



**Written evidence from the Institute of Health Visiting  
in response to NHS England Consultation on Mental  
Health in the NHS Long Term Plan**

7<sup>th</sup> September 2018

The Institute of Health Visiting's (iHV) charitable objectives are to improve outcomes for children and families and reduce health inequalities. We do this through: strengthening professional leadership; ensuring high quality and consistent education and training; developing new national quality assurance processes; creating a strengthened research base; and working in partnership with many organisations to tackle key public health issues - the root causes of poor health and inequalities.

We firmly believe there is no health without mental health, which is why we have perinatal and infant mental health (PIMH) as a priority focus. We welcome the opportunity to respond to this consultation to ensure that all families get consistent, accessible, high quality care and support for their mental health during the perinatal period.

This submission focuses on how, with the right support from the NHS and partner organisations, health visitors can ensure that *all* families with children receive the right care and support for their mental health, at the right time, in the right place.

Our response reflects the many consultations and surveys we have done with our members and other stakeholders over the recent months and years.

**Q1. What are your top three priorities for meeting the mental health needs of people of all ages in England? Over the next five, and ten years?**

**Q2. What gaps in service provision currently exist, and how do you think the NHS should address them (these can overlap with Q1 but may include a longer list)?**

Q1&2 Combined answer: **iHV top 3 priorities:**

1. Resource health visiting services through joint commissioning which formally requires health visitors to take a specific lead for perinatal and infant mental health, ensuring that all families have access to a health visitor who has sufficient capacity, competence, confidence and commitment to:
  - Recognise risk early and thereby intervene to prevent potential mental illness;
  - Promote optimum mental health of *all* family members;
  - Offer evidence-based NICE concordant interventions where there are perinatal and/or infant/child mental health problems;
  - Ensure timely referral to the most appropriate service for the most appropriate evidence-based intervention/support.

Health visitors, through their universal non-stigmatising service, were once the eyes and ears of the community, skilled at holistic assessment to identify families at risk of and/or suffering from mental health problems. However, due to the restructuring of services and the cuts to their numbers since they moved under local authority commissioning (at a time of cuts to the local authority public health budget), this function is now severely challenged. Over the past few years, health visitors

have told us that fewer families are receiving the services they need to support good mental health, due to falling staff numbers and employers focusing on Key Performance Indicators (KPIs) - rather than health outcomes. Furthermore, they state this is against a backdrop of rising poverty and increased mental health need (iHV, 2017).

2. There is a gap between knowledge of what affects child and family mental health and how services are commissioned and organised to implement this knowledge. What is required is that services are organised around the holistic needs of children and families in the circumstances where they live (that is an ecological approach), not the organisations themselves.

3. Efforts need to be made to create a much wider understanding of the epidemiology of mental illness with so much of it having its origins in the very first years of life. This should include the impact of loneliness on families (social health is closely entwined with mental health), of poor relationships, of domestic abuse and of less than optimal parenting. If all these factors were addressed in a timely manner by moving finance to the early years, the reduction on spending on secondary services would be very significant.

**Q3. People with physical health problems do not always have their mental health needs addressed; and people with mental health problems do not always have their physical health needs met. How do you think we can improve this?**

Research evidence makes clear that what happens in the womb and first 2 years of life provides a blueprint for future physical, mental and social health, heavily influencing future life chances and, in turn, affecting inequalities and economic costs across the whole of society. Increasing the number of mandated contacts undertaken by a health visitor increases the opportunity for health visitors to influence change in this early period of a child's/family's life which can significantly improve physical, social and emotional health across the life-course. Scotland has recognised that this is how it will tackle its mental health and social problems and has increased core health visitor contacts to 11, which is in stark contrast to the 5 in England.

For example, health visitors are key practitioners in supporting mothers to breastfeed and achieve their infant feeding goals, and can signpost to additional specialist services when necessary. As a universal service, they have contact with all families in the UK and are in unique positions to offer this help. There is now an extensive evidence base to show that breastfeeding improves children's physical and mental health outcomes, as well as helping develop close bonds with their mothers. It can reduce social and health inequalities, and has been shown to improve future employment prospects (Victoria et al. The Lancet 2015, 3, 4).

Health visitors are ideally positioned to offer every family a holistic assessment of physical, social and emotional needs through their universal access to all children and their families in the first 2 years of life. The timing of the universal contacts is crucial. We advocate support for all 5 of the currently mandated contacts being undertaken by a qualified HV so as to maximise the impact and effectiveness of the health messages delivered. In addition, we advocate the mandation of a contact at 3-4 months as a priority – but, overall, we support increasing the total number of universal contacts to at least 9, as in Wales.

**Q4. There are some significant inequalities in how people access and experience care for their mental health needs, and in their outcomes, including but not limited to people who have 'protected characteristics' under the Equality Act 2010. What are your views on what practical steps the NHS should take to address inequalities in the services it provides?**

There are growing inequalities right now for families because of the way HV services are commissioned. We know that in some areas families receive excellent care and support for their mental health, receiving the 5 mandated contacts and additional contacts (such as two antenatal, a 3-4 month contact), as well as a series of Listening Visits/ HV therapeutic interventions - all delivered by their HV. In other areas, the family may receive only the birth visit by the HV - with other contacts being offered by letter/telephone or by a junior member of the team. The iHV would like to see this growing inequality stopped in its tracks now. Many health visitors tell us that they work exceptionally hard to offer mental health support but do not record it as they are "no longer commissioned to do this". We would welcome the NHS working across systems to advocate:

- Every mandated contact (professional HV assessment) is undertaken by a HV;
- Mandation of the 3-4 month contact in line with the HV service specification and evidence base and working towards a further 3-5 mandated contacts;
- Move the antenatal contact to earlier and also increase to two antenatal contacts, to ensure MMH is assessed early and late in the postnatal period- in line with the evidence base (Netsi et al, 2018)
- Providing new support for fathers' as well as mothers' mental health.

Additional areas for consideration include investment in developing the areas where we know parents and children are more vulnerable in relation to equality and diversity. For example:

- Research on interventions to support parents from ethnic minorities;
- Resources and training to support practitioners working with families who have learning disabilities alongside mental health problems;
- IT systems that enable family-focused/father-inclusive practice/service development;
- Anti-stigma campaigns;
- Building community capacity and integration with minority populations.

**Q5. How best can we bridge the gap between children's and adults' mental health services?**

In specific relation to family mental health and health visiting, we advocate:

- The formal commissioning of a Specialist HV in PIMH to provide HV leadership in every organisation to ensure that babies/ children of parents with PMH problems receive safe and effective care, such as evidence-based parent-infant/child mental health interventions;
- Providing enhanced services for teenage parents, ensuring robust assessment for potential mental health problems and effective interventions and consistent care for those parents who experience P/IMH problems;
- Many HVs now work across 0-19 years and, therefore, are in an ideal position to work alongside school nurses to ensure that the future generation of parents are informed in respect of the importance of MH in the perinatal period and what the options for help might be;
- In reality, there are extremely limited (non-existent in many areas) mental health services for children under 5, with most CAMHS services refusing to see this age group. This is a huge injustice, and our youngest children showing early signs of mental distress are having to wait for a potential mental health problem to become a mental illness before services act - this has to change! We advocate training the HV workforce alongside MH professionals to address this gross inequality.

**Q6. How can we recruit, train and retain the workforce to deliver the changes we need, particularly to meet your priorities (Q1 above)?**

We need to put the passion back into health visiting services - that will happen if they are sufficiently trained and resourced and given back their autonomy to act, instead of feeling that their work is significantly about number crunching for commissioners.

In the case of health visiting, there are many potential health visitors who are put off entering the profession as the only entry gate, currently, is via completion of nursing or midwifery 3 year training. We believe there is a case to cherry pick the parts of these nursing/midwifery trainings that every health visitor needs, but then to increase the health visiting training component to 18 months. This would allow graduates from the life sciences to consider health visiting as a career, as well as mothers who want to return to work, both groups have much to offer the profession.

Universal training of all health visitors in PIMH - with a pathway of career development for the HV role in PIMH, from pre-registration-newly qualified - "PIMH Champion" – advance practitioner/specialist HV in PIMH. Access to CPD needs to be widely available again to provide for necessary skills development and updating. This is known to boost retention.

**Q7. Do you think the NHS should be doing more to prevent mental ill-health? If so, what should we do to improve this?**

We applaud the massive positive shifts we are seeing for the most ill women and their families. We would like to see proper funding alongside this for the universal element of the PIMH pathways, using the Marmot principle of proportionate universalism to tackle inequalities and shift the curve for demand on services.

Preventative work is now seen as key to tackling a pressing raft of public health challenges in order to contain the long-term costs of failure to intervene 'early' and the demographic shift that accumulates a burden of ill-health on individuals, communities and the country's economic performance. This is highlighted in the 'Five-year forward view' (NHSE, 2014) according to which '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'.

Marmot (2010) has demonstrated the health gains at population level to be achieved through improving health and reducing inequalities in the earliest years of life; and Heckman has depicted graphically the return on investment and the costs of failure. Moreover, WAVE (2013) has demonstrated that 'early years' interventions are a rare opportunity to spend money in a way that delivers social and economic benefits at the same time' (p.101).

**Q8. Do you think the NHS could do more to intervene early for people with mental ill-health? If so, are there any Mental Health problems we should prioritise to provide better early intervention?**

Early intervention with children will reduce the burden of adult mental illness! We have to get that message over to politicians and policy makers, so money is shifted upstream from secondary and tertiary care.

**Q9. People with more serious and complex mental health problems do not always receive the care they need. Which groups would you prioritise and what extra help would you like to see developed by the NHS?**

Best of all is preventing these serious and complex mental health problems by early intervention in childhood. This could very significantly reduce the burden of later mental illness. Investment into voluntary organisations to support the long-term mentally ill, e.g. Mind, would seem helpful.

**Q10. Are there examples of innovative/excellent practice (in mental health care or that could be applied from other areas) that you think could be scaled-up nationally to enhance the quality of care people receive for their mental health, reduce costs and/or improve efficiency of delivery?**

A recent economic analysis (Appendix 1) demonstrates the benefits of training health visitors in perinatal mental health in preventing and reducing the impact of mild to moderate perinatal mental illness.

The iHV Multi-agency PIMH Champion training programmes have created over 1500 PIMH Champions - this internationally-awarded and accredited programme is benchmarked against

national and international standards and one of its strengths is that it is able to be scaled up:

<https://bit.ly/2PXzVAZ>

**Q11. What do you think are the specific challenges that will prevent the NHS from being able to deliver good mental health care, and what should we do to overcome them?**

Enabling effective high-quality integration at a local level without widening the postcode lottery - so national standards and modelling of joined up systems nationally support effective high quality local care systems:

- Effective integration of services will be a key component of developing the Long-Term Plan for the NHS. The importance of developing NHS services that promote prevention and are fully integrated with all the relevant services, e.g. social care, employment and housing support, is a challenge. Local Authority PH budgets and the budget for Public Health England sitting outside and not within the scope of the funding settlement is adding to this challenge - fragmenting care at a local level and opening up inequalities.
- This is why it is essential that health visiting is moved from solely local authority commissioning to joint NHS/LA commissioning, so that health visitors once again have sufficient resource to play their part in reducing mental illness and promoting good mental health for all across the life course and inter-generationally. Since the commissioning of health visiting moved to local authorities, the number of health visitors has been slashed and their universal preventative services reduced with cuts to public health budgets.

**Please see the new iHV position statement attached on improving health visiting services alongside the new NHS 10-year plan. Also to support our response:**

- Local Authority Child Public Health Briefing (3): The health visiting contribution to children's mental health
- Local Authority Child Public Health Briefing (6): The Health Visiting contribution to maternal (perinatal) mental health
- Local Authority Child Public Health Briefing (7): The Health Visiting contribution to working with fathers

**These docs are open access and can be found on this webpage: <https://ihv.org.uk/for-health-visitors/local-authority-commissioning/>**

## References

iHV, 2017 <https://ihv.org.uk/news-and-views/news/health-visitors-fear-childrens-futures-numbers-cut/>

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WAVE (2013) *Conception to age two: the age of opportunity*. London. Wave Trust.