Through Each Other’s Eyes
An Evaluation of a Video Interaction Guidance Project delivered by health visitors and family support workers in a disadvantaged urban community

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Suggested citation

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Project website
www.mentalhealth.org.uk/projects/through-each-others-eyes.
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Executive summary

The Through Each Other’s Eyes (TEOE) programme was a one-year programme operating in the local authority of Haringey from March 2016 to April 2017. The TEOE programme sought to promote infants’ social and emotional development using Video Interaction Guidance (VIG) with families. Through VIG, parents are given increased opportunities to observe and reflect on video recordings of their positive interactions with their child.

The overall aim of the programme was to support parents to bond with their baby. This report describes the evaluation of a service development project in its implementation of a VIG programme in Haringey and makes a preliminary assessment of the programme’s feasibility and acceptability for use with families living in the borough who have infants of 12 months or younger.

Results from the preliminary outcomes and process evaluations show that VIG has benefits for parents, practitioners and managers within early years services. Findings from the quantitative assessments with families show VIG’s improvements on parents’ self-efficacy, stress, and sensitivity to and bonding with their baby.

Qualitative findings describing the experiences of parents, VIG guiders and senior managers present early findings on its feasibility and acceptability in early years services in Haringey. The parents interviewed were overwhelmingly positive about their experience of VIG and all perceived the programme to have been of benefit to them and their families. Managers felt that VIG met a current gap in service provision; however, some challenges regarding its feasibility remained. Despite the challenges reported, parents, VIG guiders and managers believe in the benefits of VIG and the continued need for investment from early years teams in order to offer families this type of support.
1. Background

Becoming a parent poses daunting challenges for most men and women, and this is heightened when the transition takes place within the context of disadvantage, such as when a family experiences poverty, housing difficulties, language and cultural barriers, or a lack of support networks.

For all parents, a number of physical and psychological changes take place during the transition to parenthood, including a re-organisation of identity, roles and responsibilities (Stern 1995; Ammaniti & Gallese 2014; Slade et al. 2009). For families facing adversity, there is a risk that these additional challenges can negatively impact on the parent–infant relationship.

After babies are born, they need their caregivers to recognise and respond appropriately and sensitively to their feelings and needs in order for a secure attachment to develop and for optimum infant development (Verhage et al. 2016). Due to the numerous challenges and stresses they face, disadvantaged families may require additional, more intensive and coordinated support to develop or prioritise sensitive and attuned interactions with their children.

The transition to parenthood is an opportune time to intervene early and provide this support, as it represents a time when parents report being highly motivated and responsive to making positive changes in their lives – expressing a desire to be a good parent and to ensure that their baby leads a better life than they themselves may have experienced (Condon et al. 2004; Edvardsson et al. 2011). This, together with the high incidence of professional contact, makes the postnatal period well timed for professionals to engage with parents, intervene early and prevent difficulties from escalating. Furthermore, there is evidence that parenting interventions during this life stage can make a real difference – to parental wellbeing, the parent–infant relationship and infant development.

What is the current evidence base for parenting interventions?

There is considerable evidence from systematic reviews to show that parenting difficulties can be prevented and/or improved with a range of parenting interventions, including those that use cognitive behavioural therapy, those with an attachment focus and those that are based on social learning theory (e.g. Menting, Orobio de Castro & Matthys 2013; Reyno & McGrath 2006; Thomas & Zimmer-Gembeck 2007). In a meta-analysis of 88 attachment-based early interventions, treatments that specifically focused on promoting parental sensitivity and increasing infant attachment security were found to be highly effective (Bakermans-Kranenburg et al. 2003).

Among the increasing number of early interventions being evaluated, the
video-feedback approach is garnering a particularly strong evidence base. In a meta-analysis of 29 studies, it was found that video feedback produced statistically significant improvements in parenting sensitivity (effect size 0.49), parenting behaviour and attitudes (effect size 0.37), and child development (effect size 0.33) for children aged 0–8 years (Fukkink et al. 2008). Many of these studies involved ‘high-risk’ dyads (e.g. low socioeconomic status (SES), 63%; parent clinical problems, 17%; child clinical problems, 52%). One such encouraging video-feedback intervention is VIG (Kennedy et al. 2011).

**What is the policy context to support VIG?**

As a result of the research supporting video feedback, including VIG, such approaches are now recommended as evidence-based interventions in the following National Institute for Health and Care Excellence (NICE) guidelines: Children’s attachment: attachment in children and young people who are adopted from care, in care, or at high risk of going into care (2015) and Social and emotional wellbeing: early years (2012).

**What is VIG?**

VIG is a six_SESSION, strengths-based, video-feedback intervention carried out in the home that encourages parents to watch and reflect on video clips of naturally occurring successful interactions with their babies, while exploring areas that the parents themselves have identified as concerns (e.g. understanding their baby’s cues).

The VIG practitioner takes a caregiver-centred approach. At all times, practitioners are attentive to the client and receive their concerns. They support the client to be actively engaged in their own change journey. The VIG practitioner takes a short video (5–10 minutes) of the parent–child interaction. The VIG practitioner selects clips to highlight moments of attuned interactions that also relate to the client’s goals. These are very likely to be exceptions to the usual pattern and exemplify various principles of attuned contact, especially the parent’s reception of their child’s initiatives.

The VIG practitioner shares these video clips with the client in a ‘shared review’ (see Figure 1) so they can explore the video carefully together, with the aim of going into care (2015) and Social and emotional wellbeing: early years (2012).
VIG supervision model and delivery

Model
In VIG supervision the process and techniques used parallel those of a VIG session with a parent, guided by the core principles for attuned interaction. The supervisor draws on the VIG values of respect and appreciation to create a safe and encouraging space to support the supervisee to reflect on their strengths and working points (see Figure 2 for further details).

The VIG supervision structure is illustrated by the diagram overleaf (Figure 3). The supervisee comes having reviewed the video of the parent–child interaction they have taken and with a goal for the supervision session. The video is micro-analysed together with the supervisor to identify strengths and working points for both the parent and the trainee guider. Time is made at the end to summarise and reflect on how the guider might implement changes in the next session with the family (‘making the bridge’).
Figure 2: The VIG Model

Figure 3: VIG Supervision
The focus of VIG supervision changes as the trainee guider progresses through the VIG training stages. At the start of the project with the trainees (in Stage 1), the focus of supervision is on developing the core VIG skills of micro-analysing the parent–infant interaction video, identifying exceptional, attuned moments in the video clips, and using video-editing software to select these moments to share with the parents. Once these skills have been mastered, the trainees also start bringing videos of themselves discussing clips with parents into the shared review, and the supervisor then helps the trainees identify attuned moments in their interaction with the parent.

**Delivery**

Provision was made for each trainee (7 trainees in total) to receive one hour of VIG supervision each week. A total of seven supervision slots were spread over two afternoons and offered in two locations for trainees to book into. In reality, supervision was offered less than weekly as trainees weren’t always able to bring a video due to cancelled visits, sickness, leave, etc. At the start of the project, additional supervision slots were arranged to practise using the iPads and video-editing software.

**What theoretical models underpin VIG?**

In the VIG theoretical model, intersubjectivity (Trevarthen 1979; Stern 1995) (which is about companionship and collaboration) sits at the core of the model, accompanied by attachment (Bowlby 1969) (which is about nurturing and being nurtured, safety and protection) and mediated learning (Vygotsky 1962) (which relates to development through learning from more experienced adults).

**Attachment theory:** According to Bowlby (1969), attachment theory asserts that infants are biologically predisposed to use their primary caregiver as a secure base from which to explore their environment, and such early attachment experiences form their concepts of self, others and the world. Attachment quality is often quantified via levels of parental sensitivity and emotional availability, which refers to the parent’s capacity to accurately perceive their infant’s attachment signals and to respond to them in an adequate, timely and appropriate way (Ainsworth, Bell & Stayton 1974). VIG works to promote repeated patterns of such sensitive reflective interaction, which, in addition to promoting secure attachment, are a key mechanism in the development of the infant’s optimal emotional and behavioural regulatory function, the development of their brain and physiology, and the security of their attachments (Beebe et al. 2010; Tronick 2007; Panksepp 1998).

**Intersubjectivity:** Once parents notice and respond to their child’s initiatives in an attuned way, the relationship can move beyond attachment (the need for safety and protection) to intersubjectivity (the sharing of experience and social understanding). The concept of cooperative intersubjectivity (interrelated connectedness) is at the heart of VIG (Trevarthen 1979; Stern 1995). This means there are two equally important...
subjects in every conversation, whether adult–adult (guider to parent or supervisor to guider) or adult–child. Parents and infants both thrive when they are able to enjoy getting to know each other, read each other’s signals, and develop together. If support is required, parents can be helped to make this emotional connection with their infant through a respectful relationship with a helping professional, working together towards a better future.

**Mediated learning:** Mediated learning theories provide a rationale for ‘attuned guidance’ between parents and infants that is integral to VIG work. Guidance that is in the ‘zone of proximal development’ (Vygotsky 1962) of the infant is encouraged, which means that parents should avoid interactions that are either too advanced or complex for the child, or delivered in such a way that the child does not grasp them. This process was first described as ‘scaffolding’ by Wood et al. (1976), and the term is now firmly established in early education literature. With babies, interaction frequently moves from attuned to mis-attuned, and VIG supports parents to recognise babies’ need for a break (‘rupture’) and gentle re-attunement to their new emotional state (repair), as described by Tronick (1989) in infant mental health literature.
The TEOE programme was a one-year programme funded by Health Education England (HEE) in 2016 to promote infants’ social and emotional development using VIG with families in the local authority of Haringey.

Research indicates that supporting disadvantaged families during the transition to parenthood by training front-line staff to deliver VIG in universal early years services may support the development of a more attuned parent-child relationship and secure attachment. Beyond this, parents can be supported to develop the capacity to mentalise and understand what they are doing when things work and why they have found certain aspects of their relationship with their child difficult in the past.

The project was implemented in Haringey due to its multiple indices predicting child and maternal adversity – including elevated levels of family homelessness, children living in poverty, children in care, and A&E attendance for infants (Child Health Profile 2017). Haringey is recognised as being one of the most deprived local authorities in the country, ranking 30th out of 326 English authorities, and is the sixth most deprived borough in London (Indices of Multiple Deprivation 2015). Many parents and families in contact with services have poor mental health, have drug and alcohol problems, suffer from domestic violence or live in poor housing (JSNA Haringey 2013/2014).

The programme has the overall aim of supporting and empowering parents who may be struggling to bond with their baby and/or may be experiencing poor levels of mental health. Through VIG, parents are given increased opportunities to observe and reflect on video recordings of their positive interactions with their child.

The programme trained and supervised seven new VIG practitioners (or VIG guiders), who each delivered a course of six VIG sessions with up to five families each. The newly trained VIG guiders comprised four health visitors and three family support workers. Six postnatal sessions, as recommended by the VIG Association (AVIGuk), were offered, and parents were encouraged to reflect on video recordings of their interactions with their child and their self-confidence and attunement towards their child, while exploring areas that the parents themselves identify as concerns (e.g. understanding their baby’s cues). Through the relationship with these newly trained VIG guiders, families were also able to increase their peer and community-based networks.
3. Evaluation of the TEOE programme in Haringey

This report describes a service development project in its implementation of a VIG programme in Haringey and makes a preliminary assessment of its feasibility and acceptability for use with families living in the borough who have infants of 12 months or younger. The report also presents evidence from VIG guiders and service managers in Haringey involved in the programme to further gauge factors related to VIG’s implementation in early years services. In this regard, the report seeks to address the following factors and related research questions:

a) Recruitment and retention: How easy was it to recruit participants? What was the rate of participation and attrition? Were there any reasons for or participant characteristics associated with dropout?

b) Acceptability: What were parents’ experiences of the intervention? What were practitioners’ experiences of delivering the intervention? What clinical or practical concerns arose from implementing the intervention?

c) Preliminary outcomes: Within the context of a small-scale study, what is the evidence that VIG is effective in improving clinical outcomes? In this regard, the evaluation of the outcomes assessed the following:

i. Whether parents taking part in VIG will report increased parental sensitivity and improved bonding with their infants.

ii. Whether parents will have improved self-efficacy and decreased parental stress.

iii. The impact of the project on the development of informal networks and community connections for the families taking part.

iv. Whether the trainee health visitors/family support workers taking part in VIG will report improved self-efficacy/clinical observation.

Report overview

The report below describes the following:

- Methods employed by the evaluation team
- The participant sample
- Results from the quantitative and qualitative assessments with participants
- Discussion of the findings
- Conclusions
4. Methodology

4.1 Evaluation design

The evaluation of the outcomes is based on a mixed-methods design that used quantitative and qualitative assessments with parents involved in the programme.

Quantitative data were collected at two timepoints: baseline, prior to taking part in VIG (T1) and follow-up (T2; last session of VIG). Quantitative data were collected via questionnaires administered by the VIG guider.

Quantitative measures

The following six measures were used to collect information on the participants’ sensitivity, relationship and attachment to their infant, as well as perceived parental self-efficacy, anxiety and depression.

1. The Keys to Interactive Parenting Scale (KIPS, Comfort & Gordon 2006) was used to assess improvements in parents’ sensitivity towards their infant, as well as changes in the participants’ relationships with and attachment to their infant. The KIPS has been externally validated as a practical means of assessing parenting behaviour via 12 key behaviours, including physical interactions and supportive directions. The KIPS uses a summary scoring sheet to aggregate information on observational notes, a five-point rating scale for each of the 12 parenting behaviours that are observed, and a family interaction planning guide to reflect on strengths and areas for growth (assuming no adaptations were made to the scale).

2. The Ages and Stages Questionnaires: Social-Emotional (ASQ:SE, Squires, Bricker & Twombly 2002) are parent-completed questionnaires that focus on the social and emotional development of young children. The questionnaires are scored using a simple 0-, 5-, and 10-point scoring system, with results indicating children at risk of social or emotional difficulties, in order to identify concerning behaviours to caregivers and recognise the need for further assessment.

3. The Maternal/Paternal Postnatal Attachment Scale (MPAS/PPAS, Condon & Corkindale 1998) is a 19-item measure of the affective aspects of the mother/father to-infant bond in infants under one year old.

4. The Maternal Confidence Questionnaire (MCQ, Parker & Zahr 1985) measures maternal confidence in parenting skills and the mother’s ability to recognise her infant’s needs. The scale consists of 14 items, each answered on a five-point scale. As the MCQ is a unidimensional score (scores range from 14–70), a higher score indicates higher perceived competence.

5. The Patient Health Questionnaire (PHQ-9, Kroenke, Spitzer & Williams
2001) was used for screening, diagnosing, monitoring and measuring the severity of depression in parents. Parents are given a score from 0 to 27 and grouped into one of four groups: minimal symptoms, mild, moderate or severe.

6. The Generalised Anxiety Disorder Questionnaire (GAD-7, Williams 2014) was used to measure changes in parents’ levels of anxiety. The GAD-7 consists of 7 items, each answered on a four-point scale (between 0 and 3) with total scores ranging between 0 and 21. The cut-off scores of 5, 10 and 15 are classed as mild, moderate and severe anxiety respectively.

Qualitative data collection

Individual semi-structured telephone interviews with families were carried out by the researcher from the evaluation team following their participation in VIG (post-T2) in order to measure further improvements against the outcomes identified above, to assess the effectiveness of the intervention overall, and to gauge the parents’ level of social support and connectedness throughout the period of the evaluation.

Process of evaluation

VIG guiders, team managers and the TEOE project manager were interviewed by members of the evaluation team following the completion of the programme (post-T2) in order to measure the outcomes related to the training and delivery of VIG, as well as the feasibility and sustainability of VIG in services.

Qualitative data in the form of brief telephone interviews were collected from three stakeholder groups: families who took part in VIG, VIG guiders, and senior managers involved in the implementation of VIG in services (i.e. the project manager and team managers). Table 1 shows the numbers of participants who took part for each stakeholder group.

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Number of participants (N)</th>
</tr>
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<tbody>
<tr>
<td>Families</td>
<td>6</td>
</tr>
<tr>
<td>VIG guiders</td>
<td>7</td>
</tr>
<tr>
<td>Senior managers</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 1: Numbers of Participants for Qualitative Interviews

4.2 Ethics

All participants provided informed written consent prior to data collection, along with verbal consent at the time of data collection to ensure they still consented to taking part on the date itself. All participants were assigned an
individual participant code to protect their anonymity. All data were stored in accordance with the Data Protection Act 1998. No formal ethical approval was required as the study did not fit the HRA requirements for research. The study was registered by the Caldicott guardian at the Whittington Health NHS Trust as a service evaluation.

4.3 Data and analyses

Quantitative data

Hard-copy questionnaire data were entered by a member of the evaluation team. Participants’ personal details were anonymised and each participant was provided with a unique ID code linked to all of their responses on the questionnaires. Quantitative data were stored and analysed using the Statistical Package for Social Sciences for Windows (version 24). Missing item data were coded within the dataset as ‘999’ to ensure that these items would not skew the results. Where participants missed a single item on a questionnaire, the mean scores were computed to allow valid overall scores to be calculated. However, where a participant had missed three or more item responses, all scores for that measure were scored as missing. When statistical analyses were conducted, ‘exclude cases listwise’ was selected to ensure that the results were not skewed by missing data. The data met the statistical assumptions as being normally distributed. Parametric paired sample t-tests were used to test for the mean differences pre- and post-VIG intervention. Parametric paired sample tests were used on anxiety, depression, parental confidence, attachment and infant development (via the ASQ:SE) to ascertain the significance of the changes across the outcomes. After observing the caregiver and child interactions via baseline and follow-up video recordings, parenting behaviours for each item were scored on the KIPS by the lead evaluator. As the data met the assumptions of normality, paired sample analyses were performed.

Qualitative data were transcribed into text and analysed using thematic analysis (Braun & Clarke 2006). Content from the interview data was explored by a member of the evaluation team and key areas were organised into meaningful themes. Themes were noted by the evaluation team from the data, many of which were related to the key aims of the project and evaluation. Transcripts were coded according to these developed and existing themes within the data. The coding was reviewed and refined, with similar themes being merged and sub-themes created where appropriate.

4.4 Recruitment and referral

Participants (families) were recruited by two services (health visiting and family support teams) under the remit of Whittington Health NHS Trust, who were involved in the project. Newly trained VIG guiders from the teams recruited families with infants aged one year or younger onto the project. Referrals of families came through a variety of sources: current caseload, peers, the project manager, the single point of access team in Haringey, and flyers in local children’s centres.
5. Results

5.1 Participants

Participant characteristics

A total of 23 parents agreed to participate in the evaluation of VIG, of which 19 completed pre- and post-evaluation questionnaires. The sample consisted of 22 females and one male, ranging in age from 18 to 42 (M=33, ±7.5). For most families, this was either their first or second child (mean number of children in the household=1.55, ±1.18). The majority of the sample (65%; N=15) reported living with or being married to their partner and 30% (N=7) identified as being a single parent (30%; N=7). The ethnic background of the respondents in this sample varied, with the largest group, Black African, representing 28% of the cohort (N=5). See Figure 4 for further details. Only 54% of respondents (N=12) reported being native English speakers; however, 90% of those (N=9) claimed fluency in English.

Figure 4: Self-Identified Ethnicity of Participants
Socioeconomic background

Household income appeared to be almost equally polarised across the sample (as illustrated in Figure 5). Of the 20 respondents, 45% (N=9) were in the highest income bracket, while 50% (N=10) of participants identified their earnings as falling within the lower two earning brackets.

Only a little over half of all participants (N=14) answered questions regarding tax benefits. Of those that responded to these questions 14% (N=2) claimed to be collecting out-of-work benefits and 64% (N=9) claimed to be receiving some kind of tax credit; one participant said they did not know if they were receiving any tax benefit.

Education and employment status (see Figures 6 and 7) varied significantly among this sample. Over half of the sample (N=12) reported having a university qualification or higher, with the remaining participants (N=10) indicating a range of other qualifications, including college-level diplomas in health and social care, childcare and reflexology. In terms of employment, 48% (N=11) of the sample identified as either part- or full-time employed, with some participants indicating maternity leave or dual student/employment status.
### Figure 6: Education

- 14% Left school before any qualifications (N=2)
- 4% O-levels/GCSEs (N=1)
- 9% A-Levels (N=3)
- 4% University Degree (N=6)
- 14% Postgraduate Qualification (N=6)
- 5% Other (N=3)
- 5% Prefer not to say (N=1)

### Figure 7: Employment Status

- 44% Full Time Homemaker (N=10)
- 26% Full Time (approx. 35 hrs/wk) (N=6)
- 4% Part Time (i.e. <35 hrs/wk) (N=5)
- 4% Currently Unemployed (N=1)
- 4% Other (N=1)
Support and wellbeing

Of the 22 respondents who responded to items under the sections of ‘Getting help and support’ and ‘Your mental health and wellbeing’ in the baseline questionnaire, the most common sources of parenting information (Figure 8) were reported as being health visitors and family support workers (82%; N=18), family and friends (59%; N=13) and the internet (68%; N=15). ‘Other’ sources of information reported by this sample included books, children’s centres and previous qualifications (e.g. in childcare). Similarly, mirroring sources of information, participants reported sources of support as being health visitors and family support workers (N=9), family members (N=9) and childcare centres (N=3). 61% (N=14) of participants reported that they had attended a parent and baby support group in the past, and 65% (N=15) expressed that they were currently attending parent and baby support groups.

When asked about the levels of emotional support received before and after giving birth, participants indicated that, as time passed, they received less emotional support (Figure 9). When they did report receiving support, this came from a variety of sources – for example, from friends and through counselling. Further information can be found in Figure 10. Surprisingly, very few participants reported that they received support from their peers (17%; N=4) or friends (9%; N=2), with family members cited as being the highest source of support received.

![Figure 8: Sources of Information for Looking After Your Baby](image-url)
Figure 9: Support Received Before and After Giving Birth

When did you receive support?

- Before and after birth: 52% (N=12)
- During pregnancy: 44% (N=10)
- After giving birth: 39% (N=9)
- After 3 months: 30% (N=7)
- After 3-6 months: 22% (N=5)
- After 6 months: 17% (N=4)

Figure 10: Types of Parenting Support Received

Type of support received

- Counselling: 22% (N=5)
- Peer support: 17% (N=4)
- NHS GP: 4% (N=1)
- Talking therapy: 17% (N=4)
- Family: 30% (N=7)
- Friends: 9% (N=2)
The participants were also asked about their wellbeing, and over half of the participants expressed that they would have liked to receive support for their emotional wellbeing but said they had not (55%; 11/20). Further, 67% (14/21) expressed having minor difficulties with their mental health. Some reasons specified included anxiety, marital problems, the death of a family member, a history of depression, lack of sleep and feeling unsupported.

### Expectations of TEOE

When asked about their expectations of the programme, parents reported that they wanted to: understand their baby’s needs and communication behaviours (83%; N=19); foster deeper connections with their baby (74%; N=17); gain useful information and advice on parenting (74%; N=17); and improve their level of enjoyment of spending time with their baby (74%, N=17). Only a few parents (30%; N=7) reported that they wanted to connect with other parents as part of the programme (see Figure 11).

![Figure 11: Parents’ Expectations of the TEOE Programme](image)

### 5.2 Quantitative findings

After determining that the distribution of responses satisfied the parametric assumptions of normality, paired t-tests were used to analyse changes in the reported outcome means between baseline (T1) and follow-up (T2). The statistical significance of the findings (i.e. p<0.05) was also considered following the analysis.

A note on the data: As the sample was self-selecting, results should be interpreted with caution. The findings are taken from a small sample size with limited follow-up, and, while some findings show preliminary clinical effectiveness, it would not be generalisable to the wider population.
Depressive symptoms
Following participation in VIG, the mean PHQ-9 score decreased, with the mean score of 6.2 (±5.4) at T1 dropping to 5.5 (±5.6) at T2 – a significant but modest decrease in reported depression and depressive symptoms (t(19)=2.39, p=.028). For our sample, both the baseline and follow-up mean scores of the PHQ-9 can be clinically classified as 'mild depression'.

Anxiety
The GAD-7 was used to assess mild, moderate and severe anxiety in participants. Scores of 5, 10 and 15 are taken as the cut-off points for mild, moderate and severe anxiety respectively. Overall, the participant mean scores declined from T1 (M=6.15, ±5.87) to T2 (M=3.85, ±4.59): results that were found to be statistically significant (t(19)=3.15, p=.005). Clinically, this shift indicates movement from 'moderate' to 'mild anxiety.'
The MCQ, which measured parents’ confidence in their parenting skills and their ability to recognise their infant’s needs, was administered to all participants. Overall, the mean scores increased from T1 (M=57, ±6.76) to T2 (M=63, ±4.68), signifying a statistically and significant increase in parental confidence (t(19)=-3.838, p=.001) following participation in VIG.

**MPAS/PPAS**

The MPAS and PPAS scores were measured both at baseline and follow-up as total scores, as well as by their three thematic subscales: (1) quality of attachment, (2) absence of hostility, and (3) pleasure in interaction for the MPAS; and (1) patience and tolerance, (2) pleasure in interaction, and (3) affection and pride for the PPAS.

Overall, MPAS scores (including subscales) increased, indicating greater levels of maternal attachment to their children. Total MPAS scores increased from T1 (M=73, ±9.9) to T2 (M=80, ±8.32): results that were found to be statistically significant (t(18)=-4.98, p<.001). Similarly, the quality of attachment mean score increased and was found to be statistically significant (t(18)=-10.07, p<.001). While absence of hostility increased in mean score (see Table 2), these results were not found to be statistically significant (t(18)=-1.58, p=.131). Surprisingly, the pleasure of interaction mean score decreased slightly between T1 and T2, indicating a slightly lower level of enjoyment of child interaction. These results, however, were not found to be statistically significant (t(18)=.64, p=.529).

As there was only one male participant in this analysis, a statistical test was not run on the PPAS data. However, it was observed (see Table 3) that the total PPAS score and the pleasure of interaction subgroup scores both declined between T1 and T2. However, the patience and tolerance subgroup score increased slightly while the affection and pride scale remained flat. Future analysis with a larger group of fathers is necessary in order to infer any clinical implications from these findings.
Maternal Postnatal Attachment Scale

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<tr>
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<th>T1</th>
<th>T2</th>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
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<tr>
<td>MPAS Total</td>
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<tr>
<td>Quality Attachment</td>
<td>34.03</td>
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<tr>
<td>Absence of Hostility</td>
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</tr>
<tr>
<td>Pleasure of interaction</td>
<td>20.53</td>
<td>4.06</td>
</tr>
</tbody>
</table>

Table 2: MPAS Mean scores and SDs at baseline and follow-up

Paternal Postnatal Attachment Scale

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
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<td></td>
<td>Mean</td>
<td>Mean</td>
</tr>
<tr>
<td>Total PPAS score</td>
<td>87.80</td>
<td>78.80</td>
</tr>
<tr>
<td>Patience and Tolerance subgroup</td>
<td>36.60</td>
<td>38.60</td>
</tr>
<tr>
<td>Pleasure of Interaction subgroup</td>
<td>31.20</td>
<td>28.80</td>
</tr>
<tr>
<td>Affection and Pride</td>
<td>20.00</td>
<td>20.00</td>
</tr>
</tbody>
</table>

Table 3: Mean PPAS Scores between T1 and T2

The KIPS

The KIPS was used to assess improvements in parents’ sensitivity towards their infant, as well as changes in their relationships and attachment with their infant.

Overall, the mean scores between baseline (M=3.67, ±0.69) and follow-up (M=4.14, ±0.61) showed statistically significant improvements (t(16)=-2.783, p=0.013). This increase in participant mean scores indicates improvements in parent–child interactions overall following the VIG intervention.

Several items within the scale also increased significantly in mean score between baseline and follow-up (see items 6, 10 and 12 overleaf). Item 6 (How well does the caregiver engage the child in language experiences?) mean scores increased from baseline (M=2.94, ±1.3) to follow-up (M=4.29, ±0.77) – a difference found to be statistically significant (t(16)=-4.226, p=0.001).
Item 10 (How supportive are the caregiver’s directions to the child?) mean scores increased significantly from baseline (M=3.31, ±0.48) to follow-up (M=3.88, ±0.81) (t(12)=−2.635, p=0.022).

Item 12 (How well does the caregiver promote exploration and curiosity?) mean scores also significantly increased from baseline (M=3.59, ±0.94) to follow-up (M=4.12, ±1.05) (t(16)=−2.314, p=0.034).
The remaining nine items within the scale (listed below) were not found to have significant mean score differences between baseline and follow-up. Item 9 was not applicable to most of the sample (N=3), which is likely to have affected the significance of the findings.

**Item 1:** How sensitive are the caregiver’s responses to the child’s cues, actions or words?

**Item 2:** How well does the caregiver support the child’s emotions?

**Item 3:** How well does the caregiver physically interact with the child?

**Item 4:** How well is the caregiver involved in the child’s activities?

**Item 5:** How open is the caregiver to the child’s agenda?

**Item 7:** How reasonable are the caregiver’s expectations for the child’s abilities?

**Item 8:** How well does the caregiver adapt strategies to the child’s interests and behaviours?

**Item 9:** How appropriate are the limits and consequences the caregiver sets for the child?

**Item 11:** How encouraging are the caregiver’s words and actions regarding the child’s needs?

**The ASQ:SE**

The ASQ:SE is used as a clinical measure. Cut-off scores of 45 and 48 for the six-month and 12-month questionnaires respectively are used to indicate warrant for concern. Scores above the cut-off range indicate a need for the referral of the child for further mental health evaluations. In this analysis, both the six-month mean score (M=33.21, ±23.09) and the 12-month mean score (M=26.25, ±11.81) at baseline fell below their respective cut-off points. Both the six-month and 12-month group mean scores declined between T1 and T2; however, only results from the six-month follow-up analysis were statically significant (t(13)=3.79, p=.002). The 12-month group mean score at T2 (M=12.5, ±6.45) further decreased from T1; however, the results from the paired t-test did not show significance (t(3)=2.2, p=.115). This may be attributed to the fact that the sample size of the 12-month group was much smaller than that of the six-month group (N=4 and N=14 respectively).

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**Figure 18: Mean Scores on the ASQ:SE Between Baseline and Follow-up**

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5.3 Qualitative findings
The purpose of the qualitative assessments with families, VIG guiders and senior managers was to understand parents’ experiences of the intervention, practitioners’ experiences of the training for and delivering of the intervention, and clinical or practical concerns of the managers implementing the intervention.

Themes and sub-themes noted by the evaluation team from thematic analysis have been illustrated via a tree diagram for each stakeholder group (see Appendix), with the primary themes noted at the top and related themes branching out underneath.

5.3.1 Families
Six parents gave their consent to give further feedback about their experience with VIG and the VIG programme’s qualitative one-to-one telephone interviews. Within the interviews, two main topic areas were explored: the delivery of VIG and the impact that VIG had for them and their families.

Delivery of VIG
Regarding the delivery of the intervention, the main themes that emerged were regarding the reasons for participating and concerns about being filmed. However, this worry quickly dissipated for all participants, and it was evident that the role of a skilled health visitor was vital for reassuring parents and facilitating comfortability around being filmed. Other themes around the practical aspects of programme delivery (frequency, length of sessions, etc.) revealed some differing opinions among participants, but overall there was general satisfaction with the current format.
Practical components of the programme

Parents felt that the practical aspects of the programme (location, content, length and frequency of sessions) were appropriate. They appreciated the home setting for the sessions and the flexibility of their health visitors.

*I was more comfortable and relaxed to have it at home.* [FAMILY01]

Flexibility was cited as a key feature of the programme to accommodate the unpredictability of working with young children. For example, one participant described their child being asleep at the time of the planned session, resulting in its being rescheduled.

Parents had varied views on the ideal frequency for the sessions and there was no consensus on this topic. The ideal frequency of sessions is likely to be down to personal preference.

There was a view from participants that it would be helpful to have more sessions spread out over a longer period of time in order to be able to notice their child’s development. However, in general, the format seemed to be acceptable.

*It was fine. I don’t think you could do it longer.* [FAMILY03]

One aspect of this feasibility project was the completion of questionnaires. While some participants (N=3) stated that completion of these questionnaires was either fine or interesting, other participants (N=3) reported having difficulty with the survey. For some, this was due to the style of questions or length of the survey. For one parent completing the questionnaire this became a distressing experience, as it caused her to reflect on her own emotions and feelings. However, by the end of the intervention, this parent felt happier to complete the questionnaire as her emotional state had changed.

*It was very upsetting to see where I was putting myself, but I was very honest about how I was feeling, so it was very upsetting.* [FAMILY01]

The feedback provided by the health visitors while viewing the videos was perceived positively by all participants (N=6).

*By analysing that footage, yeah, it makes you aware of many things that are going on and it makes you feel that you are really doing things much better than before.* [FAMILY03]

In terms of suggested improvements, one parent felt that having time to review the video footage outside of the sessions would have been useful to allow more time for reflecting on the contents.

*I know this is probably a big ask but if there could be an app that I could have signed in myself to access the footage. I think it would just be easier to have my own [...] personal, private time to be able to, kind of, digest it a little bit more.* [FAMILY04]
**Reasons for participating**

Of those interviewed, most (N=4) parents heard about the programme through their health visitor. One parent was recruited via their support worker and counsellor, and one parent through a psychologist’s talk at their local children’s centre. People had varied reasons for wanting to participate.

Two parents explicitly wanted help to connect more with their child due to perceived difficulties in this area.

*I realised that she wasn’t really connected to me as well – that we weren’t really giving each other basically eye to eye.* [FAMILYO1]

Other parents (N=2) wanted to access support for themselves or have company. One of these parents also cited their own mental health difficulties as the reason for participating.

*I felt down, quite blue and depressed, and I was always trying to pick myself up, and so I felt that it was important to reach out for a little bit of help.* [FAMILYO2]

Other parents described feeling anxious about their child and their parenting abilities, and hoped that the programme would help them to increase their confidence. For some parents, this decreased confidence was related to life events such as their baby being born prematurely or relationship difficulties with the child’s other parent.

In contrast, increasing the enjoyment of parenting was a reason for participating for one caregiver.

*I didn’t want to lose sight. I wanted to be able to enjoy it [being a mother].* [FAMILYO2]

One parent could not identify any reason for participating, which perhaps raises questions about the recruitment process. However, this caregiver was subsequently able to identify how the programme had positively impacted on her relationship with her child.

*I had the time because I was on maternity leave and I wasn’t doing anything, so when she asked me I just said yes. I didn’t really know much about it. I actually don’t think I was an ideal candidate for the project.* [FAMILYO6]

**Perspectives relating to filming**

Most participants (N=5) expressed some initial worries about being filmed with their children. For some, this was due to concerns about data protection and confidentiality (N=3), while for others the concerns were due to feeling judged.

All participants stated that they felt more comfortable after a short period of time and that the level of comfort with being filmed was facilitated by the health workers, with whom they developed a relationship and level of trust. For two participants, it was the type of technology used (iPads and smartphones), and their sense of security, that put them at ease.

*I definitely felt blue and so yes, for me to be filmed. I guess it is not natural for most people, is it? But, yes, Laura made it really nice and comfortable.* [FAMILYO2]
She was really considerate when she did the filming. So, at first, the very first session I remember being quite [...] it was quite nerve-racking. She was just great, I mean, how she just really kind of made me almost forget about it. [FAMILY03]

While the process of being filmed was described as anxiety provoking, participants did feel that the filming was an integral part of the programme and one that ultimately brought about beneficial changes for them.

Watching the footage back: that was just, I mean, that was huge for me [...] actually being able to see myself, like, almost step out of myself and see myself, and see my interaction – it really helps me understand and digest what was happening. [FAMILY04]

The impact of VIG

In terms of the project’s impact, the strongest theme that came from the participants was that the intervention increased their confidence in their abilities as parents. This had a positive knock-on effect for their mental health and relationships with others, allowing some parents to speak more openly to friends or family and build relationships. Parents indicated that the increased confidence led to their feeling able to go out more with their child. Caregivers also felt that the connection with their child improved because of the programme.
Increased confidence
For all participants (N=6), the intervention increased their confidence, and some participants directly attributed this to a subsequent increase in their mental health and wellbeing.

Most people (N=5) described how viewing the interaction between themselves and their child on video was important for improving their confidence as a parent, because they could see their own pre-existing skills and receive positive feedback about this from the health visitor.

*It was just a really clever, surprising experience to watch and I think it just really helped to – it definitely built my confidence. I feel like a completely different person now to the very early days.* [FAMILY04]

Having the external feedback from the VIG guider was described as particularly powerful for reducing anxieties in parents who previously felt anxious, guilty or judged by others.

*I felt so much ... so much emotion, so much guilt, so much, like, doubt whether I was doing the right thing, whether I was a good enough mum. So actually going through the programme and actually having that reassurance completely helped with how I felt.* [FAMILY04]

Parents also valued VIG guiders helping them to identify areas for future development, while also providing positive feedback about their existing skills.

*She would bring out some of the nice things that she could see and how I could improve.* [FAMILY06]

Parents stated that their increased confidence also had benefits for their child, which links to the next theme of connection with their child.

*It makes me feel more confident how I bring up the baby – of how I interact with the baby. In the long run, obviously the baby also benefits from me being more confident.* [FAMILY03]

Improved connection with child
Parents (N=3) described that the programme improved the connection between themselves and their children in a variety of ways.

*Yes, the benefit was for both of us – me and my baby. It was a connection that really improved.* [FAMILY01]

Some parents (N=2) felt that, through the programme, they increased their knowledge of their child and of their child’s behaviour.

*One parent described that the programme had helped her to maintain a good interaction with her child at the times that she was experiencing mental health difficulties.*
It helped me to be more calm with my baby when I am mentally not well. It helped me to be calm with her. [FAMILY01]

The feedback parents received from their VIG guider and the act of reviewing their child’s reactions on the video led to some parents (N=2) doing more activities with their baby, such as playing.

I think it has helped me to play with him more, because I can see that he really enjoys it – like, when you watch the video, you see his eyes light up and smiling when you are doing stuff. So, yes, to play with him more, not just leave him on his own to play. [FAMILY06]

Parents with more than one child (N=2) described that the intervention also benefited their interactions with the child’s older siblings too, as VIG guiders additionally gave tips and feedback about managing this dynamic.

She kind of helped me to see the importance of spending time with my other children, because the baby kind of takes up all your time and, you know, she gave me ideas. So it has improved, I would say, my relationship with my [older] son in particular, because he was the one that got the least of my time. [FAMILY06]

**Building relationships**

Participants described the programme as having impacted positively on many different relationships within their lives and also having increased their feelings of being supported.

**VIG guider**

The programme directly affected the relationship between parents and the VIG guider (i.e. a health visitor or support worker) delivering the programme.

Seeing the same healthcare professional multiple times, rather than different staff for each visit, helped participants to build trust and feel comfortable talking openly about their concerns.

It is nice to have that continuity because it helps build trust as well. [FAMILY05]

Parents described feeling supported by this relationship with the health workers. The increased frequency of contact with their health visitor was, for one parent, the main perceived benefit of the programme, while, for other parents, the health visitor or support worker was cited as having a major impact on their mental health.

She was amazing. She was just one of the main reasons I feel that really helped me get through my baby blues. [FAMILY04]

What made me, I guess, feel positive is her [commendation] because she would encourage me and let me know that I am doing really well. So you don’t really get to hear that from anyone, so it was nice to hear that from her. [FAMILY06]

**Partners, family and friends**

Relationships with partners, friends and family were also reported to have improved for some participants because of being involved in the programme.
Many participants (N=3) stated that the programme had improved the relationship with their partners, particularly where this had previously been negatively affected by mental health difficulties.

*With my husband, like, definitely in the early days I felt quite frustrated all the time. I think as part of, like, going through my baby blues ... Having been able to actually talk to him about, you know, the sessions, and he could see how I was after the sessions – it definitely improved our relationship.* [FAMILY04]

Others (N=2) described how the reassurance provided through the programme was a benefit, not only to themselves but also indirectly to their partners. They described how their partners’ anxieties had also reduced, providing mutual benefit for the family unit.

*Seeing her reassured was always of benefit to me as well.* [FAMILY05]

The increase in self-confidence gained through the programme allowed some parents (N=2) to feel more able to speak openly to friends and family. For one parent, the programme helped her to feel able to overcome the perceived stigma of talking about her mental health and allowed her to speak about this with friends.

*Having gone through the baby blues and, actually, I suppose there is a bit of a stigma attached to it – not a lot of women talk about it and I, you know, made that kind of decision that I need to talk about how I am feeling.* [FAMILY04]

Going out and widening social networks

Another impact of the programme was the theme of going out and widening social networks. Two mothers stated that they are now going out more as a result of the programme. This change was the result of different factors, including information provided by the health visitor about local social groups, as well as the important impact of increased confidence leading to less anxiety about going out and being around others.

*No matter what, people are always judging ... so that [the programme] kind of benefited me with my self-esteem and the confidence of mothering my child wherever we are, not just indoors.* [FAMILY01]

5.3.2 VIG guiders

Seven VIG guiders took part in qualitative interviews to share their experience about the training and delivery of VIG to families. Within the interviews, four main topic areas were explored. These were the VIG model, the training, delivering VIG, and the evaluation that went alongside it.

The VIG model

Regarding the VIG model, the main theme noted from transcripts was that VIG is a strengths-based model that uses positive reinforcement with parents to enhance their understanding and communication with their baby.
Overall, reflecting on the model in general, all seven VIG guiders reported positively about the VIG model as an intervention to enhance the communication between a parent and their baby. They described it as a useful intervention for those parents that needed more support, or those parents who lacked confidence in their parenting abilities or who were feeling low or anxious.

It was a really helpful and valuable intervention and it was really nice to be able to identify when a parent maybe needed a bit more support, if they had a lack of confidence, or if they were feeling a bit low, to be able to offer them something and that you could see it was making a difference. [VIGPO1]

**Strengths based**

It was unanimous across the VIG guiders that the model took a strengths-based approach – one that concentrates on the inherent strengths of individuals and families and utilises these personal strengths to change behaviour.

*It is a strengths-based model. When you are looking at the videos you are always looking at what you are doing well. Also, you can think about what you would do next time and how I can improve, but you are not looking at the video of yourself in terms of ‘Well, this is what I did wrong’. [VIGPO6]*

**Model within a model**

A number of VIG guiders (N=3) commented on VIG as a model within a model. One aspect of the model is about showing parents rather than telling parents the ‘answers’, so VIG guiders ask questions to help families get there themselves. This format was also modelled in guiders’ supervision. In addition, all individuals involved in the
programme have their interaction and communication filmed – for example, when parents learnt about their communication style with their baby, VIG guiders were also learning about their communication with the parents.

It’s a model within a model where the parents are being filmed about their communication with the child and then we are then filmed in our communication with the parent, and then the supervisor is then filmed within their training with the trainee. It makes everyone feel not alone in this process. [VIGP06]

So, where I may miss something, that’s where the supervision comes in and he can help me, but he also uses the same model that we are using in VIG. So, rather than giving me the answers, he asks me the right questions so that I can eventually get there myself. And then I am able to model this to the families as well, and that has been a massive learning curve for me. [VIGPO3]

Generalisability

Most VIG guiders were in agreement that the model could be applied to other parent population groups and to older-aged children. However, there were some mixed opinions on whether the model would be as effective if, for example, interpreters were involved, as it was hypothesised that this could potentially increase the length of visits – which were already longer than regular health visitor visits – and could impact the connection between the VIG guider and the parent. However, in spite of the reservations from some guiders, one VIG guider described using the pictorial images for VIG to explain its principles to a mother who did not speak English (which worked well), noting that, if these had not been available, there would have been a barrier to this parent receiving this type of intervention.

I think it is a really amazing tool to be able to use with families. I have kind of identified families with older children that I would like to use it with. [VIGPO6]

I didn’t use an interpreter. I didn’t have any families that needed an interpreter and I don’t know how that would have worked. I don’t know how effective it would be having to use one and, obviously, in Haringey, there is quite a high number of families where they don’t speak English or their English isn’t very strong. There is quite a lot of time involved, so I don’t know if you needed to think about things like that. I don’t know how you would manage the time aspect. [VIGPO6]

If an interpreter had to be there as well – I think particularly where you were having the review and discussing – I am not sure whether a third person in that would, kind of, impact the connection. [VIGPO1]

I thought that it went really well because what it did was make sure that the parents had that real understanding. The sessions were a bit longer, obviously, because we had a person in the middle that had to relay the information, but actually I didn’t find it a challenge using it. [VIGPO3]
**VIG training**

Training was further separated into the themes of theory and technical aspects and the VIG specialist supervision.

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**Theory and technical aspects**

The VIG training comprised an initial two-day training course, which included theory as well as a more in-depth study of parent–child interactions, including through the use of role play. VIG guiders described the knowledge and skills learnt to be an additional beneficial tool they could use to support families. They also saw how VIG was complementary to other interventions and could be used in conjunction with these. Guiders additionally reported that the training had further increased their understanding of the parent–child relationship. Only one VIG guider wished the training could have been slightly longer to allow for more practice.

*I think that is the beauty of it: it doesn’t have to be used as, kind of, the sole tool – it can be used alongside education theory stuff as well.* [VIGPO6]

*It was a lot more in depth and looking at interactions between parents and children, and that, kind of, really kind of teaching you to pick up on things and to pick up on what they are doing, and I think it really enhanced my understanding.* [VIGPO1]
Regarding the technical components associated with VIG (i.e. filming, editing and transferring videos), more than half didn’t find this to be an issue to learn; however, a few VIG guiders (N=3) did find the technical skills involved to be demanding, as they were not as technologically proficient as the others.

When it came to editing, transferring, you know, all this stuff, to me that was completely new – a new world. Anyway, this was the only challenge for me – to learn how to do all this editing – and it would have been beneficial to have had an extra day to do some more practising. [VIGPO7]

Well, it is just my lack of technology. It has taken a long time. Taking films has been fine – it has been the editing and just putting the clips together, but that has become a lot easier now. [VIGPO4]

I think seeing that in the context of the technical skills involved I think I found it more challenging, I think, than I thought I would. [VIGPO2]

**Supervision**

As part of the training, VIG guiders were also given additional specialist supervision while they began practising their new skills with families. Since they were newly trained, they were appreciative of the extra support in the form of regular supervision that was flexible to their needs. It was reassuring for them and allowed them to gain more confidence in their abilities.

The supervisor was very available and – you know, if you needed to just phone and talk about what was going on – and we were really given that kind of space to talk through, because it was a very new thing that we were using. We don’t get that kind of regular supervision [in regular health visiting] – it is kind of every three months or something – so being able to meet with someone so regularly and talk through things, you know, it really felt, I guess, restorative in a lot of ways. [VIGPO1]

That has been really good … it’s been done very regularly as it were – he has been able to offer it as necessary, be supportive … he has been quite good at helping me to identify the bits of the process that were more difficult and needed more guidance on. [VIGPO2]

**Delivery of VIG**

Regarding the delivery of the intervention, the main themes that the lead evaluator noted were broadly separated into two categories – the VIG guiders’ experience and the families’ experience – which explored the impact of the delivery of VIG on a number of areas. For VIG guiders, this included: practicalities (scheduling visits, length, etc.), feelings about being filmed (daunting), impact on caseload, the wider team, relationships with families, and the impact on their own skills as a practitioner. In terms of the families’ experience, themes noted included families’ need for reassurance, improved confidence and an improved relationship with their baby. Lastly, the evaluation as part of the VIG programme was explored.
Delivery

Guiders' experience
- Perspectives about being filmed
  - Recruitment and referral pathway
- Practicalities
- Impact on caseload
- Relationship with families
- Wider team
- Enhanced practice
  - Attuned communication
  - Increased self-awareness
  - Power of Visual

Families' experience
- Need for reassurance
- Improved confidence
- Improved relationship with baby
Guiders’ experience

Perspectives about being filmed
Several VIG guiders expressed feeling vulnerable with regard to being filmed and having these videos reviewed by their supervisor. However, the parallel experience of film and review between families and themselves allowed them to be more empathic towards families’ experience. With regard to the theme of feeling daunted, a few guiders (N=2) found that their confidence grew the more practice they had with filming and reviewing with families.

At first, it was quite daunting. Particularly the bit when we filmed the reviews and things – that was kind of, what the supervisor, kind of, hoping that you are doing it right, but then I suppose it is good because it kind of gives you that shared experience with the family – the parents – because they are probably feeling that same thing when you are filming them and reviewing them. [VIGPO1]

My confidence in using it sometimes, so obviously as a practitioner you have got, kind of, an agenda in your mind about what you want to get out of the session or get out of the video and, sometimes, you have got to put that to the back of your mind and really be led by the parent. [VIGPO6]

Practicalities

Recruitment and referral pathway
VIG guiders described the varied referral pathways of how families became involved on the programme. Families came via current caseloads, via referrals from early years services, through other health visitors, and through single point of access, GPs and children’s centres, and the project manager. For some guiders who were only able to recruit families from their current caseloads, this presented as a challenge for them due to the age criteria of working with children under one year old for the project. As a result, the referral process and overall recruitment was slower than expected.

There was an issue at one point with referrals coming in very slowly. [VIGPO2]

That was a bit of a challenge I think at different points in the project. So, primarily from health visitors and children’s centres, from any sort of agencies already working with 0 to 1s, and also we had a poster in the children’s centre and in the clinics. [VIGPO6]

Visits
Regarding the practicalities of arranging visits in families’ homes, all VIG guiders reported the length of VIG visits to be much longer than their typical health visitor or support worker visits with families. In addition to this increased length of visit, visits also had to be flexible and adapt to families’ unforeseen circumstances that could sometimes arise on the visit – for example, the baby being asleep or irritable, or the caregiver or infant becoming sick. This meant that, at times, scheduled visits had to be postponed and rearranged, which often meant for most VIG guiders that the duration of the VIG intervention with a family increased.
They did need to be longer – yes, definitely. I would normally try and free up kind of a few hours because, I think, one of the, kind of, biggest challenges with it – especially the age group that we were aiming for – there was no guarantee that you would arrange a visit and go and you would be able to do it. You know, sometimes you would go round and the child would just have fallen asleep, or it would have had a really bad night or Mum wasn’t feeling very well. [VIGP01]

I haven’t quite finished one. I have still got to do my last shared review with her and, in fact, that’s who I was going to today, but she has just cancelled again, so we are doing it tomorrow and that has been quite difficult. [VIGP05]

**Impact on caseload**

The VIG intervention impacted VIG guiders’ workload overall. VIG increased their workload significantly, in that guiders reported needing to work beyond their contracted hours often to manage both their VIG and regular caseload. Some teams were able to make accommodations for VIG staff – for example, one team manager told VIG guiders that each VIG case could count as two cases. However, not all teams could support VIG staff in this way.

It did make the workload a little bit more difficult, as there was an extra thing. I mean, in health visiting, as I am sure it is everywhere, it is very pressurised; you have got a lot of work and not enough time, and I think in an ideal world with VIG it would have meant reducing my caseload. In reality, this just wasn’t possible. [VIGPO1]

So, while we were doing VIG cases, every VIG case was counted as two cases. [VIGPO3]

**Relationship with families**

Many of the guiders (N=3) described the positive impact that the VIG intervention had on their relationship with families.

I think it has enhanced. It has definitely enhanced the relationship between myself and the families that I am working with, and I think even if I had never met them before and they were not my health visiting families, after the first few weeks they have got a lot of confidence in actually approaching me with other questions that they wanted to ask us or other concerns that had come to mind that perhaps we weren’t undertaking a video or anything. [VIGPO4]

I did feel like the families I had used VIG with – I did feel that our relationship was different and there was, there was a different level to it which was really, was really nice actually at the end. [VIGPO1]

**Wider team**

Regarding support from their colleagues and managers, differing levels of support were reported to be available to VIG staff within their teams. While, on the whole, peers and managers were supportive in the use of VIG in services, some teams could offer more practical support than others – for example, by reducing VIG guiders’ caseloads. Colleagues were interested to know more about VIG, though levels of awareness differed between teams.
They were happy to hear about it and it was good that I could, kind of, help them out. [VIGPO1]

My manager I had previously was very involved in setting up VIG in Haringey or getting involved in that, so she was really supportive. My current manager doesn’t really know very much about VIG, but I think sees that VIG is an advantage. [VIGPO2]

**Enhanced practice**

All guiders reported on the positive impact of the VIG programme (training and delivery) on enhancing their own skills as a health practitioner. Three main sub-themes were noted: attuned communication between themselves and families, increased self-awareness regarding how they work with families, and the power of videos being able to transform the conversations they have with families.

**Attuned communication**

Guiders identified that being attuned with families had improved the way in which they had previously been working with parents. They noted that, as families were learning about being attuned to their baby (being led by their baby’s needs), they themselves were learning to be led by the parents.

This has been a lot more collaboration, so I am really being led by the client as the client is being led by the child. I am taking on board a lot more of how useful it is to work in that way. [VIGPO3]

I am really, kind of, trying to slow down my communication and really be aware of what the parent is feeling in those minutes, and waiting for them and really waiting for their response before I leap in. [VIGPO6]

**Increased self-awareness**

All guiders talked about the improvements they saw in their observational skills, which made them more self-aware in their interactions with parents and allowed for more space for conversations to develop.

It made me much more aware of myself and much more present and, yes, it can only be a positive thing in the way that I work, for sure. [VIGPO5]

I feel that I am more capable to observe from a different angle. [VIGPO7]

**Power of video**

All guiders reported on the transformative nature of the visual medium (video recordings). Being able to show parents what they were doing well was extremely useful for guiders working with parents, particularly if parental confidence was an issue. Parents being able to see positive interactions with their child was empowering for them and gave them reassurance in their abilities.

I strongly believe in visual evidence. VIG is visual evidence, you know – you can actually see yourself. [VIGPO7]

Well, I think it is a really positive mode for families and you can actually discuss with families, ‘Yes, you are doing this really well’, but if the mother or father doesn’t really believe that within themselves I think actually seeing it on a video where it is actually, ‘This is what you were doing and this is how your baby is reacting’ is really positive and it...
is a very powerful medium for them to have access to. [VIGPO4]

Families’ experience
All guiders reported on the positive benefits of VIG that they had observed on families. They noted how parents watching positive interactions with their baby on the video recordings had improved the parents’ confidence in themselves, and noted that the parents were also better able to understand the needs of their baby. However, a number of guiders (N=4) also reported that some parents expressed fears and an initial reluctance to being filmed, feeling that they would be judged – perhaps based on previous experiences with health practitioners. The main themes of needing reassurance, improved confidence and an improved relationship with their baby are further explored.

Need for reassurance
Guiders reported on parents’ vulnerabilities and fears around being filmed and possibly feeling judged on their parenting behaviour. They commented on how the process of being filmed, reviewed and having recordings analysed can be a daunting one for families, as they feel like they are being put under a microscope.

‘Oh god, are they going to pick up on something wrong?’. That I noticed a lot as well. It did need to be explained quite a lot that you weren’t looking for where they were going wrong with parenting: you were looking at where they were going right. I think, I don’t know, I think it is only a fault with how things are at the moment that they do feel like professionals are more likely to be critical than positive. [VIGPO1]

But, as soon as you explain this is how it works – ‘I will video you and then edit’ – and I think it was just, maybe, just the feeling of ‘Ooohhh, fear of videos’, ‘Who will see this video when you edit it? Who will see this?’, which I understand. I think I would feel like that if, if that would be introduced to me initially. but then, no, it was ok. [VIGPO7]

I had a lot of trouble actually initially. A lot of families didn’t want to do it, simply because they were going to be filmed. [VIGPO3]

Improved confidence
Guiders also reported on the improvements they observed in parents’ self-efficacy and their esteem in themselves as parents.

Just increasing their confidence in their parenting, kind of what they are doing, is enough. [VIGPO6]

It would be quite profound in allowing them to appreciate something about themselves that they perhaps hadn’t been valuing or hadn’t even known was there. [VIGPO2]

It could definitely help improve families, parents’ confidence in their own abilities, and definitely improve the relationships between parents and their children. [VIGPO1]
Improved relationship with their baby

Finally, guiders also reported that parents gained greater understanding of their baby’s needs through learning more realistic expectations of their baby’s development and abilities. As a consequence, they were able to adjust their needs and be led by the child’s needs.

It helps them to understand what is going on a little bit more in their baby’s brain and gain a lot more of an understanding about some of the behaviours a child has. [VIGP01]

The parents were able to change how they speak, play, interact or understand their children, and the feedback from the parents was quite positive. [VIGP07]

Evaluation

As part of the programme an evaluation ran alongside the VIG intervention, whereby guiders were asked to obtain consent from families and administer questionnaires before and after the VIG intervention.

Consent

Regarding obtaining consent from families, for most guiders this didn’t present as an issue. Only some families expressed hesitation with sharing videos or participating in further qualitative interviews.

I always gave them the option of the three parts of the evaluation – so, the interview, the questionnaire and the video – at the beginning and the end, and most families were kind of up for taking part for all three. There may be a little bit more nervousness around the interview, but they were all kind of, ‘Yes, we want to take part in it and we will kind of see how we feel at the end for that’. [VIGP06]

Questionnaires

Guiders reported on their experience of administering questionnaires, saying that it did increase the length of a visit, which could be challenging with regard to working with children of the age ranges in the project. However, despite this challenge, they also reported on the positive impact of the evaluation on enhancing their work with families and creating new talking points with families.

The questionnaires did take a little bit more time, so for most parents they have got the 0 to 1 year old, maybe breastfeed, naps, they are still trying to find their routine, so quite often baby was in Mum’s arms and I would be reading the questions to the parent and they would be answering … so, just kind of doing it in partnership with them. All the families I worked with were very open about their answers to the questions. They actually helped
generate more conversation around the helping question as well. So really gave them food for thought about what exactly they wanted support with and what their worries were coming into this work with their child. [VIGPO6]

5.3.3 Managers
Three managers at different levels of delivery provided feedback about the feasibility, impact and sustainability of the VIG programme through qualitative interviews. This section describes the patterns of themes that the evaluator noted from the interview transcripts.

Feasibility
Regarding the theme of VIG’s feasibility, sub-themes recorded by the evaluation team included: VIG as an intervention that met a current gap in service provision, the generalisability of the model, the impact of the programme on staff caseloads and challenges with recruitment. These themes are further elaborated on below.

VIG model
The managers interviewed stated that they felt the VIG model had been positive and appropriate for the staff and parents within their service.

VIG has been invaluable in allowing practitioners to observe the communication between parent and child that takes place via non-verbal methods, so with their eye contact, with their body language, with their general interaction. [MANAGER01]

The benefits of parents being able to see themselves in a more objective way using video was highlighted as particularly beneficial. This provided a means to allow reflection on their own skills. In addition, the VIG model’s focus on achievements was seen as a positive aspect.

It offers a parent a chance to look at themselves – often people use the word like ‘a fly on a wall’, or from an outsider perspective – in a way they have never seen themselves before. [MANAGER01]
**VIG was good because a picture would present a thousand words, so instead of you saying constantly you are doing well, the baby is responding, they can see for themselves that you know what they are doing is a good thing and the baby is indeed responding to them. So, for me, that was what we wanted. VIG was a good tool for us. [MANAGER02]**

Managers felt that the model provided more structure for both staff and parents to communicate the needs of their baby, which was beneficial.

**Another helpful component of VIG: it gives parents a model of how to maybe play and interact with non-verbal infants. [MANAGER01]**

**Recruitment challenges**

Recruitment, either of staff to become VIG guiders, or parents, was a challenge for all the managers interviewed.

**Recruiting staff**

VIG training was free for staff to attend, which was highlighted as a positive. However, despite this, most health visitors did not apply to undertake the training.

_They were the only people that applied and I think that highlights the pressure the health visitors especially feel under._ [MANAGER01]

Issues were posed by the transient nature of the workforce, where some staff who had been trained in VIG then left to work in different posts. VIG training was open to any staff wishing to apply, so it was hypothesised that those who applied were the staff most motivated to develop themselves as practitioners, and that perhaps these were also the staff most likely to move on to new roles in the future.

_I think the people who ended up applying were the people who obviously were very interested in maybe developing themselves as practitioners._ [MANAGER01]

_The health visitor that we had involved with the VIG project, she moved to [another London borough]. [MANAGER02]_

_Three people changed job, basically, out of the four health visitors over the course of the year._ [MANAGER01]

**Recruiting parents**

In terms of recruiting parents to participate in the programme, it was reported that there were some challenges – particularly for family support workers.

For managers, who did not directly work with families, it was not always clear why some parents declined to access the VIG intervention. It was hypothesised that, for some families, stigma attached to needing support from family support workers, accessed through social services, was a barrier to uptake.

_Whereas the health visitors were working on this and they were dealing with families at a universal level so there is no threat ... when people are referred in to us, although we try to be seen in a very positive light, families always associate us – or a lot of the time associate us – with social services and they have – lots of them have – a negative relationship when we first start out._ [MANAGER01]
At other times, the barriers to recruitment related more to the criteria for accessing the services that VIG guiders worked within. For example, some parents who were suitable for VIG did not meet the team’s general threshold criteria, so senior management approval was required to provide alternative routes of referral into the team for those families to access VIG.

We had difficulty in getting cases in because they didn’t meet our threshold. We had to alter the way that we received referrals ... We did have to make lots of changes and we had to make requests lots of requests to senior management. [MANAGER01]

Additionally, the age range for the intervention was seen as a barrier to recruitment for staff who also worked with children over the age of one.

Family support workers initially really struggled to recruit under 1s because they just weren’t getting them – they weren’t coming into their service. [MANAGER01]

**Meeting current gap**

Managers felt that VIG offered a means to meet a current gap in their service provision. They described that, in the current financial climate, it was challenging for staff to access training and that some lacked confidence in their skills when working with pre-verbal children.

Yes, it is an intensive piece of work, but I just think ... we do, like, six visits with clients with mental health problems and that VIG can be used doing that, so it is still doing the work but having the tool to support you doing the work. So I really think it is a positive thing and I wish everybody could be trained on it. [MANAGER02]

They get very little training on communication between parent and child interaction, especially with the under 2s ... and it was definitely a gap that we had within our team, within our locality team, of working with those very young babies and their parents. [MANAGER01]

There was also an identified gap in provision for parents who had additional needs, either due to anxiety about their parenting skills or mental health difficulties. The VIG programme was perceived to be an appropriate intervention to be used for these parents.

We do see a lot of clients, especially first-time mums, who have what you would generally describe as 'first-time mum anxiety'. They just need reassurance really ... [the parents are] just generally calling every time about, 'Am I doing the right thing? My child is just crying – what am I doing wrong?'. [MANAGER02]

We do have a lot of clients with mental health concerns and some with poor parenting experience, so VIG to me was the perfect tool because you constantly see them, you provide reassurance, you know they are doing the right thing. [MANAGER02]

The mode of this programme’s delivery, through front-line health workers, was
linked to the theme of meeting a gap in service provision. Managers felt that training their team’s staff in VIG would achieve better VIG treatment coverage than providing the intervention only through secondary services, which required referrals.

The hope was that we could get managers and other, I guess, stakeholders […] interested in training up staff as a way of reaching more parents, really, and seeing whether that is feasible to do this training in what is currently a very, I guess, high-pressure, stressful work environment [MANAGER01]

Managing caseloads
All managers spoke about the need to consider how VIG impacted on the workloads of staff trained in the intervention. VIG is an intensive programme, which was reflected in changes to VIG-trained staff’s workload.

For example, some teams reduced the caseload of VIG-trained staff to allow extra time for the programme, although not all teams were able to do this. Even with additional time allocated, it was felt that the work required to be done in order to participate in the programme was a significant challenge.

Our health visiting service is, what do you call it, contracted to do certain visits, and the VIG project itself was very intensive, so adding this to one health visitor’s caseload was a bit problematic … at that point we were understaffed – we were recruiting, but we were understaffed. [MANAGER02]

I think they did find it a challenge to fit it in as well as their normal work. [MANAGER01]

If a health visitor suddenly had three or four cases that needed her to see them weekly, then that was hard for them to balance and juggle with the needs of the project and using VIG. [MANAGER01]

It was reported that, for some VIG guiders, this additional level of work resulted in their working overtime.

They were stretched and had, you know, were trying to find time to do this. Sometimes people would have to do it at home actually – they would sit at home and do it. [MANAGER01]

Impact of the programme
In terms of the impact of the programme, managers reported on three main themes: the impact on families, the impact on their teams and limits to the intervention’s impact.
Impact on family
Managers had not been in direct contact with the families involved in the VIG programme. However, through discussions with their team and viewing the videos, they felt that they had seen positive impacts on families using their service.

When you actually sit and watch the little clips back that the workers have done with the families, it is incredibly hard hitting. [MANAGER01]

VIG was helpful around helping parents attune to their child … going at their child’s pace, reporting more, I guess, satisfaction out of parenting because they realised that the child was actually responding to them. [MANAGER01]

VIG was perceived to be a supportive and reassuring tool to use with parents, and one that could result in increased confidence for the parents.

I guess I got that relayed back to me in supervision, around things like an increase in confidence – especially parents with premature babies. [MANAGER01]

Impacts on teams
Managers also saw that taking part in the VIG programme had a positive impact on staff and the wider team.

Impact on the VIG guider
The intervention and skills developed through the training and practice were positive in the development of staff as skilled practitioners.

You can actually see the impact that it has had on those individual families and, actually, the impact that it has had on the individual worker as well. [MANAGER01]

I think VIG is a great tool for staff development, not just as a way of
helping families out there in need. It is a great way of helping professionals become more self-reflective, which I think is an incredibly important part of any healthcare professional’s role. [MANAGER01]

Additionally, managers reported that participation in the VIG programme had a positive impact on staff morale. Staff’s levels of enthusiasm and passion at work were reported to have increased through participating in the programme.

They were really getting so much more out of the training, I think, and you could really see their enthusiasm really kind of increased I would say. They were very enthusiastic about the project. [MANAGER01]

Impact on the wider team
The VIG programme was also seen as a positive benefit for other colleagues in the team. VIG guiders were perceived to work with the more complex needs within the service, alleviating some of the workload for other staff. Additionally, the learning gained through the VIG training was disseminated through the team in some cases.

If you have a client with intense need and somebody else is going to take that off you, then you have no problems passing that work over. [MANAGER02]

They have learnt skills not only for themselves but that they can support other people with as well. You know, championing the communication and bonding and attachment between a baby and parent, baby and carer. [MANAGER01]

On a wider level, involvement with the VIG programme was also associated with other benefits, such as increased multi-agency working.

It has made us think about things in a more multi-agency way. [The clinical psychologist] has now joined me on an early help working party looking at partners in the borough and how they are working and what they are doing to get a more joined-up approach between mental health services, schools, nurseries, so it has brought people together I think. [MANAGER01]

Limits to the impact
Managers highlighted that, while VIG was perceived to be of benefit to their teams and to parents using their services, there were limits to its impact.

One limit identified was due to the few numbers of staff trained in VIG within the team, which still meant there remained an unmet need in services.

I don’t think that gap has been plugged by the few workers that we have had trained. [MANAGER01]

One manager also highlighted the challenges of working with parents with complex needs, such as those who experience domestic violence or housing difficulties. There was a question of whether VIG was the best intervention for these parents. However, it was also acknowledged that there was still potential for an intervention such as VIG to improve the relationship between a parent and their child, even if other broader issues, such as housing difficulties, remained unchanged.
VIG can’t change someone’s housing situation, for example, and it can’t necessarily change someone’s capacity to go out and meet new parents. [MANAGER01]

[VIG] certainly provides, I think, a big confidence boost in those parents who are doing ok but don’t think they are doing ok. I don’t know whether those parents might show a larger improvement in their scores possibly than people with more entrenched difficulties – I don’t know. [MANAGER01]

The intervention, aimed at parents, was reportedly not provided to many fathers. Providing the intervention mainly to mothers was stated to be due to the main caregiver of the child usually being female. However, the managers did feel that this was a potential limitation of the programme, and felt that opportunities for greater impact could be provided if fathers or both caregivers were involved.

We did notice that we only worked with mothers. We didn’t work with any fathers at all … I think it is vitally important that they bond with their mother, but I equally would have liked to have seen some father work as well. [MANAGER01]

I think, because it was a trial period, we did the right thing in that we involved the main carer, who mostly was the mum. But I think if we are going to be rolling this out then it shouldn’t just be the mum – it should be everybody that is involved, especially dads. If they are first-time dads, they do have anxiety as well, and I think they should be involved. [MANAGER02]

Sustainability of the programme

Regarding the theme of sustainability, several sub-themes were recorded, including: the need for managers to advocate continued investment, financial barriers, removing child age criteria regarding involvement, and linking VIG with other areas of work within teams to increase its sustainability.
Managers all wanted the VIG programme to continue in their areas, which includes continuing the accreditation process for the staff who had completed VIG training.

I am hoping that we will be able to continue at least two of the three that have been started on the accreditation process. We want to get them through and continue with their development. [MANAGER01]

**Advocating**
Managers described advocating the sustainability of the programme within their services, including by holding meetings with senior managers. This was an important part of sustainability, as receiving both funding and the approval of more senior management was vital.

We are fighting the VIG flag, flying the flag, and we are saying how amazing it is – hence the meeting with the head of service and with the potential for that to also involve the Assistant Director of Early Help and seeing if we can get them to, once they have seen the work, hopefully they will have an impetus to invest in it. [MANAGER01]

**Financial barriers**
Financial barriers to the continuation of the programme were anticipated, including the costs of equipment and expert supervision. However, managers remained committed to advocating the investment due to the perceived benefits.

It has come at a time when we have little funding for any external or any alternative ways of working. [MANAGER01]

I do think that I would very much like it to continue and I would also like to roll it out further to other workers. But whether or not we would be able to do that due to funds is another matter. [MANAGER01]

**Increasing age range**
In terms of the potential development of the programme, managers felt that the intervention could have a benefit for children over the age of one within their services. It was identified that, in some areas, there was a perceived gap in provision for children over the age of two who were too old for some services but perhaps did not meet the criteria for children’s and adolescents’ mental health services.

I also think, for us in early help, we would have the ability to increase the age range – so not just being for the under 1s ... I think at any age it can be beneficial. [MANAGER01]

Another beauty if VIG is its flexibility. It can be used for all ages very easily and I think health visitors also would like to use it maybe with verbal children and, for example, toddlers who they often get referred. [MANAGER01]
Links with other projects
Looking forward, managers considered linking VIG to other agendas and programmes within their departments to increase its sustainability and the specialisation of the staff. For example, linking VIG to the Healthy Child Programme, one manager advocated that VIG-trained staff within health visiting teams should become leads on mental health within their service.

As part of the Healthy Child Programme, one of the areas that we are looking at is mental health – paternal mental health especially – and I think as part of it also we are looking at certain health visitors to take the lead on it, so it will be great if the health visitors that did the VIG project would be able to follow through on it and probably become that specialist in that area. [VIGTMO2]
6. Discussion

The TEOE programme was a one-year programme operating in the local authority of Haringey to promote infants’ social and emotional development using VIG with families. Through VIG, parents are given increased opportunities to observe and reflect on video recordings of their positive interactions with their child. The overall aim of the programme was to support parents to bond with their baby.

Results from the preliminary outcomes and process evaluations show that VIG has benefits for parents, practitioners and managers. Participants in the TEOE programme had mild to moderate symptoms of mental health problems at baseline.

Outcomes evaluation

Despite a small sample size, findings from the quantitative assessments show VIG’s improvements on parents’ self-efficacy, stress, and their sensitivity to and bonding with their baby. Mean scores for both depression and anxiety decreased between T1 and T2, with anxiety scores dropping from 6.15 to 3.85, reflecting a shift from ‘moderate’ levels of anxiety to ‘mild’ following VIG. Perceived parental confidence also increased significantly from T1 to T2, and the total mean scores increased from 57 to 63. The mean scores on the MPAS/PPAS in terms of overall attachment and quality of attachment were also seen to improve and complement the increase in parental confidence. Findings on the ASQ:SE show improvements in the social and emotional development of the infant following VIG intervention, and, while the sample fell under the threshold for referral to mental health services, the overall decline in scores from T1 to T2 illustrates improvements in babies’ social and emotional development. The mean scores on the KIPS also complement the findings on the ASQ:SE, with overall scores on the survey significantly increasing between T1 and T2 from 3.67 to 4.14. Significant increases were also evidenced on several items of the ASQ:SE, such as parents’ promotion of language experiences, giving supportive directions and promoting exploration and curiosity.

Recruitment and retention

During the evaluation period three of the seven guiders had a change in job role, which had a negative impact on the numbers of families recruited to the project (in that fewer families than expected were recruited for the project). Another challenge with the recruitment of families was the strict age criteria for the child, which slowed down recruitment overall. Twenty-eight families indicated interest in being involved in the programme, of which 20 completed the VIG intervention. Thus, the rate of participation was 20/28 (71%) and the attrition rate was 8/28 (29%). Of the eight who did not take part, reasons cited included: two went on holiday and were unable to complete the intervention during the evaluation period...
period, three expressed interest but later declined, one moved out of the borough, one did not engage, and one was deemed not suitable as they had severe mental health difficulties.

**Acceptability**

Qualitative findings describing the experiences of parents, VIG guiders and senior managers present early findings on VIG’s feasibility and acceptability in early years services in Haringey. Parents who were interviewed were overwhelmingly positive about their experience of VIG, and all perceived the programme to have been of benefit to them and their families.

While being filmed was initially daunting for most parents, all of them later became comfortable with this and perceived video footage to be a beneficial element of the intervention. Participants all described the intervention as having increased their confidence as a parent. This was achieved through the positive feedback of seeing their skills reflected in video recordings, as well as the positive feedback from guiders. Through the programme, some parents described an improved connection with their child. The programme also helped some parents to widen their social networks by gaining the confidence to go out more or join a local social group.

All VIG guiders believed in the positive benefits of VIG for families and were keen to complete their training and continue delivering VIG within their teams. All of the managers perceived that the VIG programme had brought benefits to their service and were keen for it to continue. While the managers did not have direct contact with the parents, they reported that, through the video footage or feedback from VIG guiders, they felt that the programme had a powerful impact on parents’ relationships with their children. Guiders did speak of a few hypothetical factors that could make it challenging to use VIG with families. These included complex cases or needing to use interpreters. However, this may have been a challenge for newly trained VIG guiders as opposed to more experienced guiders. The main difficulty for guiders using VIG with families appeared to be regarding a parent’s readiness or willingness to take part in the intervention, which was also reflected in the rates of participation and attrition. Guiders also spoke of the positive benefits of VIG on themselves, specifically noting improvements in the way they worked and communicated with families and on their own observational skills. Managers also noted that the programme had a positive impact on their staff through increasing their skills and motivation in their work.

Regarding the implementation of VIG in services, the main challenge for guiders was time. Guiders spoke of the extra time it took to carry out VIG with families and the fact that teams are not always able to accommodate for this increased pressure on VIG guiders’ caseloads. The strict age criteria of the child for the project also meant that some visits needed to be rescheduled, increasing the length of time it took to complete the intervention with a family.
While managers stated that the VIG model was appropriate for meeting the current gap in service provision, some challenges regarding the feasibility of the programme emerged as themes. All managers highlighted the challenges for VIG guiders with regard to balancing their regular caseloads with the additional time that was required for the VIG programme. The wider team context was also highlighted as a key factor in the feasibility of the programme, which could either facilitate or be a barrier to the programme’s success. Within these teams, the recruitment of both staff to become VIG trained and participants was, at times, challenging. Despite these challenges, managers felt the programme had made a positive impact within their services and were keen for it to expand to cover wider age ranges of children in the future. Managers pointed to funding issues and the need for senior management agreement as potential barriers to the programme’s sustainability.

**Limitations**

One main limitation to the present feasibility study of VIG was the sampling procedure that the evaluation team employed. Parents involved in TEOE were either self-selecting or selected by VIG guiders, which limits the programme’s generalisability.

A second limitation was the small sample size of the quantitative assessments. While the findings indicated some clinical effectiveness for VIG, caution should be taken when interpreting these results and generalising findings to the wider population due to the small sample size.

The strict age criteria of the project also impacted the sample size. Only families with infants of 12 months or younger were deemed eligible to participate. As a consequence, recruitment was slower than the evaluation team anticipated and this meant fewer families were recruited than the original 30 specified in the HEE bid.

Additionally, it was decided by the overall project team (programme and evaluation) that newly trained guiders’ first VIG families would not be included in the evaluation in order to give guiders more time to practise and become comfortable using VIG with families. Related to this, and given the time constraints of the evaluation, guiders were advised not to work with families with too many complexities or if there were safeguarding concerns involved. As a consequence, VIG’s generalisability to other parent population groups is limited to low-risk families. Future evaluations using newly trained VIG guiders should also be cautious about including first families in the evaluation findings; however, if experienced VIG practitioners are used then these families should be included.

A second study limitation was the length of the evaluation period, which meant there was a lack of follow-up of participants to determine if outcomes had been sustained.
7. Conclusion

To summarise, the findings of the TEOE evaluation programme in Haringey show evidence to support it as a useful and beneficial intervention for families in Haringey with infants of 12 months or younger, in line with NICE guidance. However, the small sample size limits the generalisability of the results to the wider population. Nevertheless, the evaluation of TEOE has shown evidence of improvements in parents’ self-efficacy, parental stress, sensitivity and attachment to their child, which is further corroborated by VIG guiders and service managers. Regarding VIG’s feasibility and acceptability, the rate of attrition to the programme was low (29%), which indicates families’ positive reception to VIG as an intervention to enhance communication with and understanding of their baby. Guiders and service managers also reported on the positive benefits of VIG for families in their services; however, they were concerned about its sustainability after the TEOE programme is complete. In addition to this, VIG guiders noted the increased workload demands with regard to carrying out VIG, and if adjustments could not be made within teams this made it difficult for staff to manage. Despite these challenges, guiders and managers believed in the value of the intervention and that it should have investment from early years teams and be offered to parents accessing their services.
8. References


Interview Schedule – Project Manager

- Could you please say your full name, job title and briefly describe your role?
- What are your thoughts on the VIG model as an intervention to enhance communication within the relationship of a parent and infant?
- Why did you choose to be involved in the TEOE VIG project? Have you taken part in other VIG projects in the past?
- If any,
  - Did you notice/are you aware of any changes in those families who took part in VIG and their service use?
  - What do you think were the benefits of VIG for families living in Haringey?
  - Were there any downsides to using VIG with families from Haringey?
- Were there any challenges/barriers with regard to implementing VIG in services in Haringey?
  - Are there any factors that make it difficult to use VIG with families in Haringey?
  - Do you think VIG should be used with other families in Haringey? Other parents? Do you think some families may not be suitable for this type of intervention?
- Any other comments or reflections about VIG?

Interview Schedule – Team Managers

- Could you please say your full name, job title and briefly describe your role?
- What are your thoughts on the VIG model as an intervention to enhance communication within the relationship of a parent and infant?
- Why did you choose to invest in VIG in your service?
- If any,
  - Did you notice any changes in the VIG families using services in terms of their service use?
  - What do you think were the benefits of VIG for families living in Haringey?
  - Were there any downsides to using VIG with families from Haringey?
  - Did having one person in the team who was VIG trained impact team dynamics? What was the experience of having members of the team externally supervised like?
• Were there any challenges/barriers with regard to implementing VIG in your service?
• Are there any factors that make it difficult to use VIG with families?
• Will your service continue to invest in offering VIG to families after the training?
• Do you think VIG should be used with other families in Haringey? Other parents?
• Any other comments or reflections about VIG?

Interview Schedule – Practitioners
• Could you please say your full name, job title and briefly describe your role?
• What are your thoughts on the VIG model as an intervention to enhance communication within the relationship of a parent and infant?
• Can you briefly describe your experience of the VIG training, including the specialist supervision you received? PROMPT: Experience of novel components such as being filmed and reviewing video to discuss your own VIG delivery, technical aspects of the intervention such as using a camera and uploading films, etc.
• Regarding professional development, what impact do you think VIG has had on your employability and prospects within your role?
• Where did you receive referral families from?
• How did you obtain consent from families to take part in VIG?
• How were assessment visits arranged?
• What impact has training in VIG and subsequently delivering VIG had on your role? PROMPT: Improved self-efficacy, clinical observation, any other skills?
• Did this have an impact on: your workload? Relationships with your colleagues and/or manager? Relationships with clients? Work–life balance?
• If any, what are the potential benefits of VIG for families?
• If any, were there any downsides to using VIG with families from Haringey?
• Were there any challenges/barriers with regard to implementing VIG in your service?
• Are there any factors that you see making it difficult to use VIG with families?
• Will your service continue to invest in offering VIG to families after the training?
• Would you recommend using VIG with other families in Haringey? Other parents?
• Any other comments or reflections about VIG?
Interview Schedule – Parents

- Before we begin, can you tell me a little about yourself (age, gender, ethnic background)?
- How did you hear about the Through Each Other’s Eyes project (e.g. leaflet, word of mouth, other, your health visitor/ family support worker), and what made you want to take part?
- Can you describe what was happening in your life at the time you decided to sign up for VIG? What worries or concerns did you have about your infant that you thought VIG might be able to help with?
- Did you have any concerns or difficulties, or was there anything that you were worried about that might stop you from taking part in VIG?
- Can you briefly describe your experience of having VIG in your home? (e.g. number of sessions, length on average, frequency of visits, experience of being filmed and reviewing videos)?
- Did VIG have an impact on your relationship with your HV/FSW?
- Is there anything you would change about the VIG intervention?
- If any,
  - What were the benefits of taking part in VIG? Any benefits for you? Your baby? Your family? PROMPT: For example, did it increase your sensitivity or bond/relationship with your baby?
  - What were the skills or sessions you found most/least useful?
  - Were there any downsides to taking part in VIG?
- Has taking part in VIG had any impact on your mental health or wellbeing? In what ways has VIG helped (if at all)?
- Has taking part in VIG helped you feel more/less confident as a parent? In what ways has VIG helped (if at all)? PROMPT: Score 1 to 10 how confident you felt before and now, e.g. more confident in parenting skills, relationship with baby or others. Any other aspects?
- Has taking part in VIG had any impact on your relationships with others? Has it helped you make any new relationships/connections with others or helped you learn more about what support is available in the community?
- What was your experience of completing the questionnaires like?
- Any other comments or reflections about VIG?
VIG families qualitative analysis

Delivery of VIG
- Perspectives on being filmed
  - Confidentiality
  - Being judged
- Reasons for participating
  - Mitigated by rapport with health worker
- Practical components of programme
  - Completing questionnaires
  - Frequency of sessions
  - Increased confidence
  - Improved connection with child
  - Building relationships
    - Going out more
    - Feeling supported by health worker
    - Improved relationship with family/friends

Impact

VIG guiders qualitative analysis

VIG model
- Strength based
- Generalisability
- Model within a model
- Theory and technical aspect
- Supervision
- Guiders’ experience
- Families experience
- Consent
- Questionnaire

Training
- Beneficial tool
- Improved understanding of parent-infant relationship
- Use of technology
- Supportive
- Flexible
- Daunted about being filmed
- Practicalities
- Impact on workload
- Relationship with families
- Wider team
- Enhanced practice
- Need reassurance
- Improved confidence
- Improved relationship with baby

Delivery
- Recruitment and referral pathway
- Visits
- Attune communication
- Increased self-awareness
- Power of visual

Evaluation
mentalhealth.org.uk

Our mission is to help people understand, protect and sustain their mental health.

Prevention is at the heart of what we do, because the best way to deal with a crisis is to prevent it from happening in the first place. We inform and influence the development of evidence-based mental health policy at national and local government level. In tandem, we help people to access information about the steps they can take to reduce their mental health risks and increase their resilience. We want to empower people to take action when problems are at an early stage. This work is informed by our long history of working directly with people living with or at risk of developing mental health problems.

The Mental Health Foundation is a UK charity that relies on public donations and grant funding to deliver and campaign for good mental health for all.

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