are a number of research studies that demonstrate how health visitors with additional training can improve outcomes for mothers who have post-natal depression (PND) (Barlow et al, 2008; NICE, 2007). There is evidence that highlights how health visitors can assess women with PND using the Edinburgh Post Natal depression scale, and provide psychological interventions to help them with their problems (Morrell et al, 2009). Training health visitors to assess and psychologically support mothers after childbirth can prevent the development of depression over the following year, providing "new evidence of a universal, enduring preventive effect for depression in women who screen negative for depression postnatally" (Brugha et al, 2010).

Achieving Equity and Excellence (Department of Health, 2010) states that health visitors are well placed to help families link in to local communities and, where needed, to specialist care. Professionals such as health visitors can also help to connect families with similar needs so they can share experiences, suggest links to appropriate local services and community groups, and help to mobilise wider community engagement in support of children and families.

Primary care practitioners, particularly midwives and health visitors, are well placed to identify deep-seated problems such drug-abuse and domestic abuse, which are strongly associated with poor outcomes for children (Barlow et al, 2008). Health visitors are also considered to have the knowledge and skills to lead and deliver evidence-based interventions with families (Lowe, 2007), subject to being appropriately trained. This might be an expanded role for health visitors.

The focus of health visitors should be early intervention, prevention and health promotion for young children and families. This is where their nursing and public health skills and knowledge can have the greatest impact (Lowe, 2007). However this will not be uniformly achieved unless we re-establish health visitors as trusted support figures for parents and children.

Case Study: The Solihull Approach

The Solihull Approach was first developed in 1996 by joint working between health visitors and psychotherapists in Solihull, to work with families and children on feeding, sleeping, toileting and behaviour difficulties. It is now used by a wide range of professionals from different agencies. The model provides a framework for practitioners to think about children's behaviours. An evaluation found that training in this approach had a positive impact on 88% of health visitors. They felt more confident in their own skills, and it improved their job satisfaction.

An audit of services using the Solihull Approach found that while the number of referrals to child psychology services had not changed significantly the complexity of the referral had changed. Children with simple difficulties were no longer being referred and the referrals received suggested more complex difficulties. A study of mothers who received the Approach and their experiences found that mothers often connected a good quality relationship with their practitioner, to good outcomes.

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Children & Young People's Mental Health Coalition

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