Evaluation of the Video Interaction Guidance Service, Cornwall Council

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1.0 Executive Summary

This evaluation report presents findings for the Video Interaction Guidance (VIG) Service Evaluation (January to October 2016). During this period, output and impact data has been collated and telephone interviews have been conducted with clients and referrers for all cases that had completed the Video Interaction Guidance intervention during the period February to March 2016. This period was selected on the basis of time considerations, as follow-up interviews had to be undertaken with clients six months after they had completed the intervention and also within the confines of the evaluation period (January to December 2016). Findings are structured according to the research outline provided in the tender and consist of output, impact and interview data. Results are also presented for an additional element, which was recommended on the basis of findings in the interim report (May 2016) - a survey of Children's Education, Health and Social Care Service staff awareness of the VIG Service.

2.0 Introduction

There is growing concern about the links between Adverse Childhood Experiences (ACEs) and their link with negative outcomes across the lifespan (Department of Health, 2015). Adverse childhood experiences can be described as stressful experiences which affect a child directly such as neglect or child abuse, or indirectly through the home environment. These experiences are associated with an elevated risk for the young person to adopt harmful behaviours in adolescence which in turn are linked to difficulties in later life. The Department of Health (2015) estimates that around half of the English population have experienced one or more ACEs. Evidence suggests that chronic stress experienced during childhood affects the manner in which the brain develops and can change nervous, hormonal and immunological development (Anda et al, 2010, Gunnar and Chetham, 2003, DeBellis et al. 1999). Consequently, the Department of Health (2015) recommend that preventative action be taken to reduce the risk of ACEs, one such action is that of making parenting programmes which target a reduction in child maltreatment, more widely available.

2.1 Background

Early child development is mediated by the immediate environments and settings in which infants and young children live during the first years of life. Of particular importance is the relationship formed between infants and their primary carers; the dyadic bond or attachment that develops between a child and their closest carers. The concept of attachment was introduced by Bowlby (1969). Bowlby described infant attachment behaviours as an evolutionary, innate primary drive which ensures proximity to and elicits care behaviours from parents until the child is capable of independent care and species propagation. Later work led to the classification of varied attachment types and identified the negative impacts of non-secure attachments. Secure attachments are formed when a child's early needs are met by primary carers in a sensitive manner. An 'insecure avoidant' attachment develops when a child reacts to unmet needs by becoming over environmentally focused. 'Insecure resistant' attachments develop when poor relationship experiences lead to disruptive behaviours such as clinginess, tantrums and anger. 'Insecure-disorganized' attachments describe children who display a mix of both avoidant and resistant behaviours, (Ainsworth & Wittig, 1969; Main and Solomon, 1986). Schore (2001) links attachment types to child development, arguing that a child's emotional state is consistently guided by the responses of close carers. Schore contends that appropriate carer responses promote the development of a child's ability to respond to, adapt to and cope with stressors well, whilst inappropriate responses result in the development of brain processes that can neither regulate affect or cope with stress and place the child at risk of maladaptive infant mental health problems. When married with the critical period of cerebral growth found in the first two years of life, Schore's theory suggests that early negative experiences can lead to long lasting negative cerebral effects and associated problem behaviours. Supporting causal theories postulate that early attachment interaction(s) generate internal working models of behaviour that guide relationships with others throughout childhood and well into adulthood. These arguments are supported by evidence linking the child behaviours developed in early close innermost settings with later progress elsewhere. Denham et al (2003) links positive interactions with teachers and positive representations of self in educational settings with the secure attachment relationships formed earlier, and better academic success in later life.

In sum, present knowledge indicates that parent/carer–child and family relationships are a matter of vital importance. Less than optimal family relationships can

compromise children's development through a complex pathway that links problematic parental behaviour and insufficient parental capacity with child attachment, child developmental delay and later behavioural problems (Mooney et al, 2009; Manning et al 2006; Repetti et al, 2002).

This knowledge base underpins statements such as those in the Early Years Commission report, 'Breakthrough Britain: the Next Generation' (Centre for Social Justice, 2008) that describe family attachments and relationships as 'golden threads' central to a child's emotional and social wellbeing. It also sheds light on criticisms of government policies which underplay the role of attachment and family relationships in child development and wellbeing. Furthermore, informed opinion that early interventions capable of promoting family relationships in the early days of a child's life are more cost effective are of note. Research indicating that developing a child's emotional capabilities become harder and more expensive as a child gets older (C4E0, 2010,) calls for sustained effort to develop and rigorously evaluate early intervention programmes, thereby expanding the list of proven programmes within the UK (Allen, 2011). In addition there is a need for evidence of the long-term effect of current and innovative interventions, as although many early intervention programmes appear effective in the short term, evidence of longer, more continued effects is sparse (Barlow et al 2012). As stated by early intervention experts *'it is better to identify problems early and intervene effectively to prevent their escalation than to respond only when the difficulty has become so acute as to demand action. It is better for the individuals concerned, their families and society more broadly; it avoids a lot of personal suffering, reduces social problems and generally, it costs less than remedial action*' (C4EO, 2010: p. 3).

Video Interaction Guidance (VIG) is a comparatively new intervention which has been used as an early intervention with parents and young children. VIG is a technique in which a practitioner uses video clips of authentic situations to enhance communication between children and people close to them (AVIG.UK). VIG stems from a theory of inter-subjectivity which argues that children innately respond to and regulate their communication in reaction to the social cues of others (Trevarthen, 1979) and Bandura (1986) who developed the hypothesis that watching yourself perform a behaviour well increases held feelings of self-efficacy.

VIG is an interventional technique that seeks to trigger and support a process of change. In practice, this process begins with parent or primary carers acknowledging

or expressing a desire for change. Subsequent work concentrates on using video records to help parents and their children move away from discordant to more attuned patterns of interaction (Doria et al, 2013). The VIG process involves at least one video recording of naturally occurring interactions between the client and child, and one review session where the trained VIG guider and the client review the tape concentrating on micro moments of carefully selected elements of successful interaction between the client and the child.

Research has explored the impact of VIG and video feedback on various aspects of infant-parent interaction. A recent doctoral thesis (Musgrave, no date) reviews the effectiveness of parenting video-feedback programmes in improving child's behaviour. The thesis identified a correlation between improved behaviour and increasing age that supported by a previous meta-analysis (Bakermans-Kranenberg et al, 2003) suggests some uncertainty about when VIG is most effective. Wider research has focused more on the impact of visual interactive techniques on family attachment (Rusconi-Serpa, et al 2009). A growing body of research evidence supports use of VIG to promote the development of secure attachment between parents and children, especially through use of sensitive, responsive communications and interaction (Kennedy et al, 2010). Despite reservation about when VIG should be used Bakermans-Kranenberg et al (2003) conclude that interventions with video feedback were more effective in developing attachment than those without. Fukkink's (2008) conducted a further meta-analysis of 29 VIG interventions with 1844 families which produced significant results for positive changes in parental behaviour, notably improved sensitivity, responsiveness, verbal and non-verbal communications with parents becoming more skilled in interacting with their child, as well as experiencing fewer problems and gaining more pleasure from their role as a parent. Similar positive effects have been found in studies exploring use of VIG with first-time fathers (Benzies et al, 2013), parents of premature babies (Hoffenkamp et al, 2015) and mothers experiencing post-natal depression (Vik & Hafting, 2006).

Evidence of the positive effects of VIG has now extended into the realm of child neglect, Moss et al (2011) found parents who had been reported for maltreating their children demonstrated increased sensitivity and improved quality of caregiving when compared to a control group of parents who did not receive the VIG intervention. Such findings are supported by those of an exploration of using VIG with parents demonstrating child neglect which indicated that parents using VIG listened to and

understood their children better, developed better parent/child relationships, demonstrated improved parenting strategies, gave parents the confidence to implement new approaches and made them more aware of their child overall, rather than focusing on negatives aspects (Whalley and Williams 2015).

In sum, knowledge to date indicates that VIG as an intervention that can improve important relationships by developing better attunement and empathy, is being increasingly employed to support parents experiencing difficulties interacting meaningfully with their child (Kennedy, Landor & Todd, 2010; Trevarthen, 2009), and is helping them become more skilled at interacting with their children and find these interactions easier and more rewarding (Fukkink, 2008). It is therefore not surprising that the National Institute for Health and Care Excellence (2015) recommends VIG for use with pre-school children with, or at risk of, attachment difficulties who live with their birth parents and are at high risk of entering or re-entering the care system, including those who have been, or who are at risk, of being maltreated.

2.2 Video Interaction Guidance Service Evaluation

The Video Interaction Guidance (VIG) Service was set up in April 2014 as a pilot project designed to offer an evidence-based intervention to families across Cornwall. The VIG Service accepts referrals from practitioners working within the Children's Education, Health and Social Care Services; including Children's Early Help, Psychology and Social Care Services, and health visitors. The aim of the service is to provide a therapeutic intervention for families where parental sensitivity to their children, attachment difficulties and lack of reflective capacity has been identified through a range of observations or assessments. The VIG Service was designed to be an early intervention service as it was envisaged that this was the stage where the most impact could be achieved.

During the first 10 months of provision, the VIG Service received 54 referrals and subsequently worked with 36 families. The VIG Service's Interim Evaluation Report, presented positive results for the intervention in terms of the achievement of goals, increase in parenting self-efficacy and satisfaction with the Service (Lowry, O'Neill, Stephens and Augarde, 2014). As a result, the VIG Service is now a permanent service in Cornwall. An independent evaluation was commissioned in September 2015 in order to:

- Review the VIG service to ensure it is value for money and making a positive impact on outcomes for children and families.
- Evaluate the factors that contribute to successful outcomes to inform future service development,
- Indicate possible areas for future more in depth research
- Provide evidence of impact for future commissioning opportunities
- Explore the possibility of publishing the evaluation results to add to the national picture in VIG developments.

The evaluation adopts a mixed method qualitative approach consisting of three main parts. First, the output data collated by the VIG Service has been analysed to identify the number, type and duration of cases recorded. Second, the impact data collated by the VIG Service was analysed to determine whether VIG could be associated with any changes in the target monitoring evaluation and/or parental levels of self-efficacy. Third, semi-structured interviews have been conducted with clients at two time points. Time one interviews were conducted with clients who had completed the intervention within the period 1st February 2015 – 31st March 2015 and with the practitioners who had referred these clients to the VIG Service. Time two interviews were undertaken around six months after the intervention had ended. Following findings presented in the Interim Report (May, 2016) a fourth element was introduced, a short questionnaire for all staff within Children's Education, Health and Social Care Services. This report presents the output and impact data for the period 1st September 2015 to the 11th October 2016, results from the staff questionnaire and qualitative analysis of interview data for both T1 and T2.

3.0 Methodology

The evaluation of the Video Interaction Guidance Service consisted of four main stages each relating to the three main evaluation objectives. First, analysis of the output data collected by the Video Interaction Guidance Service was conducted. This data consisted of information about the number and geographical location of referrals, number of cycles and duration of the intervention. Where provided, the status of the child (early intervention, child in need, child protection) at the beginning and end of the intervention was used to inform analysis. This information was

forwarded to the evaluation team by secure transfer for the interim report on 26th April 2016 and for the final report on 11th October 2016. This report includes analysis of all cases completed between 1st September 2015 and 11th October 2016.

Second, analysis of impact data was undertaken. This analysis explored pre and post intervention data as recorded by the target monitoring evaluation (TME) and the Tool to Measure Parenting Self-Efficacy (TOPSE). The TME data gives information about the goals identified through discussion between the client and guider at the start of the intervention. Each client set between 1 and 3 goals which were broadly in line with the TOPSE sub-scales (see below). At the beginning of the intervention, clients indicated where they perceived themselves to be in relation to each goal on a scale ranging from 0 (not present) to 10 (always present). At the end of the intervention, clients were invited to indicate the extent to which they had achieved each goal, using the same scale. Both the pre and post intervention scores were analysed in order to identify whether any changes occurred in self-report scores before and after the VIG intervention.

Clients were also required to complete the multi-dimensional TOPSE scale pre and post intervention. The TOPSE scale incorporates 8 sub-scales (Emotion and affection, Play and enjoyment, Empathy and understanding, Control, Discipline and boundary setting, Pressures, Self-acceptance, and Learning and knowledge), designed to measure a particular aspect of parenting. Each of the 8 sub-scales contained 6 items which were rated using an 11-point Likert scale where a low score represented a low level of parenting self-efficacy (0 = completely disagree and 11 = completely agree). The data are presented in relation to the difference between pre and post intervention scores for overall parenting self-efficacy and for each of the sub-scales. Due to the relatively low number of respondents, it was not possible to undertake any further statistical analyses of the TME or TOPSE data.

Third, following the recommendation made within the Interim Report (May 2016), a questionnaire was devised to scope the knowledge base of the VIG service across the local authority. To do this, a questionnaire was devised and distributed to staff using the existing Netigate service as staff are already familiar with, and engage with the tool. The questionnaire sought to determine overall awareness of the VIG Service, levels of engagement, and reasons for non-referral.

Fourth, semi-structured interviews were undertaken with every client who had completed the intervention between 1st February 2016 and 31st March 2016 and consented to be interviewed for the evaluation. This time period was selected for pragmatic reasons as the evaluation consists of two phases of client interviews, one immediately on completion of the intervention and one six months following completion. In order to conduct both interview phases within the evaluation timescale (January to December 2016), the first phase of client interviews had to be completed by the end of March.

Each client was given an information sheet which explained that a team from Cardiff University was undertaking an evaluation of the Video Interaction Guidance Service on behalf of Cornwall Council and that that all parents completing the intervention during February and March were being invited to take part in two telephone interviews: one immediately at the end of the service and another six months later. Clients were informed that an interview would also be conducted with the person who had referred them to the Video Interaction Guidance Service. Clients were assured of their confidentiality and that their decision whether to take part or not would not affect their service provision either now or in the future. Thirteen clients indicated their consent to take part by signing a consent form and providing the dates and times they wanted to be contacted. These details were forwarded to the evaluation team by email. One other client's details were forwarded as they had completed the intervention just outside of the evaluation parameters (in January), and who had indicated their consent to take part by email only, as opposed to a telephone interview. This client was contacted twice by email but no response was gained. Therefore, thirteen clients took part in the first telephone interview. For each client, the person who referred them was also invited to take part in a telephone interview. Of the 13 referrers, 12 were interviewed. Although an interview had been arranged with the thirteenth referrer contact could not be made; there was no response to the four reminders (three telephone messages and one email communication).

The telephone interview for both the client and referrer consisted of questions about why the client had been referred to the service, their understanding of the TME goals, and whether these had been achieved, what the client had gained from receiving the service, and about the relationships they had with the Video Interaction Guidance Guider. In addition, clients were asked about how they felt about taking part, how they felt about receiving feedback and whether they thought that both their

and their child(ren)'s behaviour had changed since taking part and whether they would recommend VIG to others.

The follow-up interviews were undertaken approximately six months after the intervention had ended (September-October 2016). Following email correspondence with the team it was decided that due to a family bereavement, it would be inappropriate to contact one of the clients who had participated at time one. Hence, 12 of the original 13 clients were contacted to ascertain whether they would be happy to take part in the follow-up interview. Of these, one could not be reached as the mobile phone went straight to voicemail and one, despite arranging a suitable time for interview, then hung up. Hence, 10 of the 13 clients participated in the follow-up interview.

4.0 Results

4.1 Output data

4.1.1 Referral patterns

During the period 1st September 2015 and 11th October 2016, 55 cases were referred and recorded on the 'VIG service referrals and data collection' spreadsheet collated by the Video Interaction Guidance Service. The referrals were from six different locality teams, with most coming from Locality 2 (Redruth, Camborne and Pool) and Locality 4 (St. Austell; 12 cases from each locality). As previously reported (Lowry et al, 2014) this reflects the localities where the VIG Service Guiders are based.

The majority of referrals were made by social workers (n = 29), followed by family support workers (n = 11) and health visitors (n = 11), a residential worker (n = 1) and a child development teacher (n = 1). Thus, the majority of referrals were from staff whose role was with statutory services (n = 35) rather than staff from non-statutory services (n = 16).

Following the core criteria for access to the intervention, referrals were evenly distributed through those subject to an Early Help plan, those who had a current

Child in Need plan and those with a Child Protection plan. Those subject to a Child Protection plan are recorded across three different categories (Table 1)

4.1.2 VIG service uptake

The data showed that of the 55 referrals, 33 engaged in the VIG intervention. Of the 22 clients who did not participate, 15 were simply recorded as 'work did not start' this appeared to be due to clients withdrawing from the service. For seven clients the work was no longer appropriate for a variety of reasons including the children being taken into care, parental separation or other changes in family circumstances. In the final case the work was cancelled due to other intervention work being carried out with the client. Further inspection of the results did not reveal any differences between those that engaged and those that did not engage in terms of the criteria for referral (Table 1), role of the referrer (Social worker, Family Support Worker or Health Visitor) or whether the referral was statutory or non-statutory.

The data showed that on average, it took one month for the intervention to begin after the initial request was made (n = 31). Clients (n = 33) participated in the intervention for an average of 5 months and undertook between 1 and 6 cycles, with an average of 3 cycles completed.

The findings showed that a total of 94 sessions were cancelled across 33 clients where all but two clients had cancelled at least one session. Given the nature of clients referred to the service and their tendency toward chaotic lives, missed appointments are to be expected. Further analysis of the data revealed that client led cancellations accounted for 92[1] missed appointments for a range of reasons including other commitments such as dentist or hospital appointments, child illness and the parent having forgotten about the appointment or not wanting to participate.

However, all 92 sessions had been successfully rescheduled suggesting that the VIG Service is accomplished at encouraging clients to maintain participation.

[1] Guider led cancellations occurred in 2 cases due to equipment failure in one case and having insufficient time to edit the film in the other. No details were given for the final cancellation.

	Referral criteria	Engaged	Did not engage	Total of referrals
1	Children under the age of 2 where early attachment difficulties/parental sensitivity have been identified by a health visitor and a discussion has been had with a member of the VIG Service about the appropriateness of the request	3	5	8
2	Children of all ages subject to an Early Help plan where attachment difficulties/parental sensitivity are identified as a key issue following an Early Help assessment (the plan needs to stay active until VIG intervention is completed)	5	3	8
3	Children who have a current Child in Need plan where attachment difficulties/parental sensitivity are identified as a concern.	15	6	21
4	Children of all ages who have been subject to a child protection where attachment difficulties/parental sensitivity are identified as an ongoing concern.	1	0	1
5	Children of all ages subject to a child protection plan where attachment difficulties/parental sensitivity are identified as a key concern and there is confidence that the family are going to stay together.	2	0	2
6	Children of all ages in foster care placements (in care to Cornwall Council) where it has been identified through the Child in Care review that support is needed to strengthen the relationship between the foster carer and child/children.	0	0	0
7	Children of all ages who are in residential placements/children's homes in Cornwall and their key workers.	0	0	0
	Total	**26**	**14**	**40**
	Missing data	*7*	*8*	*15*

Table 1: Criteria for referrals

Discussion with the VIG Service revealed an awareness that at least some appointments will be cancelled and that staff build contingency plans into their schedules. Examples of how missed appointments are used effectively include the council's hot desking policy which enables staff to work at any council office and the willingness of staff to complete work in their cars, if necessary. Further, in covering such a large geographical area consideration is given to ensuring that appointments are clustered according to locality to minimise travel time.

4.1.3 Families using VIG

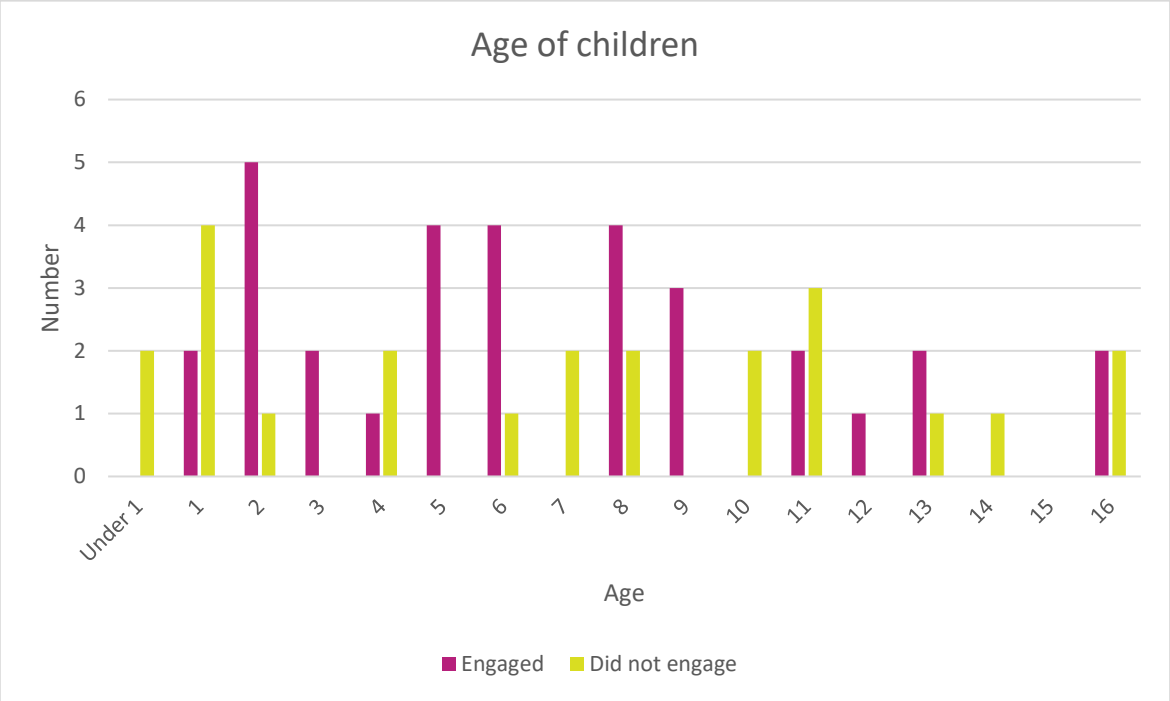

Figure 1: Age breakdown of children by those who engaged and did not engage

The majority of clients were referred for work with one child (n = 45), although referrals were made for clients to work with two children (n = 3) and three children (n = 5). The age of children ranged from 6 months to 16 years, with an average of 6 years. The majority of children referred to the service were under 10 years of age. As figure one shows, there were no differences in age range between those who did and did not engage.

4.2 Impact data

Of the 33 who engaged in the VIG intervention, TME results obtained *before* and *after* the intervention were available for 27 clients. The remaining 6 clients did not complete the intervention, either due to disengagement or removal of the child.

For the 27 clients who completed the intervention, 25 completed the TOPSE scale and two completed the MORS (Mothers Objects Relations Scores). Due to such a

small sample size for the MORS scale, only data for the TOPSE scale were analysed.

4.2.1 Target Monitoring Evaluation (TME) goals

Generally, the TME goals were devised through discussion between the client, referrer and the guider (see Interview results). Of the 27 clients where data was recorded, the majority of clients had 2 goals for the intervention (N = 27) although some had 3 goals (N = 24) and some 4 (N= 3). The TME items were linked to the subscales of the TOPSE scale (Table 3). The results show that all 27 clients had both 'Emotion and Affection' and 'Play and Enjoyment' as their goals. The majority (24) of clients also included 'Empathy and Understanding' and three clients had 'Control' as their fourth goal. Each goal was rated on a scale from 0 (not present) to 10 (always) present both before the intervention (Pre) and immediately after the intervention (Post). To date, the scores available show that all 27 clients made progress towards their goals during the time of the VIG intervention. On average, the scores increased by 3 or more points (Table 2). Although caution is needed on interpreting the result for 'Control' as only three clients had this as their goal. With this in mind, 'Emotion and Affection' had the greatest improvement although this was only slightly more than both 'Play and Enjoyment' and 'Empathy and Understanding'.

TME Goal	Pre	Post	Total difference	Average difference (Pre and Post)
Emotion and affection	81	182.5	101	4
Play and enjoyment	85.5	172	86.5	3
Empathy and understanding	70	160.5	97.5	4
Control	7	23	16	5

Table 2: Pre and Post TME goal scores

These findings support those reported by the VIG Service in the Interim Evaluation Report (Lowry et al, 2014) where the majority of goals related to the categories, 'Play and Enjoyment' and 'Empathy and Understanding'. In addition, the findings reported above, provide some support for those presented by Lowry et al (2014) where a 4 point increase was found for the categories 'Emotion and Affection', 'Play and Enjoyment' and 'Empathy and Understanding'.

4.2.2 Tool to Measure Parenting Self Efficacy (TOPSE) results

Twenty-five clients completed the TOPSE scale. Analysis of the pre- and post-TOPSE scores revealed that all but one client had an overall improvement on their parenting self-efficacy. Further inspection of the findings revealed that this client reported a score of zero on four subscales; following discussion with the Guider it appears that the client gave a rating for each subscale *before* the intervention but *after* the intervention stated that the four subscales were not relevant and as such, these zero ratings do not reflect a lack of improvement.

Analysis of the TOPSE sub-scales showed that the majority of clients reported an increase in their parenting self-efficacy across all 8 subscales (n = 22). Only 3 clients appeared to have decreased in their self-efficacy across 3 or more sub-scales. It is worth noting that a decrease in score may, in fact, reflect greater parental awareness or higher expectations of their parenting as a direct result of the intervention. Of the three clients whose scores decreased, one client decreased in five of the eight sub-scales (Empathy and understanding, Control, Pressures, Self-acceptance and Learning and Knowledge). Whilst it is difficult to draw any firm conclusions from only three clients, all three decreased on Control and Pressures. This is interesting as Control was associated with the greatest overall increase in scores.

Sub-Scale	Pre	Post	Total difference	Average difference (Pre and Post)
Emotion and affection	1089	1292	105	8
Play and enjoyment	976	1279	303	12
Empathy and understanding	958	1237	279	11
Control	732	1042	310	12
Discipline and boundaries	876	1084	208	8
Pressures	843	1020	177	7
Self-acceptance	1002	1183	181	7
Learning and knowledge	1023	1220	197	8

Table 3: Pre and Post TOPSE scores

As Table 3 shows, the areas of “Control” and “Play and “Enjoyment” showed the greatest increase in parenting self-efficacy. Both “Emotion and Affection” and

“Discipline and Boundaries” showed the lowest increase. These findings differ from those reported in the Interim Evaluation Report (Lowry et al, 2014) which found the greatest impact of the intervention to be for “Empathy and Understanding” and “Discipline and Boundaries” but support the findings that the lowest impact was found for “Emotion and Affection”.

5.0 Social worker survey

Staff from the Children's Early Help, Psychology & Social Care Services were sent an email inviting them to complete a five item questionnaire. This addition to the evaluation was made in response to a recommendation made in the Interim Report (May, 2016) as an attempt to gauge insight into overall awareness and understanding of VIG across the teams. Following email correspondence it was decided that the email would best be circulated through Cornwall Council’s existing Netigate service. As such staff were sent the email which contained a link to the online questionnaire, which remained live for one month.

A total of 43 members of staff completed the questionnaire. This low response rate can be attributed to staff capacity to undertake low priority tasks, perceptions as to the relevance to their current role and that, as an ‘add-on’, we did not undertake any further email reminders. Whilst it is difficult to draw any firm conclusions from such a low response rate, these results are presented as an illustration of how respondents perceive the service.

The first item asked which department the staff member was from and provided a drop box contained 23 departments (Table 4). It is impossible to draw any firm conclusions as to overall awareness of the VIG Service across the teams but the results do, however, show that awareness of the VIG Service extends beyond these teams (n = 14).

Of the 43 who had heard of the VIG service, only one reported that they knew nothing about the service. The majority (n = 27) knew a little with the remainder (n = 15) reporting that they knew ‘a lot’ about the service.

Department	Number of respondents
Family Plus Team	0
Pre-Birth Assessment Team	2
Child in Need Team West	2
Child in Need Team Mid	4
Child in	0
Disabled Children and Therapy Service West	0
Disabled Children and Therapy Service Mid	2
Disabled Children and Therapy Service East	2
Early Help Locality 1	1
Early Help Locality 2	3
Early Help Locality 3	1
Early Help Locality 4	1
Early Help Locality 5	0
Early Help Locality 6	1
Early Help Locality 6	0
Children in Care West	1
Children in Care Mid	1
Children in Care East	0
Child Protection West	2
Child Protection Mid	1
Child Protection East	0
Educational Psychology Team	4
Autism Spectrum Team	0
Other (please specify):	14
Gweres Tus Yowynk	*1*
Gweres Kernow - children with sexually harmful behaviours	*1*
Clinical Psychologies and Therapy team, Jigsaw	*1*
Admin for EP/AST	*2*
Senior management team for Early Help, psychology and social care	*1*
Early Years Inclusion Service	*1*
GTY/YOS	*1*
Disability Children and Therapy Service Countywide	*1*
Residential home	*1*
MARU	*1*
Children Centre Worker	*1*
ESHC	*1*
Total	*42*

Missing data = 1

Table 4: Questionnaire respondent department

When asked about how they had heard about VIG, most received this information from colleagues (Table 5)

How did you hear about VIG?	Number
Email	3
Colleague	15
Team Meeting	8
Presentation	7
VIG Guider	3
Training (unspecified)	1
Via work with clients	2
Induction meeting	1
Work with or alongside VIG Service	2

Missing data = 1

Table 5: How did you hear about VIG?

Twelve respondents had referred a client to the VIG service. Of these, work had started with all but one, who stated that they were very happy with how quickly the referral had been taken up. Of the 11 where work had begun, five stated that they were very happy with the service. In a further two cases, VIG was deemed as an effective component alongside other strategies, '*to communicate and reduce anxieties and build relationships'.* In two cases where work was ongoing, VIG was perceived positively by respondents but indicated that the impact was not yet known. One respondent reflected on the need for parents to want to engage with VIG,

> *I have varied responses to the effectiveness of VIG as it seems to depend on the parent/carer's willingness/capacity to change. Where the parent is willing to fully engage, I have observed extremely significant positive change in parenting.*

Of the twenty-nine respondents who stated that they had not referred a client to VIG, fourteen were not involved in direct work with families and four were either new to the role or had only a limited amount of casework. Four respondents stated that the need for such work had not arisen in their work with one stating that they would refer

to VIG as appropriate. Of particular interest in these findings is that one worker reported that,

> *I have tried to sell it to families but as yet have had no take up from families for the service*

Two respondents stated that they did not fully understand VIG. These results, taken together suggest that some staff members may benefit from further information about the service including the criterion on which referrals are made. Finally, one respondent stated that they had heard the waiting list for VIG was 'ridiculously long' and that their client's referral had been rejected, 'but it would have been really good for them to do it, which is a shame'.

6.0 Interview findings: on completion of VIG

6.1 Demographics

6.1.1 Participants

The parents surprisingly varied in both their background of having been involved with social services, and the reasons that they were accessing VIG. Some had, had a long involvement with social services, whilst others had only been involved with VIG. The presenting difficulties were similarly varied, from mental health of the parent, learning difficulties of both the parent and the child, domestic violence to parenting a challenging child. The vast majority of the parents wanted to build confidence and punctuate the negative spiral that they had sometimes become involved in.

The ages of the children involved were as young as 10 months up to 17 years. In this sense the intervention is very inclusive and would appear to be helpful to wide range of parents and children.

6.1.2 Gender

There were only 3 men in the sample interviewed, but it was noted that guiders always ask about the father when working with the mother and actively provide the

opportunity for the men to engage with the intervention. By actively engaging fathers, something that social workers often fail to do (Scourfield, 2003), VIG has the capacity to shift the 'assumed' responsibility of the mother as being solely accountable for the children and their difficulties.

6.2 Referrals

6.2.1 Becoming involved with VIG

All of the thirteen parents interviewed were very positive about their experiences of VIG. Many approached the work with VIG positively and embraced the opportunity to become involved. Several parents had requested the service and were very motivated to become involved. It is unusual to get this very level of positive feedback from such a diverse range of service users.

6.2.1 Views from referrers

All of the referrers were extremely positive about VIG as an intervention,

I am completely sold on the process' (Referrer 3)

'I think they are amazing' (Referrer 8)

There appears to be a very wide support base for VIG; however only those who had referred to the project were interviewed, and these may the people who are already converted to this way of working. The emphatic buy in from workers is clearly facilitating the use of the service.

6.3 The Intervention

6.3.1 The setting

The fact that the VIG intervention was carried out in the home was helpful for many parents because it is normalising, less stigmatising and places less pressure on them than an intervention taking place in a more public or clinical space. The natural setting undoubtedly enhanced the experience of both the parents and children.

6.3.2 The number of sessions and who was involved

The number of sessions that parents were involved in varied from 3 to 13. The number of sessions seem to be tailored to the needs of the family and some interventions began to include other children as the parent progressed, or worked with different combinations of parents and children. This allowed for family dynamics between different children in the family to be addressed. It was unclear from the interviews whether when the cycle of sessions ended people could contact the service in the future if they wanted to reengage for further support, or whether they would need to go back through a referral process.

6.4 Therapeutic basis

6.4.1 The underpinning ethos

The underpinning ethos and approach of VIG is strengths based and as a result is very empowering for those who engage with it. All parents noted that they set their own goals with the help of the guider. The model gives parents time to reflect on what they do well and build on that; it is very motivating for parents to be able to move forward. This strengths based perspective appeared to be motivational in that even those who referred felt that whilst it is an ideal intervention for those who are motivated, they also believed that it could have a positive impact on those who were less committed.

6.4.2 Relationship based work

What was particularly notable from the narratives of the parents was the importance of the relationship that they had developed with the guider (Ruch 2012).

> *We connected really well. It was really emotional when it was her last session. We had such a good bond it felt like I'd known her for years (Participant 9).*

> *It's fantastic and the guider knew that I loved it, I was really appreciative and it was really sad and the kids were really sad to see her go. It was amazing. The guider was really proud of me and the kids' (Participant 13).*

The VIG workers were able to give the parents time, something that social workers with busy caseloads are less able to provide:

> *Lots and lots of time. Ok... she took the time like hello, how are things going, what we're going to do today is look at... (Participant 1)*

These relationships were particularly important where they had a difficult or strained relationship with social workers now or in the past:

> *'Yeah I wouldn't have been able to do it with the social worker. Me and her don't see eye to eye' (Participant 12)*

> *'I think its good that its somebody fresh coming in to do the work' (Referrer 3)*

The relationships between parents and guiders were wholly positive with no negative comments being made by parents. Several of those who had made referrals also noted the need for the VIG guider to be independent and outside of the child protection role to preserve this trusting relationship:

> *It's having the person who is not doing the high end of involvement it's a specific role with specific tasks so it cuts all those ties to being child protection which probably makes them more willing to work with the service as well. (Referrer 7).*

What was also important to the parents was the sense of continuity in the individual relationship with the guider (no parents noted there had been any change of guider), which again other workers, because of the roles and responsibilities across teams, might not be able to provide to a family:

> *It was referred over and that was that. My Family Worker left the County and her job and what we did was we handed it over to another Family Worker that doesn't work in my team but just to support her until the VIG work started. (Referrer 1).*

If you do remain with the family that's really good of course we didn't with this family because it (changed teams) (Referrer 11)

Social work is often noted for the high turnover staff (Hussein et al, 2011) but for those who experienced this intervention there was no change in VIG guiders.

The significance of relationship continued to resonate in the findings from phase two of the study where participants still had a strong recollection and fond memories of their guider (see Section 6.5.5).

6.4.3 Attachment and attunement

The difficult and fractured relationships that some of the parents had with their children may often have been related to bonding and attachment difficulties (Bowlby, 1988). This might be because of their own experiences of being parented inconsistently or the experiences of the children (for example in the case of adoption). Many parents noted that by becoming more attuned to their children, in particular by giving the child space and time to articulate their own needs, then the bond between them grew:

Helping us interact with 'Sam' and listening to him more when it comes to play and things like that, understanding him a bit better. (Participant 5)

Our bond has got a lot closer [P1] and daughter. She's settled at nursery, she's settled at home. She's just a very content little girl (Participant 1).

Professionals also noted the link between VIG and the improvement in attachment as referrer 2 identifies:

It's an attachment based process (Referrer 2)

This development of higher levels of attachment and attunement made for better long term relationships between parents and their children (see Section 6.5.5).

6.4.4 Playing- children love it

The children particularly were reported as having enjoyed the attention and being involved in the process of VIG, as an intervention in which they were active participants:

> *There 'was an overwhelming sense of (the child) having enjoyed it' (Referrer 8)*

As parents became more attuned to their children, they responded positively to this change in engagement, possibly as a result of feeling more secure:

> *…and all of the concentration is on him so I think that's make him feel a little more, I want to say 'wanted' but does that sound right if I say that? (Participant 5)*

> *I know 'Sam' seemed to enjoy it a lot when we had one-to-one because we did it on a one-to-one basis, he really seemed to absorb the attention and get happy and joyful from it. (Participant 5)*

> *It helps with kids with their inhibitions, my son loved doing it. He was really excited every time we did it. (Participant 6).*

The VIG process interestingly seemed to be very helpful when parents were having difficulty in parenting older, adolescent children, allowing both parties to see what is going on between them without apportioning blame and to recognize the reciprocal nature of communication:

> *He's (son) would watch it and go, oh yeah you're doing this and I'm doing that (Participant 2, parent of a 12 and 17 year old)*

6.5 Follow-up interviews: Six months after VIG

Ten participants were followed up with a second interview some 6 months after their first interview. Three could not be contacted.

All of the participants who were re-interviewed were still extremely positive about VIG, all would recommend it to others and all bar one found it to have had a lasting effect on their parenting. As Participant 1 noted:

> *It has made me more positive….just sort of being more positive with her and not being negative*

In fact one of the participants had already recommended VIG to an associate:

> *I actually have. Someone was telling me the other day at my Susie project, she's been asked to go on it and I told her and she said did it do you any good and I said yeah, I'd definitely give it a go. You'll learn a lot from it (Participant 10)*

6.5.1 Status

Out of the 10 participants interviewed in Phase two, four no longer had contact with social services (Participants 3, 7, 10 and 12). Participants 5* and 6* are a couple and thus their comments relate to just one child. Participant 9's son was still in a residential home, and this was unlikely to change because of his needs remain high, although the relationship that she had with her son had much improved.

Four of the participants no longer had contact with social services and things were much improved:

> *Yes, (things have changed) a lot. He doesn't have any support now (Participant 3)*

> *I'm not with social services now (Participant 7)*

> *We've got a new baby. All help has come to an end, things are totally different (Participant 10)*

He's completely off of everything now. They even said normally when they're on child protection they go to children in need, but that didn't happen, he come straight off. (Participant 12)

Participant	Comments about their situation	No longer in contact with Social Service Department
P1	*'Everything the same'*	
P3	*'No support. Everyone's happy'*	X
P4	*'Still with Social Service Department'*	
P5*	*'Still engaged with Social Service Department'*	
P6*	*'Still engaged with Social Service Department'*	
P7	*'I'm not with Social Service Department now'*	X
P9	*'Son with autism still in residential home'*	
P10	*'All come to an end'*	X
P11	*'Basically they have decided to take it to court now'*	
P12	*'He's off everything now'*	X

Table 6: Contact with Social Services Department post intervention

Thus we can see significant change for all participants, especially those who were no longer involved with social services.

6.5.2 Continuing to use VIG

Most participants continued to use what they had learned from VIG and as a result feel that they are far more attuned to their children and this improvement has been sustained:

I now have no problems with my son, I watch how I talk to him, I involve him in things. I'm happier, he's happier, it's hard to believe where we were 12, 18 months ago. (Participant 10)

I do use it all the time. It works and as it works I will keep using it….It's because all of those things were very useful and I keep them in practice. That's why it's so fresh (Participant 11).

For one parent whose son is autistic and non-verbal and who lives in residential care, the parent felt that their relationship had been much improved as a result of VIG and of this improved attunement and understanding:

Key things, eye contact, certain body language that he uses, you can always tell what kind of mood he's in by his eyes. (Participant 9).

VIG had often changed family understandings and dynamics, as Participant 10 identifies she no longer feels that one of her children is placed on a 'pedestal' and 'can do no wrong', with the other being polarised and seen less favourably; she is now able to recognise the strengths in both of her children. She described having no bond with her son before VIG, but noted that this had completely changed:

Yes, like I said we have a completely normal relationship. It's great now, I love it (Participant 10).

Even when parents did not use VIG all of the time, it made them more reflective about their parenting and helped them consider how they could continue to improve:

I do still use them. maybe not always at the time, I think about it afterwards and think well I should have done this, maybe I should say sorry and learn from the experience again. (Participant 10)

Thus we can see a much more thoughtful and reflective approach to parenting having been garnered. For some it was helpful to go back to the materials in addition to practising:

Sometimes I have to go back over everything, I kept the notes that I was given through the VIG and I look back on them and I read through them if I forget things like what steps to take, like first, second and third and stuff like that. I do look back on them……we did say the other day we would look at the videos again to see if we could pick up an on anything that we're missing (Participant 5)

Participants were able to keep the recordings and some participants utilised these by way of revision.

Parents found that although the VIG service had been targeted at a particular child, these skills and approach could be replicated with all of their children:

> *I've used a lot of the VIG stuff with my other two as I said, even though they weren't part of the VIG in the first place….(Participant 5)*

6.5.3 Recollection and Sustainability of VIG

In Phase one we anticipated that people would have little recollection of the intervention. However only one parent identified this and noted that she has a very poor memory generally and could not remember much about VIG although she was 'no longer with social services' (Participant 7). She noted that:

> *I am pleased I done it, it was an experience for sure*

This participant was clear that she would recommend the service to others.

One couple (participants 5 and 6) were still having difficulties with their child and the mother felt that whilst:

> *It (VIG) was working for a little while but for some reason it's not working anymore so we've been trying lots of other actions with him now (Participant 5).*

This family were accessing a range of other services including family therapy, counselling and CAMHs with regard to their difficulties. Participant 5 also noted that she was still using VIG for her other two children, despite it just being for 'Sam' initially. She further noted how she read over her notes and tried to remind herself of the steps involved in VIG. She had found VIG very useful because '*it was interactive*' and; it *helps you build confidence as well'*. Her partner however (participant 6) felt that he was still using what he had learnt from VIG with 'Sam' and he would like to be doing this more often. He mentioned the use of the 'feelings' cards provided by the VIG guider as a useful tool to encourage 'Sam' to talk about how he felt. He also

noted how Sam still responded very positively when it was clear that attention was being paid to him. Participant 6 felt that VIG had been particularly beneficial for the relationship between himself and his son Sam:

> *I feel our relationship has changed yeah. He was getting more confident until he started going downhill again, but he was getting a lot more confident talking to me. Normally he would only confide in his mother, but he does talk to me a lot more now.*

Whilst Sam has started to go 'downhill', participant 6 still felt that VIG had been beneficial and had helped to improve the relationship between him and his son which might make these current and future difficulties more manageable.

6.5.4 Working with a range of interventions and professionals

It seems that VIG can work well either by itself or as part of a range of services being provided as determined by family need. As such it would not conflict with any other approach and different by being home based. Whilst a range of professionals had been involved with family 3 the participant noted:

> *I think VIG did the best bit in that it showed us that we weren't losing control as we felt that we were losing control…… Obviously the OT was more about his sensory needs and the Ed Psych was about his school life. VIG was more about at home and what we were doing.*

One participant noted that it had been helpful for her to access VIG as well as mental health counselling and these had worked well in tandem:

> *One thing I learnt which was between the VIG and the parenting class, combine the two (worked well) (Participant 11)*

Similarly, another participant (10) noted that the combination of VIG and mental health support had been invaluable for her.

As relationships improved between parent and child/ren this meant for some that they felt more confident taking the child out, and so more community based services could also be accessed:

> *He's a lot more loveable towards me now, we do things together, he's started to go to clubs and start to interact, which he wouldn't do (previously). (Participant 10).*

Thus we can see that the relationship between parent and child in this situation has improved, as have the confidence levels of both parties, such that her son now feels sufficiently assured with regard to 'interacting' with others and accessing more community facilities.

Lastly, in some cases working with VIG also helped other professionals to trust and see the strengths in parents with whom they had previously had an ambivalent relationship:

> *It did yeah because it showed the social workers that I can have a bond with my child and he was, he was all for Daddy, he was kissing Daddy and what not (Participant 12).*

The child in this family was taken off the child protection register, as through VIG the father had demonstrated his ability to care for his child and respond appropriately to their needs.

6.5.5 Positives that made it stand out

Participants noted many aspects of VIG that made it a particularly positive and lasting intervention. One of these was that VIG 'was not about teaching us techniques' (Participant 3), but more building on their own strengths and focusing on what they did well; participants were quite clear about what they had not being doing well and rarely needed someone else to point this out. Participant 3 highlighted this point:

> *No, she (the guider) only shows you the positive bits. That's the point of it. I think we were very aware of all the things we were doing wrong.*

Similarly Participant 12 noted:

I turned around and said 'well I'm not doing that and I'm not doing that' and she said 'no, don't look at that, look at what you are actually doing well.

This strengths based approach had a powerful impact on all of the participants. VIG also highlighted the important aspects of communication which sometimes go unrecognised:

VIG showed us that …..we were doing was right, we just didn't realise that those were the things that were important (Participant 3).

Building on these strengths was seen as vital in an otherwise deficit based landscape and culture where few positives can be identified:

Yeah it helps with my depression because everything's so, to find something good in there gave me a big boost that I wasn't completely bad at everything (Participant 10).

For me it was. It was because as you know there was so many things that happened in our life, you get so involved in all that negativity, you can't see the positives. For me I needed to see that. (Participant 4)

Another positive factor noted by Participant 10 is that VIG is simple and easy to follow:

it wasn't too complicated which was another thing. It wasn't too complicated so it was quite easy to remember how to do the things because it wasn't set out in a complicated way. It was very easy to follow and to understand and that's why it has stayed with us for quite a long time.

The fact that people saw themselves interacting with their children was powerful and the visual image remained with people because as one participant noted you, '*Actually see yourself doing it*' (Participant 6). This type of experiential learning (Kolb 1984) is effective in allowing people to be in charge of their own change.

Possibly one of the most valuable aspects of the VIG experience was the consistency and relationship building that occurred between parents and the guiders, and between the guiders and children:

> *The guider was good, she was lovely she made us feel at ease, she had good interaction with child as well. (Participant 3).*

Here we can see that the guider herself had very good communication skills with both the parent and child and was modelling attuned behaviour in line with social learning theory (Bandura. 1986) which the parents were able to emulate.

> *Just that the lady that did it was fantastic, she was always accommodating round me and she was just really good (Participant 10).*

> *She was absolutely lovely (Participant 12)*

This consistency and high quality of relationship (Ruch, 2012) continued to be highly regarded even 6 months after the intervention: this may be, particularly valued in light of the turn-over of many social care staff:

> *I think it was just because she was consistent and I had the same person over and over again and so many of the services, groups or people I've been given I've had one, one week and one another and you didn't learn to trust them or anything. It's horrible, as soon as you get trust them you get someone else and you end up having to tell your story over and over again. I didn't like people in authority trying to help me anyway it felt like people were interfering but to get the same one you can actually make a bond with and you don't have to keep going over and over again, that makes a big difference (Participant 10).*

There were no participants who felt negatively about VIG and all gave the experience a ringing endorsement; it would seem that VIG is a significant and lasting

intervention, which is strengths based and well received by a wide variety of parents in a range of differing situations.

7.0 Conclusion

During the evaluation, 55 cases were referred to the VIG Service and 13 cases were completed during the interview period (February-March). The majority of referrals were statutory in nature, reflecting the referral criteria. The majority of children referred to the service were under 10 years of age. Generally, clients took part in between 1 and 6 cycles of the intervention. The majority of clients expressed a desire to increase the extent to which they displayed emotion and affection to their child and the time spent on play and enjoyment. At the end of the intervention the majority of clients perceived that they had achieved this. When these goals were linked to the parenting self-efficacy results, the intervention had a positive impact on both goals with the greatest impact made on play and enjoyment.

The findings revealed that VIG was perceived positively by both clients and referrers. Conducting the intervention within the home environment enhanced the experience of both the parents and children, where the children enjoyed being involved in the process as active participants. All parents noted that they set their own goals with the help of the guider. The intervention gave parents time to reflect on what they do well and the opportunity to build upon this. Many noted that by becoming more attuned to their children, in particular by giving their child space and time to articulate their own needs, then the bond between them grew.

Six months after the intervention, all of the ten participants were pleased that they had participated in VIG. The majority of parents continued to use VIG. The findings suggested that some parents had adopted some of the techniques with their other children and continued to review the materials to refresh their knowledge. To a greater extent, the intervention appeared to foster greater reflection on parenting and awareness of what to do to rectify issues or improve their approach. The VIG intervention appears to complement other service provision in two main ways; parents gained confidence in their parenting skills and professionals were able to see the strengths in their parenting ability. Slightly less than half of participants were

still in contact with services but this encompassed a wide range of services including mental health, CAMHS and a residential home.

The overarching finding is that VIG offers a strengths-based approach that is valued by parents and appears to lead to greater parental attunement and awareness of how their parenting skills effect the relationship they have with their child. The VIG guiders were perceived very positively and were deemed to be integral to the intervention. Guiders explained the approach in simple terms which parents clearly recalled six months after the work had been completed. Having the same Guider throughout the intervention was highly regarded as parents felt able and comfortable to develop their skills in a trusting environment.

The VIG Service would therefore appear to be a cost effective, yet minimal intervention which is time limited and was felt to have lasting benefits and impact.

8.0 Recommendations

- Some staff members may benefit from further information about the VIG Service including the criterion on which referrals are made.

- It is helpful for those people delivering VIG not to be the social worker involved with other aspects of the case.

- It may be useful to design a toolkit for clients to refer to once the intervention has finished. This could be a simple A4 reference sheet of the main techniques covered.

- Some families were unclear as to whether they could undertake the intervention again at a later date. This may require further consideration as to the appropriate criterion for re-referral or whether a ‘refresher’ cycle could be offered to those still in contact with services.

- In light of the positive findings presented, the VIG Service may benefit from incorporating dedicated teams for particular service users. For example, the evaluation found that VIG had a positive impact on the attachment of an adopted child. It was suggested that VIG could also be expanded to foster carers.

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