

Training health visitors in cognitive behavioural and person-centred approaches for depression in postnatal women as part of a cluster randomised trial and economic evaluation in primary care: the PoNDER trial

C. Jane Morrell¹, Tom Ricketts², Keith Tudor³, Chris Williams⁴, Joe Curran⁵ and Michael Barkham⁶

¹Associate Professor, School of Nursing, Midwifery and Physiotherapy, University of Nottingham, Queen's Medical Centre, Nottingham, UK

²Nurse Consultant in Psychotherapy, Assistant Clinical Director, Acute, Community & Primary Care, Sheffield Health and Social Care, NHS Foundation Trust, Sheffield, UK

³Associate Professor & Programme Leader, Department of Psychotherapy, AUT University, Auckland, Aotearoa New Zealand

⁴Professor of Psychosocial Psychiatry and Honorary Consultant Psychiatrist, Centre for Population Health Sciences, College of Medical, Veterinary and Life Sciences, University of Glasgow, Glasgow, UK

⁵Cognitive Behavioural Psychotherapist, Psychotherapy Services, Sheffield Health and Social Care, Michael Carlisle Centre, Sheffield, UK

⁶Professor of Clinical Psychology, Centre for Psychological Services Research, Clinical Psychology Unit, Department of Psychology, The University of Sheffield, Sheffield, UK

Aim: This paper aims to describe the training preparation for health visitors who took part in the intervention arm of a cluster randomised controlled trial and economic evaluation of training for health visitors – the POstNatal Depression Economic evaluation and Randomised (the PoNDER) trial. A secondary aim is to make available, by electronic links, the training manuals developed for and used for the cognitive behavioural approach (CBA) and the person-centred approach (PCA) training for the health visitors. The paper is of relevance to health visitors, general practitioners, nurse practitioners, midwives, clinical psychologists, mental health nurses, community psychiatric nurses, counsellors, and service commissioners. **Background:** The trial clinical outcomes have been published, indicating the pragmatic effectiveness of the package of training for health visitors to identify depressive symptoms and provide a psychologically informed intervention. The training was associated with a reduction in depressive symptoms at six months post-natally among intervention group women and some evidence of a benefit for the intervention group for some of the secondary outcomes at 18 months follow-up. **Methods:** The two experimental interventions examined in the PoNDER trial built upon promising work on the potential for psychological interventions to help women recover from postnatal depression as an alternative to pharmaceutical interventions and to address the limitations of previous research in the area. **Findings:** The package of health visitor training comprised the development of clinical skills in assessing postnatal women and identifying depressive symptoms, and the delivery of a CBA or a PCA for eligible women. This was the largest trial a health visitor intervention and of postnatal depression ever

Correspondence to: Dr C. Jane Morrell, Associate Professor, School of Nursing, Midwifery and Physiotherapy, University of Nottingham, Queen's Medical Centre, Nottingham, UK.
Email: jane.morrell@nottingham.ac.uk

© Cambridge University Press 2010

conducted. We are aware of no other rigorously performed trial that has published details of an extensively tested training programme for the benefit of health-care professionals and clients.

Key words: cognitive behavioural approach; depressive symptoms; education and training; health visitors; person-centred approach; postnatal women

Received 1 April 2010; accepted 19 July 2010; first published online 1 October 2010

Introduction

This paper describes the preparation for health visitors who took part in the intervention arm of a cluster randomised controlled trial and economic evaluation of training for health visitors: the Post-Natal Depression Economic Evaluation and Randomised controlled (PoNDER) trial. The main trial outcomes have been published (Morrell *et al.*, 2009a) and this paper provides details to make the training programme as reproducible as possible. It is relevant to health visitors, general practitioners, nurse practitioners, midwives, obstetricians, clinical psychologists, mental health nurses, community psychiatric nurses, counsellors, and service commissioners.

Summary of the PoNDER trial

Health visitors in 101 clusters in 29 Primary Care Trusts, from the Trent region, and 4084 women consented to take part in the three-year study. The research was a prospective pragmatic randomised cluster trial with clusters allocated to either health visitor training (intervention arms) or health visitor usual care (control arm). The group training was for six full days and four half days. The trial aim was to estimate any differences in outcomes for postnatal women, child or family, attributed to training health visitors in systematically identifying depressive symptoms and delivering psychologically informed sessions (up to eight sessions of one hour per week, based on either cognitive behavioural principles (Clark and Fairburn, 1997) or listening based on person-centred principles (Sanders, 2000) in primary care for women at greater risk of postnatal depression. By this we mean women who had a raised score on the Edinburgh Postnatal Depression Scale (EPDS; Cox *et al.*, 1987) which was designed to

help indicate the one tenth of women most likely to be suffering from depression, rather than a formal diagnosis of depression.

The secondary aim was to establish the relative cost-effectiveness of both psychological approaches, relative to 'health visitor usual care'. The primary outcome was the proportion of at-risk women still scoring 12 or more on the EPDS at six months postnatally.

Literature synthesis of health visitors using psychological approaches to support women with postnatal depression

A number of small studies have examined 'non directive type counselling' by health visitors (Holden *et al.*, 1989); psychological interventions in 'preparing for parenthood' (Elliott *et al.*, 2000); brief training for health visitors in 'listening visits' or 'non-directive counselling' (Gerrard *et al.*, 1993); and training health visitors to identify and to manage postnatal depression using counselling and cognitive behavioural techniques (Seeley *et al.*, 1996).

Health visitors have been working in multi-disciplinary teams for some time in the prevention and early identification of depression, and offering support for affected women (Cullinan, 1991; Allen, 1993; Bostock *et al.*, 1994). A series of proposals and guidance has supported the role of health visitors in perinatal mental health (SIGN, 2002; DH, 2003; NICE, 2007).

In the short term, postnatal depression was found to be amenable to treatment, but not prevention. Antidepressants are effective, but compliance is not good and it is not known which class is most helpful. Psychological interventions offer a practical alternative. There was not enough

evidence to determine the most effective intervention for health visitors to offer; whether ‘non-directive type counselling’ (Holden *et al.*, 1989) or cognitive behavioural counselling (Appleby *et al.*, 1997). The PoNDER trial was commissioned on the basis of growing demand for psychological interventions for postnatal depression.

The outcomes of health visiting studies and endorsements from official reports indicated that health visitors were in an ideal position to identify women with depression, to establish a trusting, supportive relationship with postnatal women (Plews *et al.*, 2005), and use their interpersonal and communication skills, which lie at the core of health visiting. The PoNDER trial built upon the potential for health visitors to develop appropriate skills, to adopt an effective role in the identification of depression, and to offer effective support to eligible women, whether non-directive (person-centred) type counselling or cognitive behavioural counselling.

Identifying depression in postnatal women in the PoNDER trial

There is a general problem with the identification of depression in primary care (Cooper, 2003) and postnatal problems are often not recognised in routine practice (Kumar and Robson, 1984; Hearn *et al.*, 1998). Within the PoNDER trial it was not appropriate to train health visitors to offer psychologically informed sessions without first developing their skills in assessing women and identifying depressive symptoms. Health visitors were trained to administer the EPDS as it is one of the most widely used and researched mood assessment instruments (Hewitt *et al.*, 2009). It was not developed as a diagnostic test and is not adequate to confirm postnatal depression without a clinical interview (Leverton, 2005). Health visitors were also trained to use clinical assessment skills to assess a mother’s mood, including depressive symptoms and suicidal thoughts, and to explore her feelings about the baby.

The package of health visitor training comprised the development of skills in assessing women, identifying postnatal depressive symptoms, and delivering either a cognitive behavioural approach (CBA; Clark and Fairburn, 1997) or a person-centred approach (PCA; Tudor and

Worrall, 2006) to eligible women. On account of the random allocation of clusters to group (control, CBA, or PCA), the health visitors were not able to choose either of the approaches as a preferred option.

Training in psychological approaches

The implementation of the psychotherapeutic health visitor training and intervention was informed by the methodological prerequisites for comparative psychotherapy research (Hill and Lambert, 2004; Kendall *et al.*, 2004). The implementation of the health visitor training programmes was assisted by the establishment of a Training Reference Group (TRG). This group comprised experienced, academically based psychotherapy and counselling trainers from England and Scotland, including representatives of both the cognitive behavioural and person-centred approaches. This group aimed to enhance the rigour and effectiveness of training for both psychotherapeutic approaches; maximise the comparability of the programmes; and ensure that the trial would be considered by advocates of each method to have been a credible representation and fair test of that method.

The TRG considered the potential for bias and distortion of results attributed to researchers’ loyalty to their preferred therapeutic approach (Luborsky *et al.*, 1999). The potential impact of a researcher’s therapy allegiance was minimised in two ways. First, several experts representing both the CBA and the PCA were involved in planning the training for each of the two active approaches. Second, the health visitors in the CBA arm were supervised by an expert in CBA and the health visitors in the PCA arm were supervised by an expert in PCA.

Principles and standards of training for the intervention

The TRG held two verification meetings, chaired by Professor David Shapiro, at the University of Sheffield. Recognising the training employed in previous trials using ‘*a brief training in the principles of person-centred counselling*’ (Holden *et al.*, 1989) and using cognitive behavioural therapy

Primary Health Care Research & Development 2011; **12**: 11–20

(Appleby *et al.*, 1997), the PoNDER trial training was to prepare health visitors to offer a brief, derivative intervention, not psychotherapy, mainly for pragmatic reasons. That is, the outcomes to be compared between the intervention group and control group would be associated with a brief training in delivering critical elements derived from one of the two therapies (cognitive behavioural therapy and person-centred approach to therapy). The training had to be delivered at an appropriately engaged and pragmatic level, to enthuse health visitors and develop their skills and theoretical knowledge. This recognised health visitors' preference to support women with psychological difficulties, rather than become mental health workers. It was not intended that the health visitors should regard themselves (or be regarded) as therapists, whose training takes much longer than eight days. Therefore, the terms 'PCA' and 'CBA' were to be used consistently, to avoid the use of the terms therapy and counselling, therapists or counsellors.

Training manuals

The two lead trainers (TR and KT) were specialists with experience in practice, as trainers, and as supervisors. They prepared a manual for each health visitor to keep and refer to throughout the trial, and a separate trainer's manual. The manuals included the theoretical basis for the relevant psychological approach and the training plan, so that if necessary, the training could be replicated elsewhere.

The TRG verified that the training manuals for both intervention arms were comparable, with an appreciation of the differing ethos and styles of the two psychological approaches.

The training experience was planned to be similar and balanced, as far as possible, for all intervention group health visitors. All training cohorts were no larger than 12 (to allow for four small groups of three health visitors working together). The training used the term client or woman rather than patient, and health visitor rather than participant. Key qualities of the training environment were that they were uninterrupted, secure and congruent with what would be expected of a training environment, with a pragmatic consideration of reproducibility and deliverability in the National Health Service.

Primary Health Care Research & Development 2011; **12**: 11–20

Appropriate training

The TRG emphasised avoidance of unfamiliar language and jargon, for example, 'negative automatic thoughts', to avoid putting off health visitors, and to provide accessible, distinguishable, theoretically congruent, and reproducible models with key skills. As well as being appropriate for the health visitors, the intervention was planned to be appropriate for the women, with little time or energy to do too much 'homework'.

Clinical supervision

The health visitors needed clinical supervision and support when dealing with distressing information from a client, such as aggressive thoughts towards the baby. Regular, formally structured reflective practice sessions were offered for all health visitors, some using role play, especially for those who had not had the opportunity to work with affected women. Health visitors also attended locally organised peer supervisory sessions.

Generic skills

The common aim for both training approaches was to enable health visitors to acquire further generic skills in developing warm, therapeutic, helpful relationships, such as positive regard and empathy.

Training for the cognitive behavioural approach

Introduction and background to the approach

Cognitive behavioural approaches to depression have been well evaluated and are recommended within NICE Guidelines (NICE, 2007). In postnatal depression, a study comparing fluoxetine and cognitive behavioural counselling (Appleby *et al.*, 1997) focused on issues regarding feelings of not coping, lack of enjoyable activities, lack of practical support, and caring for any older children. The intervention involved primarily behavioural activation strategies such as planning and reviewing tasks. The cognitive behavioural intervention was delivered by non-specialists. The training in the PoNDER trial reported here was designed to enable health visitors to deliver such interventions.

In order to retain clarity of the approach for the health visitors, the Five Areas approach (Williams *et al.*, 2008; Williams, 2009) was utilised throughout the teaching. The five areas are the environment (life situation/relationships and practical problems), cognitions (altered thinking), emotions (altered mood), physiology (altered physical symptoms), and behaviour (altered behaviour). The model presents these as an accessible vicious circle that summarises and shows the relationship between changes in any of the areas. The approaches were placed in the context of a collaborative therapeutic relationship between the health visitor and the client and there was little emphasis in the training on the theoretical or research underpinnings of the approaches being utilised. Trainers were, however, expected to be clear regarding the underpinning approaches while avoiding jargon.

The emphasis within the training was on delivering a single model linking together behavioural and cognitive approaches for which each has an evidence base in the treatment of depression. The three approaches taught were behavioural activation (Garland *et al.*, 2002), cognitive restructuring (Beck *et al.*, 1979), and problem solving (Mynors-Wallis *et al.*, 1997).

The teaching structure and approach was designed to be reproducible by accredited cognitive behavioural psychotherapists with prior teaching experience. Although the teaching was timetabled, variation according to the needs of the group was appropriate and desirable, while ensuring that all aspects of the programme were covered.

Purpose of the cognitive behavioural approach teaching programme

The purpose of the training was to prepare health visitors to offer a simple, easily communicated intervention related to the phenomenology of postnatal depression. The basis of the training was the worksheet approach, where health visitors learned to carry out a problem-focused assessment in five key areas of the woman's experience, then select and use appropriate postnatal depression specific worksheets for each woman.

The teaching programme was designed to equip health visitors with the requisite knowledge, skills, and attitudes to enable them to assess clients suffering from postnatal depression and conduct an intervention based upon cognitive behavioural approaches. Learning outcomes are detailed in Table 1.

Table 1 CBA training learning outcomes

By the end of the teaching programme participants will be able to:

- Describe the key features of therapeutic relationships
- Form, develop, maintain, and appropriately end therapeutic relationships
- Conduct assessments of clients with postnatal depression using a Five Areas approach
- Implement a range of simple cognitive behavioural approaches
- Evaluate the effectiveness of the interventions

CBA = cognitive behavioural approach.

Structure of the teaching and teaching approaches used

Each teaching programme was made up of five teaching days delivered over four weeks followed by four three-hour reflective practice sessions at weeks 6, 10, 14, and 18 (Table 2). There was some variation of the exact dates to maximise attendance. The majority of the taught component of the programme took place over the first four weeks of attendance, with the taught sessions being in the form of whole day workshops that involved all participants

Table 2 The structure of the CBA training

Week	Day	Title
1	1	Introduction to CBA and the Five Areas model/therapeutic relationships
1	2	Practical problems/relationships and the problem-solving approach
2	3	Managing altered behaviour
3	4	Managing altered thinking
4	5	Linking assessments to approaches/recap and review

CBA = cognitive behavioural approach.

undertaking each unit of the programme. Approaches used within the five teaching days included didactic sections to provide information; structured small group discussions linking prior experience to theory; whole group feedback and discussion; modelling of skills by course lecturers; practice of skills using provided case material, with feedback; introduction to the CBA manual (<http://www.nottingham.ac.uk/nmp/research/cmsh/research-projects/the-ponder-trial.aspx>); and use of materials.

The reflective practice sessions focused on supervision and practice of skills, using case material brought by participants in small groups of five to seven health visitors. Skills were developed through the use of discussion, reflection on learning, and rehearsal of skills in a safe, supportive setting. These sessions included training in peer supervisory methods. In order to facilitate health visitors being involved in their own development and to aid reflection on practice, each course participant was asked to complete a 'record of learning experiences' for the duration of the course.

Training for the person-centred approach

Introduction and background to the approach

The person-centred approach, with its origins in client centred therapy (Rogers, 1951) is one of the oldest and longest established approaches of counselling and psychotherapy. It is also one of the few psychological therapies which has been developed as an *approach* to different aspects of life, such as education, groups, personal relationships, conflict resolution, and organisations and is thus well founded and well suited as an approach to helping and listening (Wood, 1996).

Two small studies, each with methodological limitations, specifically on perinatal depression found that women in person-centred therapy appeared to have better outcomes than the control women (Holden *et al.*, 1989) and that person-centred counselling appeared to be better than treatment as usual (Wickberg and Hwang, 1996). A slightly larger study found that there was a reduction in the EPDS score at 18 weeks among women allocated to either a non-directive counseling (NDC), cognitive behavioural therapy, or dynamic psychotherapy (DPT) group, but there were higher dropout rates in the NDC and DPT groups (Cooper *et al.*, 2003).

Primary Health Care Research & Development 2011; **12**: 11–20

Purpose of the person-centred approach training programme

The purpose of the training was to prepare health visitors using key principles of the approach and reflections on becoming a mother in such a way that they would be able to help the women to accept, understand, and ameliorate their depressive process. It was also to inform health visitors about a person-centred approach to postnatal depression; and to help them develop a PCA or 'psychological posture' to their listening.

Postnatal depression

From a person-centred perspective, physical and mental disorders, unless clearly organic in origin, are generally viewed as describing a process rather than a fixed 'condition'. 'Talking of a *depressed process* rather than depression seems to make it clearer that there is a continuum of feeling and function' (Rowland, 2002). In acknowledging depression as a *process* we understand that it can change and that it involves a relationship, with oneself and with others. Working with the client's subjective experience means that the helper is open to understanding what the *client* means by her depression (as distinct from deriving meaning from a diagnosis). A woman with a new baby may be scared or angry (or both) but may be presenting in a depressed way. Acknowledging this perspective, one of the five days' training was devoted to understanding the experience and impact of becoming a mother.

Psychological posture

This posture or attitude derives from certain principles; identification of necessary and sufficient conditions of the therapeutic or helping relationship; and attitudes or qualities of the therapist or helper (Rogers, 1969). Two full training days and further time on other days were devoted to the practice and development of these attitudes and skills.

Specific aims of the course were laid out in the health visitors' PCA manual (<http://www.nottingham.ac.uk/nmp/research/cmsh/research-projects/the-ponder-trial.aspx>).

Philosophy of education and its implications for the approach to training and the structure of the programme

Central to the person-centred approach to education is the relationship between trainers and

Table 3 Course structure for the PCA training

Week	Day	Title
1	1	The person-centred approach and its applications
1	2	Becoming a mother
2	3	The necessary and sufficient conditions of helping (1)
3	4	The necessary and sufficient conditions of helping (2)
4	5	Personal and professional integration

PCA = person-centred approach.

participants. This is characterised by the facilitative conditions, which cannot necessarily be reproduced. The development of the trainers' manual reflected the commitment to the fluidity or flexibility of a person-centred perspective on education and training (Mearns, 1997; Merry, 1999).

Parallel to the therapeutic process of helping, the process fostered by person-centred approaches to education is one in which participants are free to express themselves. The aims of Rogers' 'more human education' (Rogers, 1969) is a movement towards:

- A climate of trust in the classroom.
- A participatory mode of decision making in all aspects of learning by all participants.
- Helping students prize themselves.
- Developing excitement and curiosity in intellectual and emotional discovery.

Teaching and learning approaches and structure of the teaching and learning

Consistent with the person-centred approach to education, the training course paid attention to developing trust, participation, acceptance, excitement, and curiosity, partly by having check in, group and process time at the beginning and end of each day, which encouraged personal sharing and processing; and partly by being flexible about the order of the content of the course. Person-centred education or training courses are often experienced as intensive, as they place an emphasis and, therefore, a high demand on participation, personal sharing, and reflection. It was important that the course venue also facilitated this level of participation and processing. The training aimed to hold and balance a person-centred perspective to education and training with expectations to 'deliver', 'training', and achieve outcomes. In response to this, the course was designed

with a theme for each day, which was introduced, elaborated, and facilitated by means of:

- Presentations, backed up with information given in the health visitors' training manual,
- Paired and small group exercises,
- Group discussion,
- Demonstration of practice in the training group,
- Skills practice and reflection in small groups, and
- Group process.

The course was also designed to allow space and scope to respond to the particular interests and concerns of participants.

Each course comprised five days delivered over four weeks (Table 3), followed by four three-hour reflective practice group sessions at weeks 6, 10, 14, and 18 held in three different venues to facilitate attendance. These sessions focused on supervision of practice, revision of the application of the principles of the approach, and revision of practice skills using case material brought by the health visitors.

Five-day training evaluation for both approaches

When each training cohort was complete, the health visitors were asked to complete a questionnaire to provide feedback on the training delivery. The replies of these indicated a high level of satisfaction with the content and methods of the training. The detailed training outcomes are presented in a separate paper.

Contemporary context for health visiting services

Postnatal depression is a global public health problem and it is suggested that service providers

Primary Health Care Research & Development 2011; **12**: 11–20

should consider the routine assessment of all postnatal women (Almond, 2009) and health visiting should be commissioned to address key public health priorities (Cowley, 2009). There is a need to strengthen the health visiting evidence base, and evidence should be readily available for the purpose of commissioning, quality assurance, practice, and education (Cowley, 2009).

This trial was the largest trial of postnatal depression and the largest trial of a health visitor intervention ever conducted. The trial has generated evidence of the pragmatic cost-effectiveness of a package of training for health visitors to 12 months postnatally (Morrell *et al.*, 2009b).

This paper provides details of the intervention to ensure that the health visitor intervention is reproducible. We are aware of no other rigorously performed trial that has published details of the training programme for the benefit of health-care professionals.

It would be appropriate to deliver this training as part of Specialist Community Public Health Nurse (SCPHN) educational programme; as part of a BSc or MSc Public Health Nursing; or as a post basic training module for qualified health visitors, from whom the evidence of effectiveness was generated.

A further paper presenting the analysis of the training outcomes will supplement this descriptive paper.

Summary and conclusion

There is evidence that postnatal women could benefit from the health visitor training that was associated with positive outcomes for the intervention group women in the PoNDER trial. The ‘*Clinical Management and Service Guidance on Antenatal and postnatal mental health*’ (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’. Primary Care Trusts are required to commission a portfolio of services for promoting health and well-being, and reducing inequalities (Department of Health, 2008). There has been a pledge of £40 million of support to fund additional training for health visitors (Conservative Research Department, 2010). We provide here details of training which was found to be both

Primary Health Care Research & Development 2011; **12**: 11–20

clinically effective and cost effective (Morrell *et al.*, 2009b). This training module might now be commissioned with sustained encouragement from Trust managers adequately influencing educational programmes and contract setting with universities (Cowley, 2009).

Acknowledgements

The PoNDER trial, including the health visitor training, was commissioned, funded, and sponsored by the NIHR HTA programme. We thank the women, health visitors, general practitioners, and primary care trusts for supporting the trial, and the trial advisory group. We are extremely grateful to the Training Reference Group – Professor David Shapiro, Honorary Professor, Universities of Leeds and Sheffield; Dr Ruth Williams, Institute of Psychiatry, Kings College, London; Professor Brian Thorne, The Norwich Centre; the late Mr Anthony Merry, School of Psychology, University of East London.

References

- Allen, S. 1993: Early detection of postnatal depression. *Nursing Standard* 8, 25–28.
- Almond, P. 2009: Postnatal depression: a global public health perspective. *Perspectives in Public Health* 129, 221–27.
- Appleby, L., Warner, R., Whitton, A. and Faragher, B. 1997: A controlled study of fluoxetine and cognitive-behavioural counselling in the treatment of postnatal depression. *British Medical Journal* 314, 932–36.
- Beck, A.T., Rush, A.J., Shaw, B.F. and Emery, G. 1979: *Cognitive therapy of depression*. New York: Guilford Press.
- Bostock, J., Anderson, S., Beck, A., Parker, A. and Towers, J. 1994: *Health visiting outcome group: promoting mental health*. Nottingham: Nottingham Community Health NHS Trust.
- Clark, D.M. and Fairburn, C.G. 1997: *Science and practice of cognitive behaviour therapy*. Oxford: Oxford University Press.
- Conservative Research Department. 2010: Helping new families: support in the early years through universal health visiting. Retrieved 8 June 2010 from <http://www.conservatives.com/~media/Files/Downloadable%20Files/Helping%20new%20families.aspx>
- Cooper, J.E. 2003: Detection and management of psychiatric disorders in primary care. *British Journal of Psychiatry* 182, 1–4.
- Cooper, P.J., Murray, L., Wilson, A. and Romaniuk, H. 2003: Controlled trial of the short- and long-term effect of

- psychological treatment of post-partum depression. I. Impact on maternal mood. *British Journal of Psychiatry* 182, 412–19.
- Cox, J.L., Holden, J.M. and Sagovsky, R.** 1987: Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150, 782–86.
- Cowley, S.** 2009: *Health visiting matters: re-establishing health visiting*. London: UK Public Health Alliance. Retrieved 8 June 2010 from <http://www.ukpha.org.uk/>
- Cullinan, R.** 1991: Health visitor intervention in postnatal depression. *Health Visitor* 64, 412–14.
- Department of Health.** 2003: *Women's mental health. Into the mainstream, implementation plan: mainstreaming gender and women's mental health*. London: Department of Health.
- Department of Health.** 2008: *Transforming community services: currency and pricing options for community services*. London: Department of Health.
- Elliott, S.A., Leverton, T.J., Sanjack, M., Turner, H., Cowmeadow, P. and Hopkins, J.** 2000: Promoting mental health after childbirth: a controlled trial of primary prevention of postnatal depression. *British Journal of Clinical Psychology* 39, 223–41.
- Garland, A., Fox, R. and Williams, C.** 2002: Overcoming reduced activity and avoidance: a five areas approach. *Advances in Psychiatric Treatment* 8, 453–62.
- Gerrard, J., Holden, J.M., Elliott, S.A., McKenzie, P., McKenzie, J. and Cox, J.L.** 1993: A trainer's perspective of an innovative programme teaching health visitors about the detection, treatment and prevention of postnatal depression. *Journal of Advanced Nursing* 18, 1825–832.
- Hearn, G., Iliff, A., Jones, I., Kirby, A., Ormiston, P., Parr, P., Rout, J. and Wardman, L.** 1998: Postnatal depression in the community. *British Journal of General Practice* 48, 1064–66.
- Hewitt, C.E., Gilbody, S.M., Brealey, S., Paulden, M., Palmer, S., Mann, R., Green, J., Morrell, J., Barkham, M., Light, K. and Richards, D.** 2009: Methods to identify postnatal depression in primary care: an integrated evidence synthesis and value of information analysis. *Health Technology Assessment* 13, (36).
- Hill, C.E. and Lambert, M.J.** 2004: Methodological issues in studying psychotherapy process and outcomes. In Lambert, M.J., editor, *Bergin and Garfield's handbook of psychotherapy and behaviour change*, fifth edition. New York: Wiley, 84–135.
- Holden, J.M., Sagovsky, R. and 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, 223–26.
- Kendall, P.C., Holmbeck, G. and Verduin, T.** 2004: Methodology, design and evaluation in psychotherapy research. In Lambert, M.J., editor, *Bergin and Garfield's handbook of psychotherapy and behaviour change*, fifth edition. New York: Wiley, 16–43.
- Kumar, R. and Robson, K.M.** 1984: A prospective study of emotional disorders in childbearing women. *British Journal of Psychiatry* 144, 35–47.
- Leverton, T.** 2005: Advantages and disadvantages of screening in clinical settings. In Henshaw, C. and Elliott, S., editors, *Screening for perinatal depression*. London: Jessica Kingsley Publishers, 34–46.
- Luborsky, L., Diguier, L., Seligman, D.A., Rosenthal, R., Krause, E.D. and Johnson, S.** 1999: The researcher's own therapy allegiances: a 'wild card' in comparisons of treatment efficacy. *Clinical Psychology* 6, 95–106.
- Mearns, D.** 1997: *Person-centred counselling training*. London: Sage.
- Merry, T.** 1999: *Learning and being in person-centred counselling*. Ross-on-Wye: PCCS Books.
- Morrell, C.J., Slade, P., Warner, R., Paley, G., Dixon, S., Walters, S.J., Brugha, T., Barkham, M., Parry, G. and Nicholl, J.** 2009a: Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women – pragmatic cluster randomised trial in primary care. *British Medical Journal* 338, a3045.
- Morrell, C.J., Warner, R., Slade, P., Dixon, S., Walters, S.J., Paley, G., Brugha, T. and Cox, D.** 2009b: Psychological interventions for Postnatal Depression: cluster randomised trial and economic evaluation. *Health Technology Assessment* 13, (30).
- Mynors-Wallis, L.M., Gath, D., Davies, I., Gray, A. and Barbour, F.** 1997: A randomised controlled trial and cost analysis of problem-solving treatment given by community nurses for emotional disorders in primary care. *British Journal of Psychiatry* 170, 113–19.
- National Institute for Health and Clinical Excellence (NICE).** 2007: *Antenatal and postnatal mental health. Clinical management and service guidance*. London: National Institute for Health and Clinical Excellence.
- Plews, C., Bryar, R. and Closs, J.** 2005: Clients' perceptions of support received from health visitors during home visits. *Issues in Clinical Nursing* 14, 789–97.
- Rogers, C.R.** 1951: *Client-centered therapy*. London: Constable.
- Rogers, C.R.** 1969: *Freedom to learn*. Columbus, OH: Charles E. Merrill.
- Rowland, B.** 2002: Depressed process: a person-centred view of depression. *Person-Centred Practice* 10, 27–34.
- Sanders, P.** 2000: Mapping person-centred approaches to counselling and psychotherapy. *Person-Centred Practice* 8, 62–74.
- Scottish Intercollegiate Guidelines Network (SIGN).** 2002: *Postnatal depression and puerperal psychosis*. Edinburgh: Scottish Intercollegiate Guidelines Network.
- Seeley, S., Murray, L. and Cooper, P.J.** 1996: The outcome for mothers and babies of a health visitor intervention. *Health Visitor* 69, 135–38.
- Tudor, K. and Worrall, M.** 2006: *Person centred therapy: a clinical philosophy*. London, UK: Routledge.

- Wickberg, B.** and **Hwang, C.P.** 1996: Counselling of postnatal depression: a controlled study on a population based Swedish sample. *Journal of Affective Disorders* 39, 209–16.
- Williams, C., Cantwell, R.** and **Robertson, K.** 2008: *Overcoming postnatal depression: a five areas approach*. London: Hodder Arnold.
- Williams, C.** 2009: *Overcoming depression and low mood: a five areas approach*, second edition. London: Hodder Education.
- Wood, J.K.** 1996: The person-centered approach: towards an understanding of its implications. In Hutterer, R., Pawlowsky, G., Schmid, P.F. and Stipsits, R., editors, *Client-centered and experiential psychotherapy: a paradigm in motion*. Frankfurt am Main: Peter Lang, 163–81.