Maternal and Early Childhood Sustained Home Visiting provides Foundations for Lifelong Health

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Statement of Interest:
Lynn Kemp developed and trialled the Maternal and Early Childhood Sustained Home Visiting Programme (MECSH), which is being rolled out in eight sites across England and Jersey. Sarah Cowley acts as a patron to the programme, having first introduced it to colleagues in this country and remaining part of its associated Community of Practice. We are both academics with a strong commitment to developing evidence to improve child and family public health, to reducing inequalities and improving standards of practice and service provision.

This commentary has been written in response to the release of a report by the Early Intervention Foundation (EIF) which is described (EIF 2016 page 6) as being 'about how to help parents improve how they relate, engage, communicate, play and live with children so as to improve children's experience of childhood and hopefully enhance their capability to flourish and avoid harm.' In practice, the report focused upon reviewing the impact that programmes have on emotional and cognitive development and, primarily, upon parent-infant attachment. MECSH is not an attachment-based programme, so none of the research about it has measured attachment-based outcomes. Accordingly, we rebut as factually inaccurate the conclusion that MECSH has 'evaluation evidence of not providing substantial benefits for parents or children,' (EIF 2016 page 85).

Further evidence about MECSH will be given below, but first some explanation is needed about why health visitors and others should be interested in this critique of the EIF report. There are two broad schools of thought about how best to improve scientific evidence about public health and health improvement, which equally apply to early interventions. One approach, typified by the values embedded within the EIF report, but not made explicit, holds that trials focused on a specific issue or topic of interest (perhaps breastfeeding, or sleep management or – as in the EIF report – attachment) show better and stronger evidence than broader-based studies. This approach leads to the conclusion that

> *"programmes that address identified issues in child development tend to have greater evidence of effectiveness than programmes that are more universal or are targeted on the basis of family and contextual risk," (EIF 2016, page 154*).

In short, the preferred approach in this view is to target individuals or families with identified symptoms and diagnoses; 'early intervention' is viewed as a treatment for problems that have been picked up at the earliest opportunity.

The second approach, typified by the values embedded within MECSH and – we would argue – the universal health visiting service, is to regard 'early intervention' as a preventive mechanism, targeting situations that give rise to difficulties as well as supporting people living in challenging circumstances. They may have identified difficulties, but often do not, as yet, experience any specific 'problems.' These parents may reasonably show concern about the potential stigma of being singled out as needing additional support but will accept offers of help directed at improving their own and their children's future lives. This second approach leads to the conclusion that:

> *"Many argue that the expansion of home visitation should be built solely around programs that have been proven through carefully structured clinical trials that engage a well-specified target population. We believe this approach is valuable but insufficient to achieve the type of population-level change that such reforms generally promise. We propose a home-visitation policy framework that embeds high-quality targeted interventions within a universal system of support that begins with an assessment of all new parents. This assessment process would carry the triadic mission of assessing parental capacity, linking families with services commensurate with their needs, and learning to do better."* Daro and Dodge 2010, page 79)

A concern about focusing on separate topics alone is that service commissioning may be driven by single-issue provision, instead of a broad-based health visiting service. Attachment and infant mental health are important issues, but they do not offer the whole picture for child development. The Centre for the Developing Child at Harvard University (2010) explains the importance of the earliest weeks and months of life – from pregnancy to two or three years of age by describing three essential 'foundations of lifelong health,' which are stable, responsive relationships (which includes attachment); safe, supportive environments; and appropriate nutrition.

The Maternal and Early Childhood Sustained Home Visiting (MECSH) programme responds to the complex needs of families living in challenging or vulnerable situations, by uniquely providing a fully embedded proportionate universal intervention. Rather than focusing upon a single health issue (attachment), MECSH reorients existing health visiting resources and child and family service systems to provide a structured, anticipatory and salutogenic response to the broad range of needs of vulnerable children and families on health visitors' caseloads. MECSH is specifically designed to be delivered at whole population scale (that is, by every health visitor for the vulnerable families on their caseload) and, through training and professional and system capacity building, to promote improved ways of working that have 'spill over' effects that benefit all families within the community and build community resilience. This programme approach is commensurate with the Healthy Child Programme, the Health Visitor Implementation Plan and the emerging policy position internationally, as expressed (above) by Daro and Dodge (2010).

MECSH is not an attachment-based programme

In failing to fully acknowledge that the report is, in fact, limited solely to seeking specific forms of evidence about parent-child attachment and emotional development, the EIF has seriously misrepresented the evidence that has accrued for the MECSH programme. This has led to a factually inaccurate description in the EIF report (2016), of MECSH as an attachment-based programme. MECSH is not an attachment-based programme, but is instead a multi-faceted programme with five key purposes:

1. **Supporting mother and child health and wellbeing**, including observation and support of child, maternal and family health and development, parent-infant interaction, and provision of primary health care and health education.
2. **Supporting mothers to be future oriented and aspirational** for themselves, their child and family.
3. **Supporting family and social relationships** within the extended family, with the family's communities and with other health and social services.
4. **Additional support in response to need** including interventions by the MECSH health visitor and additional support accessed through the tiered service system.
5. **Child development parent education** programme delivery. This is a structured programme of parent education about child development. The MECSH trial used the "Learning to Communicate" (LtC) programme.

http://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/mecsh-program-components

MECSH has not measured attachment, but has demonstrated successful outcomes in many other areas

Since the programme is not attachment-based, the MECSH trial did not measure attachment. It is, therefore, factually inaccurate to say that there is evidence that MECSH does not provide substantial benefits for parents or children. Parent-infant interaction, directed at improving the primary outcome of mother and child health and wellbeing, is one element amongst many that featured in the programme and there were a number of measured, positive outcomes in the trial (Kemp et al 2011), ie:

- Improved parental emotional and verbal responsivity to the child
- Increased breastfeeding duration
- Reduced pregnancy-induced hypertension
- Improved knowledge of SIDS prevention risk
- Improved perinatal maternal health
- Improved postnatal maternal enablement

These outcomes are achieved through provision of the MECSH programme embedded within the universal healthy child programme, rather than through trialling in artificially controlled contexts. The results are commensurate with those shown in the first Family Nurse Partnership trial (Olds DL, et al. 1986), which reported a trend (p=0.06 at 12 months, p=0.08 at 24 months) for improved child mental development for a subsample of higher risk mothers. MECSH similarly reported a trend (p=0.07) for child mental development at 18 months for a higher risk subsample. Encouraged by these similarities between the first MECSH trial results and those of the first trials of Nurse Family Partnership (NFP, or FNP in the UK) the MECSH programme is currently undergoing a multi-study, multi-design programme of research (see Table 1). Completed research publications can be found at http://www.earlychildhoodconnect.edu.au/home-visiting-programs/mecsh-public/mecsh-research-publications

Table 1: MECSH research in progress

Population	Study design	Reporting date
Urban Indigenous population in NSW, Australia	Quasi-experimental trial: whole population intervention compared with historic control	End 2016
Seven localities in Victoria and Tasmania, Australia	Randomised controlled trial: individual randomisation, arms-length (independent) trial	Mid 2017
Somerset, UK	Quasi-experimental study: 1. MECSH intervention families in two localities compared with matched sample drawn from other non-intervention localities 2. Whole population outcomes for two implementation localities compared with whole population from other localities	From mid 2017 (perinatal outcomes) to mid 2019 (child development outcomes)
Essex, Plymouth and Lewisham, UK	Mixed method studies 1. Cohort studies comparing MECSH intervention families with whole population outcomes 2. Case studies	From end 2016 (case studies) to end 2018 (child development outcomes)

The 'strange situation test' is not used in MECSH, because it is considered unethical

Although MECSH is not a targeted attachment programme, the relationship between the parents and the child is of key importance. MECSH will not, however, measure attachment using the strange situation test (Ainsworth and Bell 1970), because the test

intentionally causes the child a level of distress through removal of their caregiver and exposure to a stranger, and is thus of questionable ethics. We are surprised that the EIF report makes no mention of this controversial aspect of the measure.

Further, in the ongoing development of the MECSH model, we note that an independent review of home visiting programme approaches to improving maternal-infant attachment concluded:

> *"In general, for the purposes of a home visiting service, it seems best to focus on promoting responsive developmental caregiving rather than trying to promote attachment feelings or thoughts in either the mother or the child."* (Moore et al 2013, p55).

Accordingly, MECSH will continue to focus on responsivity (an area with already documented impact for MECSH families) and supporting effective parental caregiving.

Assessment of programme costs is not explained in the report.

The price range estimated by EIF and indicated in their report appears to include the total cost of delivering a proportionate universal health visiting service, incorporating MECSH for parents requiring 'universal partnership plus' level of intervention. Missing from the EIF assessment is any explanation of how they reached this cost conclusion, or any understanding of MECSH as an intervention embedded within the healthy child programme as an offer available for all families within the universal caseload for whom sustained additional support would be of benefit. The costing in the EIF document does not recognise that MECSH families are those for whom the health visiting service is already providing a response. Nor does the costing recognise that MECSH has purposeful 'spill-over effects' for every family and whole communities through health visitor training, supervision, resources and reorientation of the service system.

The programme is designed specifically to support a proportionately universal approach, with marginal additional costs accruing from the licence, which includes training and support, and the pre-requisite that the health visiting service is sufficiently resourced for fidelity to the programme to be maintained.

Conclusion

Perinatal mental health, including attachment and infant mental health, is very important and it is helpful to have a guide that explains how best to deal with concerns that arise in this area; however, it is not the whole picture for child development. It would have been more helpful if the EIF report had made clear that their report does not show evidence for enhancing child development in general, nor for programmes directed at improving population health and reducing health inequalities, which generally make use of broad-based programmes. MECSH, taking its cue from the wealth

of international opinion summarised above, is one such broad-based programme. It fits well with a proportionate universal service and there is good trial-based evidence of benefit to parents and children.

References

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