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Strengthening Family Support by Integrating Mental Health Practitioners into the MECSH Programme in Jersey and Guernsey Health Visiting Teams

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Strengthening Family Support by Integrating Mental Health Practitioners into the MECSH Programme in Jersey and Guernsey Health Visiting Teams

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Abstract

The Maternal Early Childhood Sustained Home-visiting (MECSH) programme is a structured, evidence-based intervention aimed at improving maternal and child health outcomes for families with increased vulnerability. This paper explores the integration of a Mental Health Practitioner (MHP) within MECSH teams across Jersey and Guernsey, examining the rationale, implementation process, and outcomes.

Evaluation findings from health professionals indicate that embedding MHPs enhances early identification and support for parental mental health needs, improves service accessibility, reduces stigma, and strengthens team confidence. Quantitative and qualitative data from both Channel Islands demonstrate significant improvements in parental mental health and increased engagement among families with complex needs. The study contributes to the limited evidence base on skill-mix models in health visiting, supporting the value of integrated, relationship-based care and highlighting MECSH as a flexible and scalable approach for delivering sustainable, equitable family support, grounded in the principle of proportionate universalism.

Background

The Maternal Early Childhood Sustained Home visiting programme (MECSH) was introduced to Jersey in 2015 and Guernsey in 2018. MECSH is a structured evidence-based home visiting programme designed to improve outcomes for families at risk of poorer maternal and child health and development (Kemp et al, 2011; 2017). In the UK and the Channel Islands, it is delivered by health visitors trained in the programme, to families needing an enhanced level of health visiting (such as targeted or specialised services). It is based on the model of proportionate universalism, ensuring families with greater vulnerabilities are provided with a higher level of service that is proportionate to their needs (Kemp et al, 2017). The MECSH programme is offered through 25 scheduled contacts from pregnancy or up to 6–8 weeks postnatally until the child is 2 years old. Each family on the MECSH programme has a named health visitor who works in partnership with parents,

offering them a structured child development parent education programme, and enabling the development and use of community-based support groups and services. A unique feature of the programme is its ability to effectively mesh families and services together, creating a cohesive support system. This approach ensures that families receive timely access to the right mix of professional skills and resources tailored to their individual needs.

This paper explores a MECSH model that incorporates a Mental Health Practitioner (MHP) within the health visiting team. It outlines the rationale for embedding mental health expertise within the health visiting teams in Jersey and Guernsey, and provides a brief history of the implementation process across the two islands, including key drivers, challenges, and collaborative strategies that supported integration. Finally, it presents evaluation findings from the practitioners' perspective that examine outcomes for parents and health visiting team members, highlighting the impact of the MHP role on family engagement, emotional wellbeing, service accessibility, and professional confidence.

The Mental Health Practitioner in Jersey and Guernsey

Jersey

The MHP role was introduced into the health visiting team in 2016, in response to findings from a local evaluation of family needs. This evaluation highlighted that mental health challenges, particularly perinatal anxiety and depression, were prevalent among a significant proportion of families engaged with the MECSH programme. These issues often interfered with parents' ability to fully engage with the intervention and presented a barrier to achieving optimal outcomes for their child. The MHP role was developed to address low to moderate levels of parental mental health needs within the home environment. The MHP provided time-limited (typically 6–8 sessions) mental health support, including assessment, brief interventions, and, where necessary, escalation to acute or specialist services. The focus of the role was to deliver targeted mental health and wellbeing support directly to parents participating in the MECSH programme. Working in close collaboration with health visitors, the MHP supported families in identifying effective coping strategies,

improving emotional wellbeing, and building confidence in managing mental health challenges. This integrated approach aimed to ensure that parents received timely, accessible support, enabling better engagement with MECSH and improving outcomes for both parents and children.

Following a referral from the MECSH health visitor, the MHP and health visitor conduct a joint home visit to carry out an initial assessment. This collaborative approach ensures that the family's mental health needs are fully explored, and the most appropriate intervention pathway is identified. In some cases this will highlight the need for referral to specialist service JAMHS (Jersey Adult mental Health service) Perinatal Mental health Service. In other instances, parents may require preparatory therapeutic support to access community-based interventions such as Mellow Parenting Groups, Relate Counselling and Jersey Talking Therapies. Remove sessions with Clinical Psychologist. Where support from the MHP is deemed appropriate, parents are offered six to eight structured, sessional contacts in their home. These sessions are designed to be collaborative, goal-oriented, and aligned with the broader aims of the MECSH programme. Grounded in a strengths-based, trauma-informed approach, the intervention focuses on the 'here and now', helping parents to build emotional capacity and availability to respond to their child, key factors in shaping a secure and emotionally regulated environment for early child development (Siegel and Bryson, 2020). The MHP will also offer joint sessions with partner/family member if needed, to support or consolidate intervention strategies developed in sessions to optimise outcomes for the referred parent. The MHP will also offer sessions to assess, support and signpost partners and other caregivers with mental health challenges, thus supporting the whole family.

During the first session, a mental health risk assessment is completed, which is reviewed regularly to ensure ongoing safety and appropriateness of care. Following NICE (2020) guidance, validated outcome measures such as the Edinburgh Postnatal Depression Scale (EPDS) and the Generalised Anxiety Disorder Questionnaire (GAD-7) are administered at the initial one-to-one session and again after the final session to monitor progress and inform evaluation. The one-to-one sessions are individually tailored to the parent's needs and draw on a range of evidence-based interventions. These may include:

- CBT informed strategies
- Decider Skills
- Psychoeducation around perinatal mental health
- Parenting support, including reflective parenting approaches
- Mindfulness techniques and breathwork

Through this work, parents build a practical ‘toolbox’ of strategies that can support their ongoing mental health and emotional resilience. This not only benefits the parent but also enhances the parent-child relationship and the child’s developmental outcomes. In addition to direct work with families, the MHP plays a vital supportive role within the health visiting team by contributing to the capacity-building of the team through delivering perinatal mental health training updates, consultation on mental health concerns, and reflective supervision to health visitors.

The MHP collaborates closely with the Perinatal and Infant Mental Health Midwife and the Perinatal Mental Health Service teams, actively participating in weekly multi-disciplinary meetings, promoting early intervention and providing a gateway to sustained, integrated support throughout the MECOSH programme in Jersey. Additionally, the MHP supports a community-based weekly MECOSH group, helping parents build relationships and develop supportive networks. Clinical supervision is provided by the MECOSH Lead and a Consultant Clinical Psychologist from the Child and Adolescent Mental Health Service (CAMHS).

Guernsey

MECOSH has been available in the Bailiwick of Guernsey (in Guernsey, Alderney, and Herm but not Sark) since June 2018. As part of its implementation, local service leads explored how the programme was structured in other jurisdictions. Similar to Jersey, it was decided that families in Guernsey would benefit from the inclusion of a MHP in the MECOSH health visiting team, to provide timely, tailored support for mental health and emotional wellbeing. The primary aim of introducing the MHP role was to support health visitors in maintaining a focus on the mother–child relationship while allowing the MHP to work directly with clients on mental health challenges, offering early intervention, developing coping strategies, and escalating to specialist services where needed.

The establishment of the MHP role presented a significant learning curve, with differing professional perspectives around where the role should be most effectively focused. One of the main contextual challenges in Guernsey was the structure of its largely private healthcare system. Historically, any parent experiencing mental health issues was required to see a GP to access secondary mental health services. This presented a substantial barrier to access, both in terms of administrative burden and cost (at the time, a 10-minute GP appointment cost £53). Although services have moved on, and the health visiting service can refer directly into the Duty Team of secondary mental health for perinatal mental health concerns, referrals into other mental health services, such as psychiatry and psychology, still require a referral from a GP (appointments now costing £70 for 10 minutes). These financial and systemic access barriers reinforced the importance of the MECSH MHP providing targeted interventions for mild to moderate mental health concerns, as many families could not otherwise afford or access support in a timely manner.

The MHP service in Guernsey began in 2019, initially split between the health visiting team and Duty and Assessment. This led to challenges, as acute cases were often prioritised, limiting time for ongoing work with the health visiting team and their clients. Following an 18-month staffing gap, the MHP service was re-established in 2022 by the current practitioner, a mental health nurse with experience across acute and long-term secondary mental health services. Since then, the role has developed with a strong focus on early intervention and prevention. This includes telephone screening of MECSH referrals where current or historical mental health concerns are identified, enabling timely assessment and support, often starting before birth and continuing postnatally.

Referrals, primarily from midwifery and health visiting services, can be made from as early as 8 weeks' gestation through to just after delivery. The process includes initial discussion with the referrer, telephone screening, and a home visit for assessment, within 5 days for moderate-risk cases, and within 14 days for low-risk cases. During the initial visit, parents are provided with information on perinatal mental health and Decider Skills, alongside completion of the EPDS, a comprehensive assessment, and the development of an individualised care plan. To date, 34 referrals have been received, including two fathers. Feedback from both families and professionals have

been overwhelmingly positive. The flexibility of the role allows for tailored, whole-family support using a range of therapeutic tools, including:

- CBT-informed strategies
- Psychoeducation
- Mindfulness and breathwork
- Decider Skills
- Eye Movement Desensitisation and Reprocessing (EMDR)

The role is supported by clinical supervision from secondary mental health services, ensuring safe and reflective practice. Health visiting staff report valuing the support, supervision, and joint working opportunities provided by the MHP, which has helped to develop their confidence and practice.

Outcomes for families

The feedback and outcomes for the MHP role within the MEC SH team continue to be positive and highly valued by families, staff and partner agencies in both Channel Islands.

Jersey

In Jersey regular outcome data is collected using the EPDS, GAD-7 and qualitative feedback from parents. Since 2017, the MHP has supported 232 parents (predominantly mothers).

The outcome measures on both scales (EPDS and GAD-7) show a positive shift for depression and anxiety (Table – 1). The average score for depression on the EPDS decreased from 16 (moderate depression) to 7 (mild depression), and anxiety on the GAD-7 decreased from 15.5 (severe anxiety) to 5.5 (mild anxiety).

Table 1: Average assessment scores for parents seen by the MPH between 2017 – 2024:

| | Mean EPDS Score | Mean GAD-7 Score | Interpretation |
|----------------------------|-----------------|------------------|---|
| Before intervention | 16 | 15.5 | Moderate depression Severe anxiety |
| After intervention | 7 | 5.5 | Sub-clinical depression Mild anxiety |

While it is recognised that other confounding factors may have influenced the results, qualitative feedback from parents, collected through routine service evaluation (Box 1), is overwhelmingly positive and highlights the meaningful impact of the service, reinforcing the quantitative findings presented above.

Box – 1: Feedback from parents who received MHP support in Jersey

“I had a lady called X in MEC SH who saved my life. She helped me understand I was ok, and gave me tools to cope with anxiety. But mostly she just listened, that worked best”

“I don’t think I would have made it through without her”

“I felt really supported and my feelings were validated”

“The coping strategies were invaluable”

“Every session there were new ideas and techniques for me to put into practise to help me in day to day life”

“Home visits were more relaxing and safe for me, I felt too anxious and overwhelmed to get to my GP”

“I feel without the home visits I wouldn’t have been able to get the help for my mental health that I needed”

“I feel I have truly begun my healing process”

“A space of calm in which I could talk openly”

“MHP has been an amazing support.....she has given me the courage to continue my journey of receiving support for my mental health”

Guernsey

The current MHP started in 2022 and began supporting 11 clients from 2021 and 2022 who had not previously received mental health input due to the role being vacant. Since then, referrals and caseloads have steadily increased.

In 2023, 24 referrals were received, primarily from midwifery services (22), with two from Healthy Minds (Primary Care Mental Health Service). Of these, 22 referrals involved current or historical mental health concerns, and two cited a history of postnatal depression. That year, 25 clients were in receipt of the MECOSH programme, with 12 identified for mental health reasons and 10 receiving direct input from the MHP. In 2024, 27 referrals were received, 25 from midwifery and two from Healthy Minds (one referral was duplicated), with 19 involving mental health concerns and three relating to past postnatal depression. There are currently 30 clients on the MECOSH programme, 13 were referred for mental health reasons, and 13 have received MHP support to date.

The two case studies presented in Box 2 further illustrate the complexity and value of the MHP role. Client A, diagnosed with Bipolar Disorder Type 2, avoided secondary mental health services due to past negative experiences. With antenatal and postnatal support, a collaboratively developed Wellness Recovery Action Plan (WRAP), and coordination with her private psychiatrist, a significant relapse was avoided. The MHP provided ongoing input, including follow-up over a year later when early signs of relapse reappeared.

Client B, a father of two, was referred due to ongoing low mood and stress. Assessment indicated possible Autism Spectrum Disorder, leading to a referral for formal diagnosis. Through regular sessions with the MHP, he developed insight into the connection between ASD, anxiety, and mood, and built effective self-management strategies. His case highlights the inclusive, whole-family approach of the MHP role.

These examples, alongside referral data, highlight the growing and evolving impact of the MHP role within Guernsey's MECOSH programme. A unique strength of MECOSH is its integration of health, parenting, and social support within a structured, strengths-based framework. Embedding a Mental Health Practitioner within this model enhances its ability to offer timely, targeted, and ongoing mental health

support. This integrated approach not only addresses parental wellbeing but also strengthens the parent-child relationship, while effectively navigating the limitations of local service pathways. The result is a more responsive, joined-up service that benefits both families and the wider health visiting team.

Box - 2: Case studies of parents supported by the MHP in Guernsey

Client A

Client A was referred to the MECSH team by midwifery services due to a diagnosis of Bipolar Disorder Type 2 and ongoing care from a private psychiatrist. Having previously had negative experiences with local secondary mental health services, Client A expressed a strong preference to avoid re-engagement with them. Initially seen by the MECSH health visitor at 35 weeks gestation, Client A was prescribed Quetiapine and had discontinued Venlafaxine due to pregnancy. Despite her mental health history, including depressive episodes marked by withdrawal and suicidal ideation, and periods of mild mania, she had never been hospitalised. A full mental health assessment was completed at 37 weeks by the MECSH MHP, confirming her diagnosis and outlining support needs.

Client A and her partner collaborated with the MHP to develop a Wellness Recovery Action Plan (WRAP), which was shared with relevant professionals, including midwives, health visiting team, her private psychiatrist, and the perinatal mental health team (with her consent). After delivery, Client A was assessed and discharged by secondary mental health services, though this was not communicated to the MECSH team.

Postnatally, the MHP provided weekly support for six weeks and fortnightly input for three months, identifying and addressing early mood fluctuations. No significant episodes occurred, and she was discharged from MHP care 10 months postnatally. At 14 months, Client A self-referred again, concerned about emerging manic symptoms. Medication was adjusted in consultation with her UK psychiatrist, and the MHP provided intensive, twice-weekly support, which successfully prevented escalation. Client A's case illustrates the importance of consistent, personalised mental health input within the MECSH framework, particularly for individuals reluctant to access mainstream secondary services.

Client B

Client B is a 41-year-old father of two who was referred to the MECSH Mental Health Practitioner (MHP) following a prolonged period of low mood and stress, previously managed by his GP. His wife had experienced significant postnatal depression after both births and had received MECSH support.

During assessment, Client B presented with traits suggestive of Autism Spectrum Disorder (ASD), including limited eye contact, fixed speech patterns, and difficulty with conversational redirection. An ASD screening tool (AQ-50) indicated a high likelihood of ASD, and a formal referral for assessment was made with his consent.

Client B described ongoing stress over a four-year period due to caring for his unwell partner, adjusting to parenthood, and working in an unsupportive environment. This chronic stress had negatively impacted his mental health and emotional wellbeing.

Since the referral, Client B has engaged in regular sessions with the MHP, initially fortnightly and later bimonthly. He has reported improved mood, increased insight into the relationship between ASD traits, anxiety, and low mood, and has developed more effective strategies for managing his mental health. His case highlights the inclusive and flexible nature of the MECSH model in supporting fathers and addressing broader family needs.

MECSH health visiting team members' perspective

A mixed-methods survey was conducted with MECSH health visiting team members across both Jersey and Guernsey between February and June 2025 to explore their views on the MHP role. The questionnaire (Appendix – A) was co-produced by MHPs, health visiting staff, and the UK MECSH team, and distributed via Microsoft Forms. Ethical approval was granted by the Guernsey Ethics Committee, and permission to proceed was obtained from the Jersey health service.

Questionnaire data were analysed using descriptive and thematic analysis. Anonymised survey data was received from 25 practitioners, 18 from Jersey and 7 from Guernsey, and included health visitors (HV), HV Team Leads/managers, community nursery nurses (CNN) and MHPs (see Figure- 1).

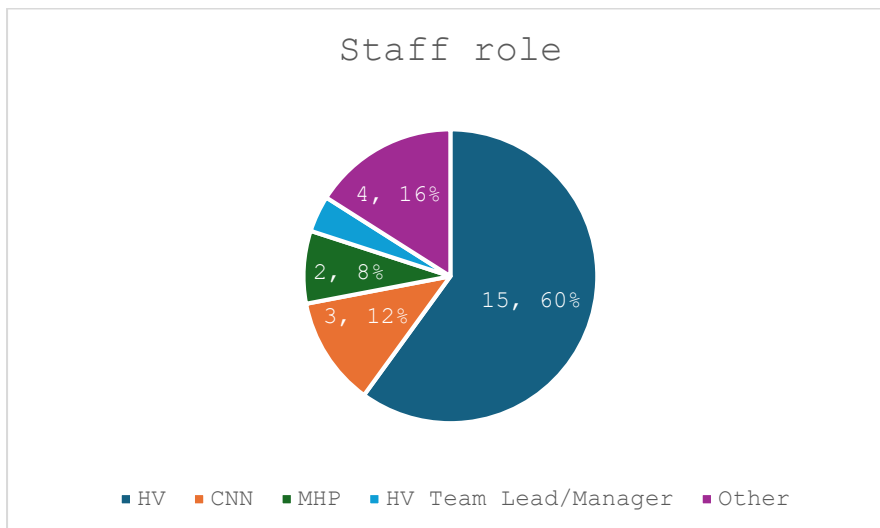


Figure 1: Breakdown of staff group

The practitioners reported wide-reaching positive impacts of introducing the MHP role within the MECSH programme across families, team members, and the broader service, as evidenced in Figures 2–4.

Figure 2: Impact on families

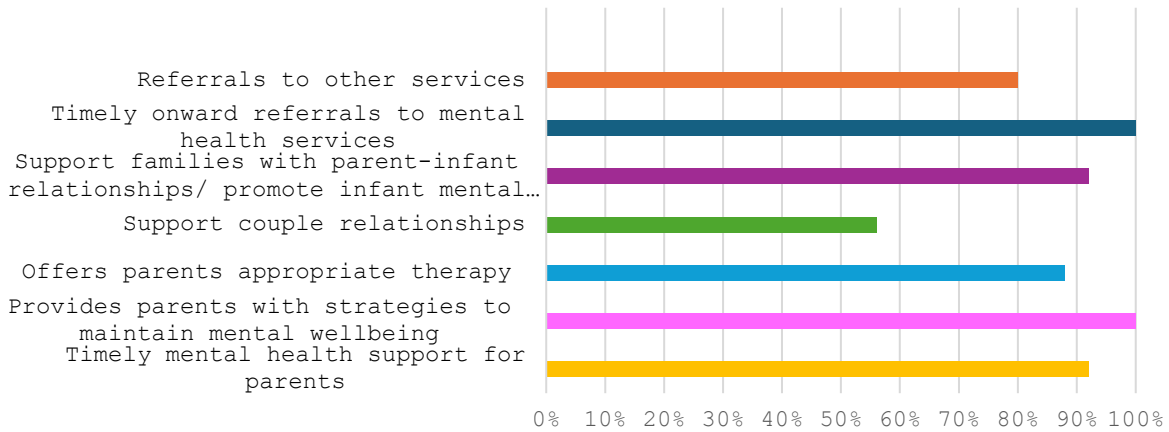


Figure 2 highlights the benefits reported for families. The majority of respondents reported that the MHP provided timely mental health support for parents (92%), offered strategies to maintain mental wellbeing (100%), and delivered appropriate therapeutic input (88%). There was also strong recognition of the role in promoting parent-infant relationships and infant mental health (92%) and facilitating timely referrals to mental health services (100%). These outcomes support the MHP’s role in creating emotionally supportive and responsive home environments as part of the MEC SH programme aims, crucial for early child development.

Figure 3: Impact on team members

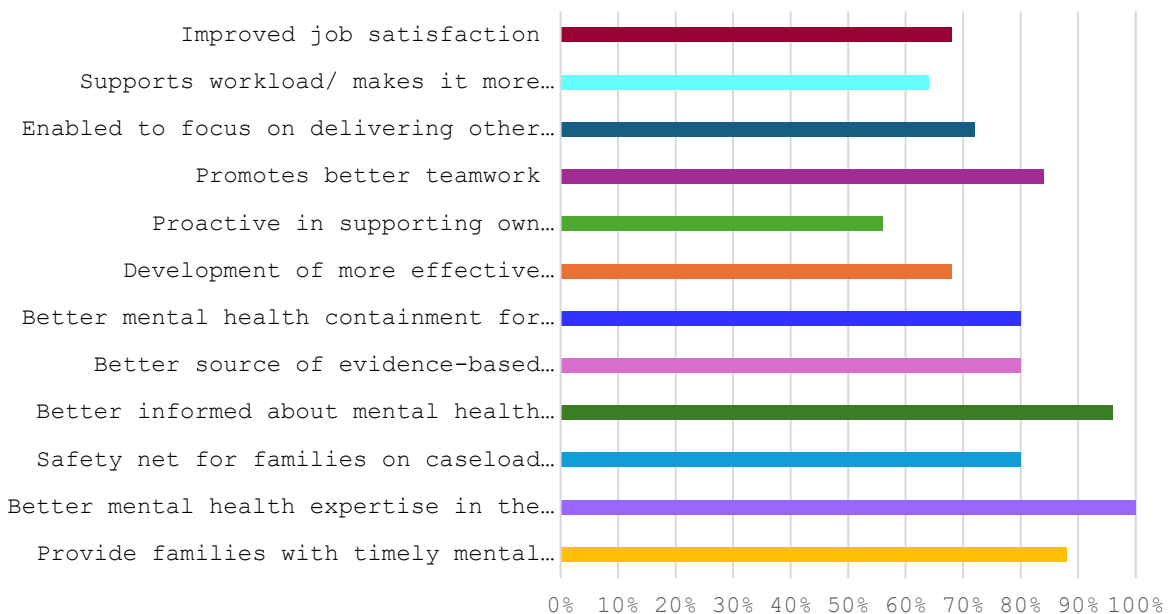


Figure 3 outlines the significant positive impact of the MHP role on MECOSH team members. 84% of respondents agreed that the MHP promoted better teamwork by ensuring the right skills, in the right place, at the right time, and all (100%) noted improvements in mental health expertise within the team, and a strengthened safety net for families on the caseload (80%). The presence of the MHP enabled practitioners to focus on delivering other aspects of the programme, while also improving their job satisfaction and providing better containment and support around complex cases. Additionally, staff felt better informed about available mental health resources and valued the opportunity for interdisciplinary collaboration and development.

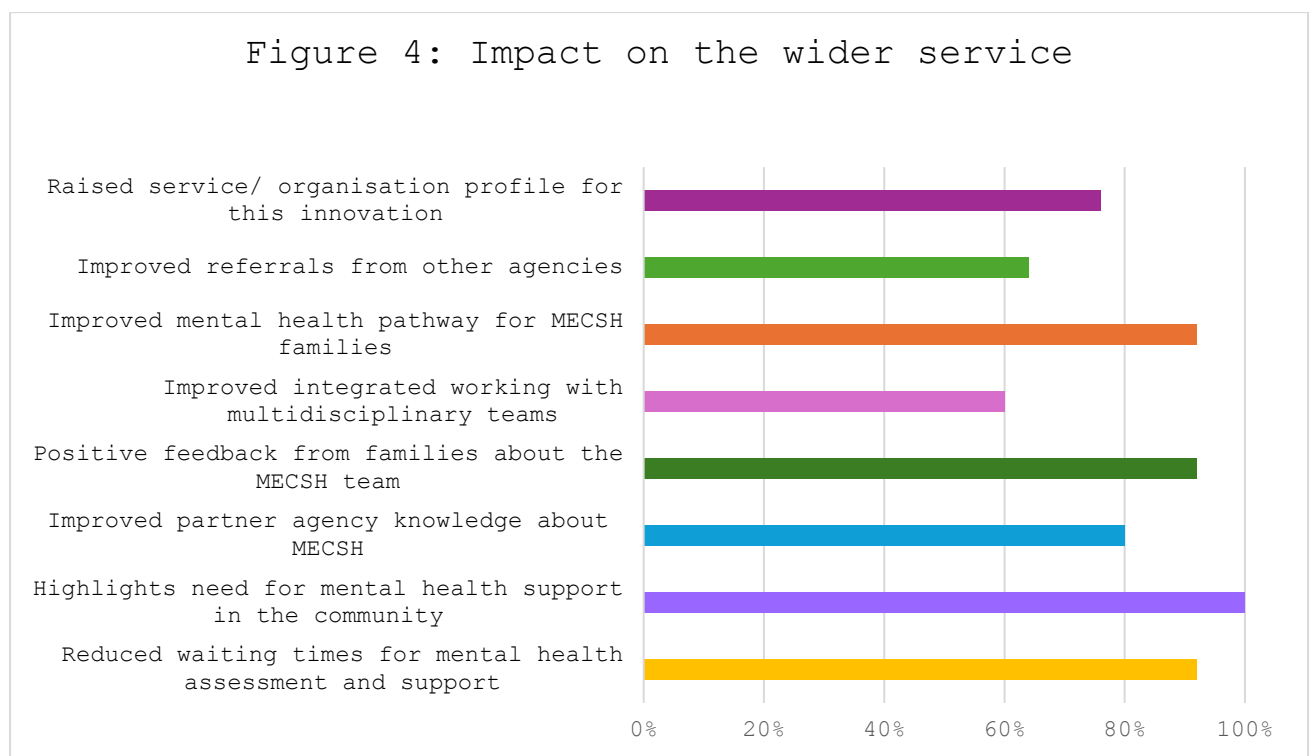


Figure 4 demonstrates the broader service-level impact. The MHP role was seen as pivotal in improving the mental health pathway for MECOSH families, contributing to reduced waiting times for mental health assessment and support (92%), and improving inter-agency communication and referrals. It also enhanced the organisation's profile (76%), increased partner agency awareness of MECOSH (80%), and highlighted the growing need for mental health provision in community settings

(100%). Feedback from families was reported to further reinforce the value of this role, with high levels of satisfaction and appreciation reported (92%).

These findings show that the MHP role is not only meeting a clear clinical need but is also improving service integration, workforce wellbeing, and family outcomes, aligning with both the aims of the MECOSH programme and wider public health priorities.

Qualitative feedback collected through questionnaires strongly supported the quantitative findings, identifying several key themes that demonstrate the value and impact of the MHP role within the MECOSH team.

1. Timely access to mental health support

Practitioners consistently emphasised the value of prompt, early intervention in preventing the escalation of mental health issues:

“This support is almost immediate, very little waiting time for the client who needs this vital support.”

“It is a service that is almost instant on referral. They don’t need to wait a long time for that initial visit.”

“MH support in a timely manner... allows me to focus on the MECOSH programme.”

“Being able to access low to moderate level support in a more timely fashion.”

“Prompt and appropriate referrals when mental health concerns are highlighted. Prevents poor mental health from escalating into a crisis.”

“Identifying mental health difficulties/needs earlier-(also identifying the MH needs of Partners/care giving Family members-and onward referral to other services to support MH) escalating referrals more quickly to the Perinatal Mental Health Team and also supporting the Client to self refer or MHP referral for longer term therapeutic support from other agencies.”

2. Continuity and relationship-based care

Practitioners highlighted the benefits of consistent care from a known practitioner within the MECSH team, enabling trust and deeper engagement.

“It’s the same person that the client sees so helps build on those relationships.”

“Developing a trusting therapeutic relationship with the mother/primary carer... always focusing on the aspirational thinking of the client.”

“Longer term access to support for families that require it. A good and consistent point of contact during the early years.”

“Client/family-centred care, seen in a timely manner by an experienced practitioner with continuity of care.”

3. Reducing stigma and increasing accessibility

The home-based, non-clinical delivery model helped remove barriers to accessing mental health services, particularly related to stigma.

“Families who have previously avoided mental health services due to the stigma associated with certain buildings etc are accessing support for their mental health in the comfort of their own home.”

“They are less intimidated... it’s a service specific to mums/families with new babies.”

“Feeling listened to, no time pressure, reduces stigma.”

“Conversations about mental health are normalised.”

5. Enhancing parent-infant relationships and parenting capacity

Several comments highlighted the MECSH trained MHP’s impact on strengthening the parent-infant bond and supporting parental confidence.

“Supporting the parent-infant relationship and attachment.”

“Empowering the client, supporting and developing parental confidence... creating emotional availability for the baby/child.”

“Families feel really supported at the right time. They feel contained and so this impacts their capacity to respond better to their children. They find it much better to have a service at home”

6. Integration and professional support

The role was seen as enhancing the wider service through better communication, shared working, and access to expert input. Practitioners also reported high levels of support they received for their own professional development as well as maintaining good work-life balance. The benefits of the MHP were also extended to families not receiving the MECOSH programme.

“Communication between practitioners is much improved as we work as a team.”

“Very, very helpful to have a mental health practitioner working alongside the HV team. Excellent source of information for health visitors who are not mental health trained. Allows cohesive and collaborative working to best meet needs of the clients.”

“Support for the team through training, updates, supervision, containment”

“A lot of MECOSH clients are referred for anxiety and some with wider mental health needs. My mental health knowledge is limited. Therefore this role provides expert knowledge to the client and helps myself with a clearer understanding and boundaries.”

“Being able to speak to someone easily when difficulties arise with clients is a gamechanger. Having that knowledge available and being able to 'run something by' someone helps in managing my own workload”.

The confidence of the team around mental health has just grown and grown.

“Helped me balance work and family demands.”

“The MHP role is invaluable to our MECOSH program and offers huge benefits not only to clients but also to the team. The ripple effect it has is also beneficial for clients who are not accessing MECOSH, through HV using the resources and tools learnt and supported from the MHP.”

7. Positive change in MECSH perception and job satisfaction

The presence of the MHP has enhanced perceptions of MECSH and improved morale among staff.

“The narrative around MECSH has changed... Clients share that they see the MECSH Programme as aspirational.”

“I feel MECSH as a programme has improved not just my professional practice but on a personal level. I have so much satisfaction in my job role that the positivity then filters into team moral and having a positive work ethos.”

Overall, practitioners emphasised the long-term benefits of investing in mental health support early and the MHP role was seen as pivotal to improving child and family outcomes and preventing future crises.

Discussion

The integration of the MHP role within the MECSH programme across Jersey and Guernsey has consistently shown positive outcomes for families, practitioners, and the broader health service. Quantitative data from Jersey have revealed significant improvements in parental mental health, with reductions in depression and anxiety scores (EPDS and GAD-7), supporting previous research on the benefits of early mental health interventions (Smith et al., 2020). Similarly, in Guernsey, a growing caseload and illustrative case studies highlight the role's effectiveness in supporting parents with complex needs and engaging underserved families, aligning with findings by Kesten et al. (2022) on the importance of targeted mental health support in reaching vulnerable populations.

Survey feedback from MECSH team members further reinforces these outcomes, with overwhelming support for the MHP role in improving timely access to mental health support, promoting parent-infant relationships, and enhancing team capability and confidence. Practitioners repeatedly highlighted the ability to deliver responsive, relationship-based care that reduces stigma and fosters trust, particularly through home visits. These findings resonate with those of Wilson and Gray (2021), who

stress the importance of relational, community-based interventions in improving mental health outcomes.

The MECSH model, grounded in the principle of proportionate universalism, ensures that families receive support tailored to their specific needs. The inclusion of mental health expertise within the health visiting team enhances this approach, ensuring that mental health needs are identified and addressed early. Incorporating mental health professionals into the MECSH programme ensures non-stigmatising, timely access to care delivered in the comfort of the home, making it adaptable to the evolving and diverse needs of families. This is also likely to save costs in the long run, through the management of mild to moderate perinatal mental health issues within the community and reducing referrals to secondary services. Further research incorporating economic evaluations in this area would be valuable.

Within many health visiting teams, the role of specialist perinatal mental health champions or health visitors mirrors that of the MHP described in this study. The Institute of Health Visiting's Perinatal and Infant Mental Health (PIMH) model further elaborates on the integration of such specialists, highlighting their critical role in improving maternal and infant mental health outcomes. These specialist roles can bridge the gap between universal and specialist services (iHV, 2023), offering a holistic, supportive approach to perinatal mental health that complements the MECSH model. These integrated roles align with the growing body of literature emphasising the need for multi-disciplinary approaches to mental health within health visiting teams (iHV, 2023; Fisher et al., 2020).

To our knowledge, this is a unique model for delivering the MECSH programme in the UK. However, it is essential to acknowledge that there are multiple models of skill-mix within health visiting teams, and the question of whether specific service delivery models offer distinct advantages remains unanswered. Whittaker et al. (2021) note that while different configurations of health visiting services are in place, research into the outcomes of various models remains limited. More research is needed to better understand the specific outcomes for children and families when health visiting services are operationalised in diverse ways. This study, therefore, makes a valuable contribution to filling this gap, particularly by highlighting the positive impact of integrating MHPs into health visiting teams.

Conclusion

The successful integration of the MHP role within MECSH highlights the critical need to embed mental health support into universal health visiting frameworks. This model not only enhances outcomes for families by providing timely, targeted support, but also strengthens the overall service system by fostering collaboration, reducing barriers to care, and building practitioner confidence. As health visiting teams continue to address increasingly complex and diverse family needs, integrated models such as MECSH offer a clear pathway for delivering more responsive, strengths-based, and sustainable support, contributing to the broader goals of improving health equity and access to quality care (Marmot, 2010; Kesten et al., 2022).

Acknowledgement

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References

- Fisher, S., Thompson, L., Wilson, R. (2020). The role of health visitors in supporting maternal mental health: A systematic review. *Journal of Public Health*, 42(3): 429-438.
- iHV (2023) Specialist Health Visitors in Perinatal and Infant Mental Health: Where they are and what they're doing. Institute of Health Visiting.
- Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., Schmied, V., Aslam, H., Zapar, S. (2011) Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. *Arch Dis Child*, 96(6): 533–540.
- Kemp L, Cowley S, Byrne F. (2017) Maternal Early Childhood Sustained Home-visiting (MECSH): A UK update. *Journal of Health Visiting* 5(8):392-397).
- Kesten, J. M., Henderson, L., Wright, M. (2022) Improving outcomes for families with complex needs: A review of service delivery models in perinatal mental health. *Journal of Health Services Research*, 38(1): 98-106.
- Marmot, M. (2010) Fair society, healthy lives: The Marmot Review. Strategic Review of Health Inequalities in England post-2010.
- National Institute for Health and Care Excellence (2020) Clinical Guideline 192. Antenatal and postnatal mental health: clinical management and service guidance. <https://www.nice.org.uk/guidance/cg192/chapter/recommendations>
- Siegel, D.J. and Bryson, T.P. (2020) *The Power of Showing Up: How Parental Presence Shapes Who Our Kids Become and How Their Brains Get Wired*. New York: Ballantine Books.
- Smith, D., Peters, M., Roberts, S. (2020). Early intervention in parental mental health: Implications for practice and policy. *International Journal of Mental Health Nursing*, 29(6): 882-891.
- Whittaker, S., Hudson, J., Stevenson, H. (2021) Exploring skill-mix models in health visiting teams: What works and why? *Health Policy*, 125(4): 523-532.
- Wilson, R., Gray, R. (2021) Relationship-based care in health visiting: The impact on mental health outcomes. *Health and Social Care in the Community*, 29(2):182-190.

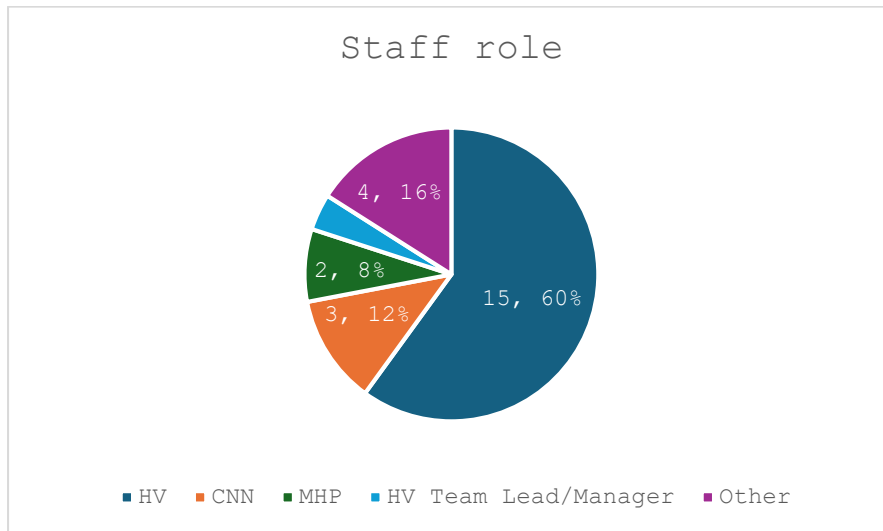


Figure 1: Breakdown of staff group

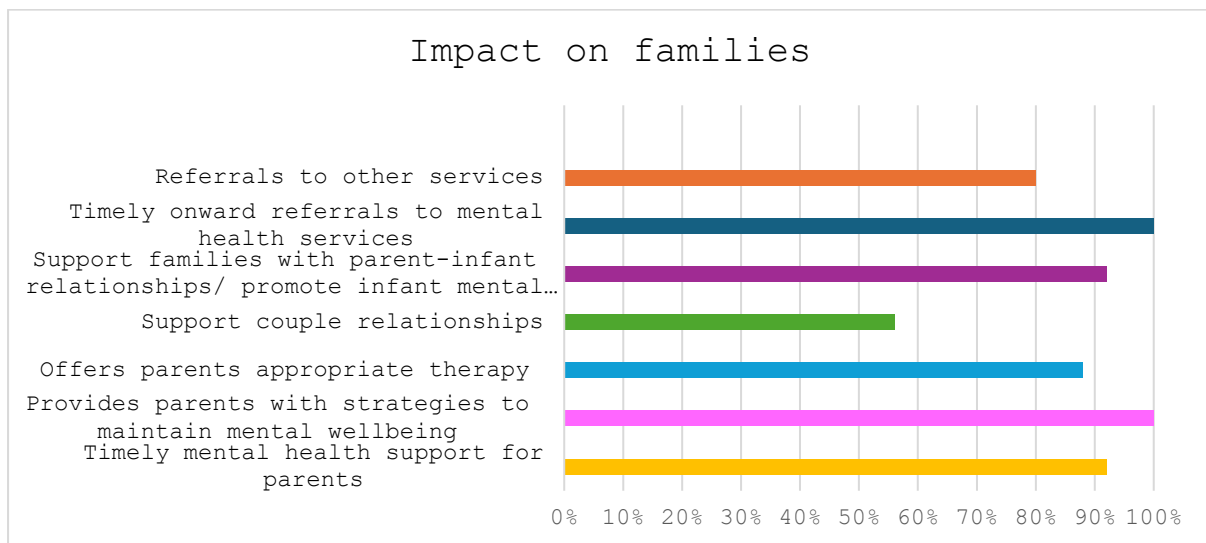


Figure 2: Impact on families

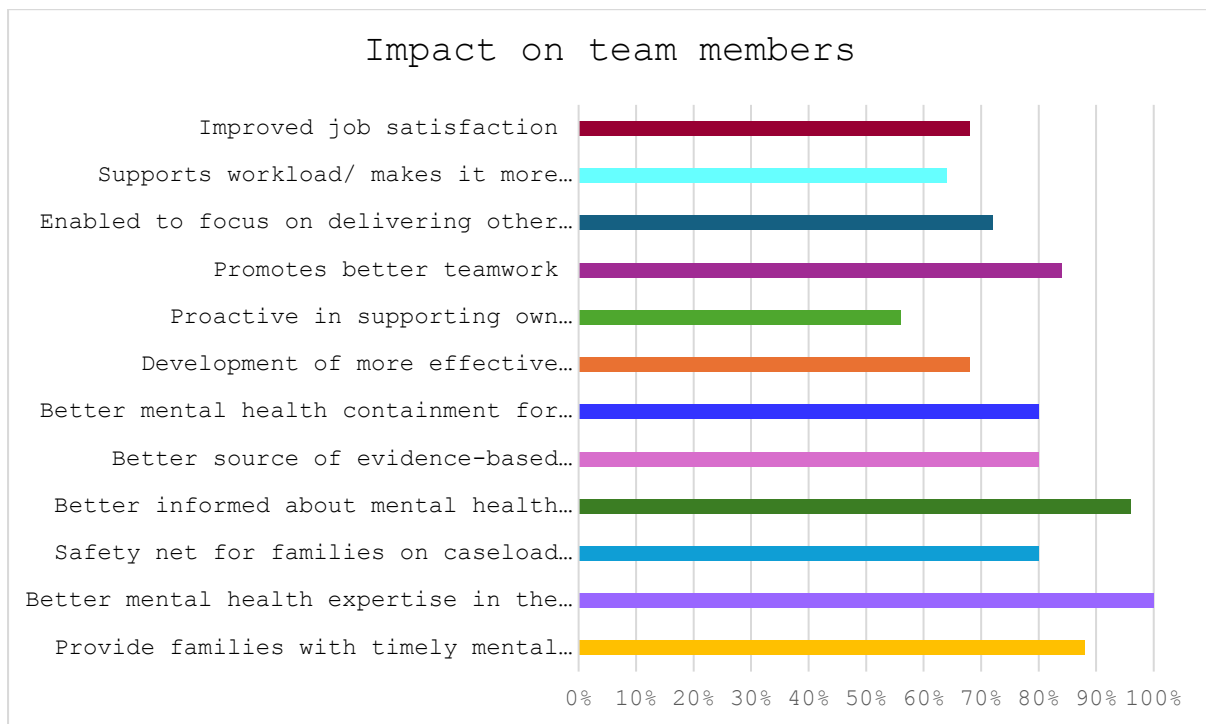


Figure 3: Impact on team members

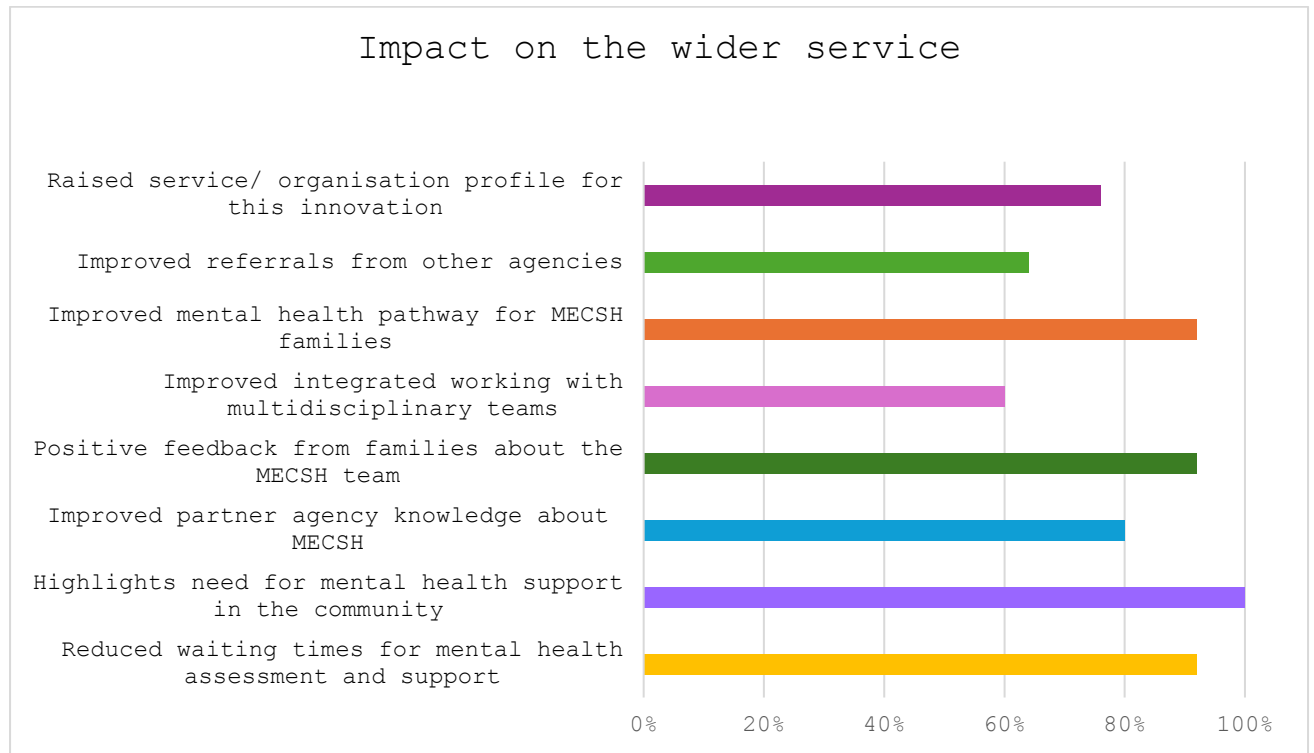


Figure 4: Impact on wider service

Table 1: Average assessment scores for parents seen by the MPH between 2017 – 2024:

| | Mean EPDS Score | Mean GAD-7 Score | Interpretation |
|----------------------------|-----------------|------------------|---|
| Before intervention | 16 | 15.5 | Moderate depression Severe anxiety |
| After intervention | 7 | 5.5 | Sub-clinical depression Mild anxiety |