E-SEE STEPS: A universal proportionate intervention model for parents of children under two years to prevent social-emotional difficulties

Service Design Manual: Version 2 (January 2018)

About this manual

E-SEE Steps is a designed model of preventative intervention, which is being implemented and evaluated in England with support from the National Institute for Health Research (NIHR). At the heart of the model are two, as yet untested, parent training programmes drawn from the Incredible Years© (IY) series. Effective interventions have been suggested to be highly focused, delivered consistently and underpinned by strong rationales (1, 2). In order to enable the consistent implementation and replication of these services and to facilitate their evaluation, it is essential that they be articulated clearly and modified if necessary so that they meet agreed criteria for evaluability (3). Developing so-called 'manualised interventions' is a widely-acknowledged means of boosting programme fidelity.

This **service design manual** explains what the E-SEE STEPS programme model is, the theoretical basis for its development and why we anticipate an impact on parents' and children's mental health and development. The manual is an overarching document that sits across delivery sites, and is accompanied in each site by an **implementation booklet**, with site-specific details on how it is being implemented there. Knowing exactly what is to be delivered, and how, is critical for a number of reasons. One is that programmes delivered with fidelity achieve the best results. Another is that it is essential from an evaluation perspective to know what is being delivered – otherwise it is not clear what worked (if the results are positive) or did not work (if the results are negative). This manual *does not* replace the Incredible Years programmes' technical manuals and associated training (under license arrnagements), which describe in detail how to deliver the Incredible Years Baby and Toddler programmes. Rather, it complements these, explaining how the E-SEE STEPS model as a whole works, who will be served and how, and the fit with existing systems and services.

In tandem, the service design manual and implementation booklets are designed to serve two related functions:

1. To provide a succinct but thorough description of the objectives of E-SEE STEPS and the way in which it seeks to achieve those objectives. In other words, it answers the question 'What does E-SEE STEPS do, and why?' This will enable both staff and their managers to remain focused.
2. To provide the basic raw materials for implementing the services (and, subject to its success, for replicating it in another location) what might be thought of as a template or blueprint. Thus, it answers the question 'How are the services to be implemented?'

This document is written as a guide for those involved in implementing and evaluating E-SEE STEPS, namely Health Visitors and health service professionals, and Children's Centre and children's services' managers and staff. However, the information can be adapted for use with other stakeholders – parents, teachers, local services, policy makers and so on – to help them understand what this intervention is about. It will not make the reader an expert in delivering Incredible Years; no-one can effectively deliver the programme without the

appropriate training and without using the technical manuals which have been designed for parents (4). The manual is also a 'living document', which has been and will continue to be updated and refined as the evaluation informs the development of the intervention. In particular, while the core programme components are unlikely to change, it is an aim of the evaluation to build a better understanding of how these individual programmes can form components of a larger complex intervention; the barriers and facilitators to their use, and how they fit with the configurations of health and children's services systems in the delivery sites; and how they work to improve parent and children outcomes.

The service design manual and implementation booklets reflect the work of a multidisciplinary service design group comprising representation from the Universities of Exeter, York, Central Lancashire and Sheffield. The group has consulted extensively with the managers of the Children's Centres in which the programme will be implemented for the pilot sites and with parents through parent forums. Additionally, a small qualitative study involving interviews and focus group discussions with parents/carers who had either previously attended or were currently attending a parent programme was conducted to get their views on: 1) identification, engagement and recruitment to the study, and also to parent programmes; 2) retention of participants to parenting programmes; 3) retention to the study and data collection; and 4) next steps and continued public involvement throughout the study, including dissemination (5). This was used to inform the development of the current E-SEE STEPS intervention.

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Glossary of Terms

E-SEE STEPS	Enhancing Social-Emotional health and well-being in the Early years: a universal proportionate model of delivery of Incredible Years Baby and Toddler
Universal proportionate	Providing the right service at the right time for the right person – dose delivered according to need
Incredible Years Baby programme	Parenting programme designed by Professor Carolyn Webster-Stratton to be delivered to parents with a baby 0-12 months
Incredible Years Toddler programme	Parenting programme designed by Professor Carolyn Webster-Stratton to be delivered to parents with a child 1-3 years
Incredible Babies book	A book (hard copy or audio) designed to accompany the Incredible Years Baby programme. It contains information/advice and space

	for parents to record activities and milestones
Attachment	The bond between a baby and his/her caregiver
Postnatal depression	Non-psychotic depressive episode that starts in or extends into the postpartum period. Usually occurs within the first 4-6 weeks after giving birth
Co-parent	An adult responsible for the well-being of the child in addition to his/her primary caregiver, for example a father or grandparent
Responsive parenting	Parenting which meets the child's developmental, behavioural and emotional needs in a timely manner
Facilitator	Professional leading the Incredible Years parent training groups who has been trained to deliver the programme
Co-facilitator	Professional trained in the Incredible Years programme who co-delivers the group with the lead facilitator
Supervision	Review of the facilitators' delivery of Incredible Years group sessions using video recordings, parent satisfaction forms, and discussion
Fidelity	Delivering the programme as it was designed
Logic model	Representation of how a programme is expected to work, including inputs (resources), activities, outputs, outcomes and impacts
Theory of change	Overview of the steps required to reach a specified long-term goal
PHQ-9	Patient Health Questionnaire – 9 questions to measure on a scale a person's level of depression
Randomised controlled trial (RCT)	Participants are randomly allocated to two or more groups – usually an intervention group (who get the programme being tested) and a control/comparison group (who receive nothing or services as usual). The groups are followed up to see if there are any differences in outcomes after the intervention is completed
Outcomes evaluation	Assess the effectiveness of the specified programme in producing a change in desired outcomes
Process evaluation	Assess how the programme was delivered, including fidelity, stakeholder experiences, problems encountered, etc. which helps to explain the outcomes achieved in different environments and for different people
Cost-effectiveness	Do the benefits of delivering the programme outweigh the costs associated with its implementation

Introduction

The risk of negative outcomes in later life, including low educational attainment, criminal activity, alcohol or drug misuse, mental ill health and the inability to form secure relationships, is increased for children who have impaired social and emotional health and development. The early years in a child's life are a critical period in development, during which time responsive and empathic parenting can promote positive outcomes in later life.

Behavioural and mental health disorders have become a public health crisis and by 2020, are likely to surpass physical illness as a major cause of disability (6). The onset of mental health issues is difficult to detect in very young children, making the early identification and prevention of key risk factors important. Parents' mental health and parenting capacity, as well as the home environment, are strongly correlated with the health and development of their children (7, 8).

It is not just maternal mental health that influences the mental health and emotional development in the child. Indeed, evidence suggests that paternal mental health can also impact on the mental health and wellbeing of both the child and mother (9). Stress and depression in parents can lead to unresponsive and ineffective parenting strategies, including emotional neglect, which impacts negatively on the mental health, emotional wellbeing and development of the child. This in turn can have longer-term adverse consequences for the child, including failure to thrive, difficulties in school, drug or alcohol misuse, juvenile delinquency, aggression, ineffective relationship building, criminal activity and mental health issues as an adult (10).

Children from lower socio-economic backgrounds are also more likely to have worse health outcomes and achieve a lower level of education than children from higher socio-economic backgrounds. This can subsequently have negative impacts on their employment prospects, living standards, and mental and physical health in later life (11, 12).

This service design manual details a universal proportionate model of parenting support, called E-SEE STEPS, for the parents of children at risk of social-emotional difficulties. The core components of the model are taken from the well-known, evidence-based parenting series called the Incredible Years (IY) (http://www.incredibleyears.com/). Two programmes from the series have been included in the E-SEE STEPS model: the Baby and Toddler programmes are designed to promote social and emotional health and wellbeing in the early years of children's life.

We will explore first the risks to children's social and emotional development and what we know about how best to promote well-being, and then detail how the E-SEE model is designed to support parents and children.

Risks for social and emotional problems in children

This section:

- Defines social and emotional wellbeing in children
- Explains why it is important to prevent social and emotional ill-health
- Outlines how social and emotional problems develop

Introduction

In the UK, 10 percent of children and young people aged 5 to 16 years present with a mental disorder (13). The term 'mental disorder' covers a broad spectrum of symptoms or behaviours that are associated with distress and interference with personal functions, including emotional, conduct and hyperactivity disorders (13). It is mainly expressed in the home and school, particularly among younger children, but can also result in anti-social activities within the community, especially in adolescents and young people.

Social and emotional wellbeing is important in preventing behavioural and mental health problems and, in the early years, lays the foundations for later educational attainment and healthy behaviours. Emotional wellbeing refers to being confident and happy and not anxious or depressed, while social wellbeing involves having good relationships with other people in the absence of behavioural problems, such as being disruptive or violent (14). So, what causes poor social and emotional wellbeing in children and why it is necessary to intervene early in order to prevent the problem?

Importance of attachment and bonding

Secure attachment in the early years is regularly cited as an important predictor of the healthy development of young children. Attachment refers to the bond between a baby and its parent or caregiver (15, 16). In order for the attachment to become secure, the caregiver should be responsive and available to the child as and when necessary and intervene promptly should the child be in trouble (17). In essence, an attachment figure provides protection and security, giving the child the emotional support necessary for him/her to explore the world whilst acting as a safe place for the child to return to in times of fear (18).

A secure attachment between baby and carer is associated with the development of a range of competencies, for example self-esteem, self-efficacy and social skills. These competencies in turn are correlated with better future social, educational and employment outcomes (11). Conversely, impaired language development and school misbehaviour, followed by early school exit, along with aggression, defiance and hyperactivity, are associated with insecure

attachment in the child's first few years of life (16). Additionally, individuals who had insecure attachments in childhood are more likely to be referred for psychiatric treatment than those who had secure attachments (17). The effects of early attachment on relationships continue throughout life and can affect future adult relationships, for example with a spouse, child, employer or therapist (17).

The ability of the parent, typically the mother, to respond to the infant's signals promptly and appropriately (known as sensitivity) has been identified as an important factor in the development of a secure attachment (19) . Sensitive and responsive parenting in the first six months of life lays the foundations for future secure attachment (18). Summarised by Balbernie, *"the secure child is naturally confident and socially responsible, able to get along with others while appreciating their feelings and point of view, and is generally busy checking out what the world has to offer and learning through play; the insecure child, on the other hand, becomes an adult who is baffled by this and resorts to insisting that children sit still and be instructed instead"* (18: pp. 6).

Negative influences on attachment

Several factors have been found to be associated with negative outcomes in children, including parental unemployment and low family income; homelessness; low birth rate; and living in a disadvantaged neighbourhood (20). Additionally, the relationship between a child and his/her parents has been recognised as the most important influence on the child's life, having an impact on their mental health, behaviour and educational development (20). Significant and life-long inequalities in health and wellbeing begin during pregnancy and the early years (21). As such, parental depression and poor parenting have been strongly linked with hampering the emotional and educational development of children (20, 22).

Postnatal depression

Low mood after childbirth is very common, affecting between 3 and 8 in every 10 women in the first few weeks (23). This period of 'baby blues' is usually short-lived. However, approximately 10 to 15% of new mothers develop a deeper and longer lasting form of depression (24). This 'postnatal depression' can be defined as "a nonpsychotic depression episode that starts in or extends into the postpartum period" ((25): pp 454). It differs to general depression by the timing of its onset as it usually occurs within the first four to six weeks after giving birth, with the mothers' risk of depression remaining raised for the first six months (26, 27). The symptoms include mood and sleep disturbances, fatigue, change in appetite or anorexia, anxiety, feelings of guilt and inadequacy, and poor concentration (26, 28). Severe postnatal depression, called postpartum psychosis or puerperal psychosis, is rare affecting only 1 in 1,000 women and is regarded as a psychiatric emergency (24).

Postnatal depression can also occur in men, with between 4% and 25% of fathers experiencing depression symptoms in the postnatal period (29). A range of factors can increase the risk of a parent developing postnatal depression, including previous experience of depression, particularly in the antenatal period; lack of support/relationship difficulties; negative life events around the time of birth; and other life stressors, for example poverty (28, 30). Depression in mothers can negatively affect the child's cognitive, social and behavioural development, while depression in fathers has been associated with later behavioural and peer difficulties (21).

Despite postnatal depression having a relatively short duration, its consequences can be longer lasting (22, 31). The most pressing consequence is the impact that postnatal depression has on the child. Research has demonstrated a link between the presence of postnatal depression in either parent and poorer developmental outcomes in children, due to an impaired relationship between the parent and the baby. Unresponsive parenting can lead to ineffective parenting strategies and inadvertent emotional neglect, impacting negatively on a child's emotional wellbeing and mental health. For example, the presence of postnatal depression in mothers can cause them to be withdrawn and less able to interact with their baby, or their interactions with the baby to be less warm and more intrusive. These withdrawn (disengaged and unresponsive) or intrusive (hostile) interactions, if continued, can have negative effects on the ability of the child to form a secure attachment to the mother (31). As described above, secure attachment in infancy encourages the development of the child's self-esteem, confidence and social skills, which positively influence a range of outcomes later in life; postnatal depression hinders the development of these competencies (11).

Although paternal postnatal depression has been associated with unfavourable outcomes in children, it has received much less attention than maternal depression. The predictors of postnatal depression in fathers are similar to those for mothers, including a personal history of depression, depression in a partner, and the quality of the relationship with the partner. As such, depression in one parent can encourage emotional distress in the other and have lasting consequences on the relationship of the couple and the family environment, further increasing the risk of adverse effects on the development of the child (32). The risk of later conduct problems, particularly for boys, and emotional and behavioural problems is increased if the father is depressed either pre-or postnatally (33). Additionally, family services in the UK are generally targeted towards mothers and a lower proportion of fathers attend parenting classes than mothers (34).

Other forms of depression

As described above, postnatal depression occurs soon after birth and has a relatively short duration. Depression at other times, including antenatally (during pregnancy) and throughout infancy, can also have negative effects on attachment and the child's future social and emotional health and development, both directly and indirectly. For example, the

relationship between two co-parents/carers can be negatively affected if the mental health of either carer is comprised. This may make them less effective at solving problems as a couple and working together to provide appropriate nurturance, guidance and limit-setting to their children (35). Evidence suggests that the more persistent and prolonged the period of parental depression is, the greater the risk of emotional and behavioural problems in children (33, 36). While there may be a direct impact of carer depression on children's health or development, it is likely that the impact is indirectly realised through impacts on parenting – negative, critical, unresponsive and helpless parenting behaviours are common in the presence of depression (7). This may be due to skill deficits that are often displayed by parents with depression, namely poor problem solving, mood regulation and recall of previous events (31, 37). Depression can also result in the parent being less attentive and responsive to their children's needs (31).

Antenatal depression and associated disorders in women are as common as postnatal depression, with a prevalence of between 10% and 14% (38, 39). During pregnancy, depression can increase the risk of babies being born preterm and low birthweight, as well as having a negative impact on the longer-term social and emotional outcomes for children (23). Regardless of the timing of the depressive episode/s, symptoms of parental depression are associated with poor outcomes in children (7). Table 1, taken from the Canadian Paediatric Society (31), shows the consequences of maternal depression at various time-points throughout the child's life.

Table 1. Consequences of maternal depression

Behavioural, cognitive or academic	Consequence of maternal depression on the child
Prenatal	
	• Inadequate prenatal care • Poor nutrition • Higher risk of pre-term birth • Low birth rate • Pre-eclampsia • Spontaneous abortion.
Infant	
Behavioural	• Anger and protective style of coping • Passivity • Withdrawal • Self-regulatory behaviour • Dysregulated attention and arousal.
Cognitive	• Lower cognitive performance.
Toddler	
Behavioural	• Passive non-compliance • Less mature expression of autonomy • Internalising and externalising problems • Lower interaction.

Cognitive	• Less creative play • Lower cognitive performance.
School age	
Behavioural	• Impaired adaptive functioning • Internalising and externalising problems • Affective disorders • Anxiety disorders • Conduct disorders.
Academic	• Attention deficit/hyperactivity disorder • Lower IQ scores.
Adolescent	
Behavioural	• Affective disorders (depression) • Anxiety disorders • Phobias • Panic disorders • Conduct disorders • Substance abuse and alcohol dependence.
Academic	• Attention deficit/hyperactivity disorder • Learning disorders.

Source: Bernard-Bonnin, Canadian Paediatric Society, 2004 (31).

Social and structural factors

In addition to depression, low parental income/wealth, occupational social class and education; high parental job strain; lack of housing tenure; parental isolation; and neighbourhood and material deprivation are key social factors associated with negative impacts on the physical and socio-emotional health and development of children (8, 11). These factors can also increase the risk of depression, with a higher prevalence of depression evident among adults of lower socioeconomic status (40-43). Interventions to promote the positive social and emotional health and development of children may therefore have greater effect and go some way towards reducing inequalities in later life if they are delivered in areas of high deprivation (44).

Co-parenting relationship

The relationship between caregivers, or co-parents, is another factor that can influence a child's social and emotional development. Children born to married parents, rather than co-habiting parents, tend to have better social and emotional developmental outcomes, possibly due to the greater instability in a co-habiting relationship when compared to married couples (45). The effect of single parenthood on child social and emotional development is inconsistent; it could have a negative effect on the child due to the increased stresses placed on the lone parent, for example financial pressures from a lower household income, or conversely the child may experience better social and emotional development due to the absence of family conflict and stronger attachments with the parent (46, 47).

Five major domains of family life have been proposed by Cowan and Cowan as affecting parenting and children's outcomes: 1) the quality of the mother- and father-child relationships; 2) the quality of the parents' relationship, such as communication styles, conflict resolution, problem-solving, and emotional regulation; 3) patterns of both couple and parent-child relationships passed through the generations; 4) levels of adaptation of each family member, their self-perceptions, and indicators of mental health; and 5) balance between life stressors and social supports outside of the immediate family (44). Consequences of poor couple relationships on children, for example marital dissatisfaction or unresolved couple conflict, can include academic difficulties, behavioural problems and depression in children and adolescents (48). This may be due to parents giving more of their attention, time, energy and resources to the relationship difficulties rather than to the child, which can influence the stress level of the parent as well as the quality of their parenting (49).

One pathway through which the parent relationship quality can adversely affect child outcomes is domestic violence. Domestic violence is defined as *"any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional"* (p.2) (50). The presence of domestic violence has been associated with parenting effectiveness, attachment, and maternal mental health (51, 52). However, although its effect on mental health is consistently negative, the link between domestic violence and parenting effectiveness can be positive or negative. For example, parents who are victims of violence are less likely to be emotionally available, sensitive or responsive to their child's needs, and have a greater risk of becoming depressed (53). On the other hand, the experience of violence may lead the parent-victim to compensate by giving more attention to the child and being more responsive to the child's needs (51).

There is a higher prevalence of domestic violence among mothers who have experienced depression in the antenatal and/or postnatal period (54). For example, women who had probable depression in the antenatal period were found to be between two and five times more likely to experience intimate partner violence within one year after giving birth than women without probable depression (54). The impacts of both parental depression and domestic violence on childhood outcomes have been detailed individually above, yet they are related, with the prevalence of one increasing the risk of the other. Young children who witness violence in the home also experience adverse outcomes as a result of this direct exposure, for example sleep disturbances, emotional distress, excessive irritability, and developmental delays (53). Evidence suggests that these children are more likely to exhibit later behavioural problems, including aggression, as well as depression, phobias, insomnia, bed-wetting, low self-esteem, and lower scores on tests of motor, verbal and cognitive skills (55). Additionally, there is a high risk for direct child abuse in families in which a woman is

abused, children are also abused in more than half of these cases, which further increases the risk of social and emotional problems in the child (56).

Consequences of poor social and emotional development in young children

Unresponsive parenting in the first years of life, for instance due to postnatal depression or other stressors, can adversely affect the social and emotional development of children and impact on their mental health. Children's mental health issues are associated with significant costs to the individual and society and both short- and long-term negative outcomes, for example failure to thrive, school difficulties, drug/alcohol problems, juvenile delinquency, aggressive behaviour, adult mental health issues, ineffective relationship building, and criminal activity (10). The risk of becoming a young parent with the possibility of regenerating the cycle is also increased (57).

Good social and emotional development is based on children acquiring a particular set of competencies and skills. The concept of social-emotional learning (SEL), defined as *"the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions"* (58) includes the concepts of self-awareness, self-management, social awareness, responsible decision making, and relationship skills. These factors interact to determine a child's social-emotional learning ability (58, 59) (Figure 1).

Figure 1. Social and emotional learning core competencies (Collaborative for Academic, Social and Emotional Learning, 2018)

There is a wide literature on the importance of and impact of poor SEL, particularly for predicting the school readiness and academic performance of children (60) Although most SEL literature and interventions focus on school-aged children or older children, the associations between the factors involved in SEL and social and emotional development (as discussed earlier) are strong. For example, children who have strong social and emotional skills on entering school tend to have better outcomes in education, mental health and later life (61), while children who do not develop these skills have more negative outcomes, mirroring the consequences of poor social and emotional development and attachments listed in Table 2. This suggests that beginning to build these competencies in the early years can provide the foundations for these later SEL school-based interventions.

Table 2. Consequences of poor social and emotional development in childhood and later life

Childhood	Later life
Behavioural	
School misbehaviour	Antisocial behaviour
Aggression	Crime
Defiance	Drug / alcohol misuse
Hyperactivity	
Antisocial behaviour	
Juvenile delinquency	
Educational	
Impaired language development	Early school exit
Lower scores on intellectual developmental tests	Under-attainment
	Limited employment prospects
Social and peer relationships	
Insecure attachment with parents / carers	Ineffective relationship building
Mental health	
Low self-esteem / confidence	Depression
	Anxiety

Summary

Promoting healthy social and emotional wellbeing in the first years of a child's life lays the foundations for future health and educational attainment. The relationship between a child and his/her parents has been identified as having the most significant impact on their mental health, behaviour and educational development. Depression and poor parenting can prevent the formation of a secure relationship between parent and child and consequently have a detrimental impact on the future health, wellbeing and social outcomes of the child. Social and structural factors, including low social class, neighbourhood deprivation and parental education, can also hamper the personal development of children. Implementing interventions targeted at families with key risk factors for poor child development, such as depression and deprivation, could therefore go some way to improving the social-emotional health and wellbeing of young children and reduce inequalities in child developmental outcomes.

The following section focuses on what works to promote social and emotional health and wellbeing in young children, and the need for intervention in the first years of a child's life.

What works to promote social and emotional health and wellbeing in children?

This section:

- Summarises the theory underpinning programmes that are effective in promoting social-emotional health and wellbeing in children
- Describes the need for intervention in the early years
- Sets out evidence for the effectiveness of parent training interventions

Introduction

The previous section dealt with the importance of promoting positive social and emotional health and wellbeing in children from the very start of life, and the potential consequences of not doing so. Although several factors can negatively influence the formation of secure attachments and subsequent social and emotional development, for example parental depression and disadvantage, there are ways in which the effects of these can be reduced. Parent training interventions, such as the IY series, are one such method.

Policy around early intervention

Promoting positive parenting practices to encourage the healthy development of children in their first years has become a key focus of UK policies over the past decade. The Government's 'Healthy Child Programme: Pregnancy and the First 5 Years of Life' (10) sets out standards to improve the health and wellbeing of children. The priority is to support parents "to provide sensitive and attuned parenting, in particular in the first months and years of life" (p. 10). Graham Allen's 'Early Intervention – The Next Steps' report promotes a range of prevention and early intervention programmes, including Incredible Years (IY), delivered early to give children "the essential social and emotional security they need for the rest of their lives" (p. vii) (62). The cross-party manifesto 'The 1001 Critical Days' also emphasises the importance of the 0 to 2 years age range, recommending a tiered or proportionate universal approach focusing on parent-infant interaction (15). NICE guidance further suggests that the social and emotional wellbeing of vulnerable young children should be tackled through home visiting, early education and childcare (63). The guidance is based on reviews of programmes promoting maternal sensitivity, the mother-child relationship, and parenting skills and practice, and stresses the need for universal and targeted interventions. The policy documents described above highlight the importance of including fathers and grandparents who provide childcare support in parenting programmes due to their influence on the health and wellbeing of both mother and child.

Need for intervention in the early years

Inequalities in health and development begin during pregnancy and in the first five years of a child's life. Events during this time affect a child's physical, emotional, social, behavioural, cognitive and language development (21), making it a crucial period in which to implement parenting interventions. This is because babies' brains are only 25% developed when they are born, but by 3 years of age are at 80% of their adult volume. Most of this growth occurs within the first year of life, during which time the development of the brain is determined by the baby's experiences and interactions. These therefore lay the foundations for future health and wellbeing (21).

Language and communication skills are also learned during the early years and these set the foundations for a child's future learning. Educational achievements at school, and subsequent employment prospects, can be predicted by the level of development at 2 years of age. Disparities in development between children from prosperous and disadvantaged backgrounds emerge in these first years (64), further making the case for intervention in the 0 to 2 years period. Despite evidence of children from disadvantaged backgrounds experiencing more negative development and future life outcomes than those from more advantaged families (20, 62), effective parenting can overcome these effects. In particular, responsive and sensitive parenting in the first years can encourage a secure attachment (strong positive emotional bond) between parent and child. This leads to better emotional and behavioural regulation for the child and greater self-confidence (64). Allen (62) has suggested, based on evidence from the UK and abroad, that early intervention "that develops social and emotional capability can reduce truancy, antisocial behaviour, crime, health problems, welfare dependency, the need for statutory social care, under-attainment, exclusion from school and the need for educational alternative provision" (p. 7) (62). Social and emotional wellbeing in the early years can provide the personal development that enables children to take full advantage of life chances and helps to protect against risks associated with deprivation and other adversities. Interventions in early childhood that promote positive parenting and family relationships can reduce the risk of children developing physical and mental ill health and prevent generational cycles of social dysfunction (14).

Parent training programmes/interventions

The postnatal period, along with pregnancy, is a key point at which to deliver interventions as parents are motivated to learn how to behave and what is best for their child (62). The family setting is an important influence on the health and development of children. An environment in which there is good nutrition, secure attachment with warm and loving

family members, and regular exposure to opportunities for physical play, learning and development will enable babies and infants to thrive (65). The quality of the relationship between a child and parent affects the child's future relationships – the more secure the attachment, the more likely it is that the child will eventually become independent and develop strong relationships with other people. Effective parenting skills are necessary for parents to form these secure and warm relationships with their children, as well as to communicate with them effectively and provide a stimulating home environment to support their learning (65). There are many different types of group-based programmes that aim to promote a positive parent-child relationship and parenting quality; they can be categorised in terms of their main outcome focus (66).

i. Attachment and parental sensitivity – programmes that focus on promoting parental sensitivity and responsiveness, and parent-infant/toddler interaction, with the aim of *promoting secure attachment.*
ii. Social, emotional and behavioural development – programmes that focus on improving parent-child interaction (via enhanced parenting skills/style), with the aim of *improving the social, emotional and behavioural functioning of young children.*
iii. Language and communication skills – programmes that focus on promoting parents' playing and reading with children, with the aim of *promoting children's language and communication* in particular but also their wider development (e.g. cognitive, socio-emotional).

Parenting programmes target the intra-and interpersonal elements of parenting behaviours in order to encourage healthy child development. These elements include knowledge, parenting stress, relationships, and skills and resourcefulness (67). A primary goal is to develop the parents' sensitivity, responsiveness and self-regulation abilities, which involves learning the skills necessary for behaviour change and problem solving (68). Put simply, parenting programmes attempt to increase parents' confidence in their ability to be a good parent by equipping them with the necessary practical knowledge and skills. Programmes can empower parents and offer support for improving their parenting skills, adopting healthy behaviours and preparing families to make the best choices for their children, as well as helping parents to create a home environment that is conducive to the play, health, safety and development of their children (65).

Parenting interventions can be delivered in a range of different settings using a variety of approaches (65). Several parent training interventions have been delivered in the UK, for example the Triple P Positive Parenting Program, the Solihull Approach, Family Nurse Partnership, and IY. Triple P was designed to improve the parenting knowledge, skills and confidence of new parents. It provides training and support through interventions of different intensities that are matched to the needs of the parents and children (67, 69). A small-scale evaluation of Triple P for babies (Baby Triple P) of mothers with postnatal depression found that the programme was found acceptable by women, but it was not

associated with improvements in the mothers' mood or interactions with their babies over treatment as usual. However, despite the lack of significance, all measures of happiness, self-regulation, subjective bonding and depression improved after the programme (69). Family Nurse Partnership (FNP) is a home-visiting parenting intervention that works with vulnerable young first time mothers (aged 19 years or under at conception) from early pregnancy until the child is two years of age. The programme uses a structured home visiting service to improve pregnancy outcomes, child health and development, and parents' economic self-sufficiency (70).

A European-wide systematic review found that parenting programmes had more favourable outcomes when they included intensive support, information and home visits, and focused on developing the skills of parents and children. They involved combining educational programmes with workshops and beginning in early pregnancy (44). A separate meta-analysis of group-based parenting programmes further found them to be effectiveness in improving the mental health of mothers, with significant improvements in levels of depression, anxiety/stress, self-esteem, and couple relationship emerging when the results of 17 studies were analysed together (71).

Many parenting programmes are delivered within Children's Centres or Family Hubs. As part of the Government's Sure Start initiative, centres were based within the more deprived areas of the UK and were set up to improve the outcomes of young children and their families while reducing inequalities in child development and school readiness by working with the families who have a greater need for support (72). Positive effects on children's social development, social behaviour and independence at 3 years have been reported for children taking part in Sure Start Local Programmes than for children from similarly deprived areas who were not in receipt of Sure Start services. Additionally, parents taking part in a Sure Start Local Programme displayed fewer negative parenting practices and provided a better home-learning environment for their children than did parents who were not taking part in a programme (73).

Summary

Pregnancy and the first five years of life lay the foundations for future health and wellbeing, making this a crucial period in which to implement interventions that promote the positive physical, emotional, social, behavioural, cognitive, and language development of children. The family setting plays a crucial role in child development, particularly the quality of relationships between children and their parents/carers. Interventions implemented during the first years of a baby's life that promote effective and responsive parenting can therefore encourage healthy child development and reduce the risk of poor physical, mental and social wellbeing in later life.

The Incredible Years Parent Training Series

This section:

- Introduces what the Incredible Years programme is
- Summarises the evidence for use of Incredible Years parent programmes

Introduction

Professor Carolyn Webster-Stratton, at the University of Washington in Seattle, US, has been developing the Incredible Years (IY) series over the last 30 years (www.incredibleyears.com/). The series of programmes is designed to promote social and emotional health and wellbeing, prevent or reduce behaviour and emotional problems, improve parent-child interactions, and improve school relationships. Separate interlocking programmes are delivered to target the key developmental stages in a child's life: Baby and Toddler Programme (0 to 3 years), Preschool Programme (3 to 5 years), and School Age Programme (6 to 12 years). A separate programme is run for teachers of children aged 3 to 8 years (4). The preschool and school aged programmes have been rigorously researched over the last 20 years using randomised controlled trials with positive results that have been replicated by independent researchers. The accumulated research evidence has demonstrated the effectiveness of these programmes in both preventing and treating conduct disorders in children aged 3+ years and increasing their social competencies. This manual is focused on the Baby and Toddler programmes, which are the most recent additions to the IY series and have received less research testing thus far. They aim to help babies and toddlers to achieve three developmental milestones: 1) build a secure attachment with their parents; 2) language and social expression; and 3) begin to develop a sense of self.

Incredible Years theory and logic models

The IY suite of parenting interventions were developed based on theories of learning and behaviour change. In particular, Bandura's social learning theory – which suggests that learning is a cognitive process taking place in a social context and occurs through the observation and modelling of behaviours (74) – informed the development of IY, along with theories of attachment (17), as described earlier. As such, programme facilitators use a variety of teaching methods throughout the group sessions, including video modelling, role play and group discussions. Figures 2, 3 and 4 below represent the theories of change, or logic models, for the IY Baby and Toddler programmes and illustrate how these methods are

predicted to impact on risk factors for poor social-emotional health and the short- and long-term outcomes that the programmes are targeting.

Figure 2. Brief IY Baby and Toddler logic model

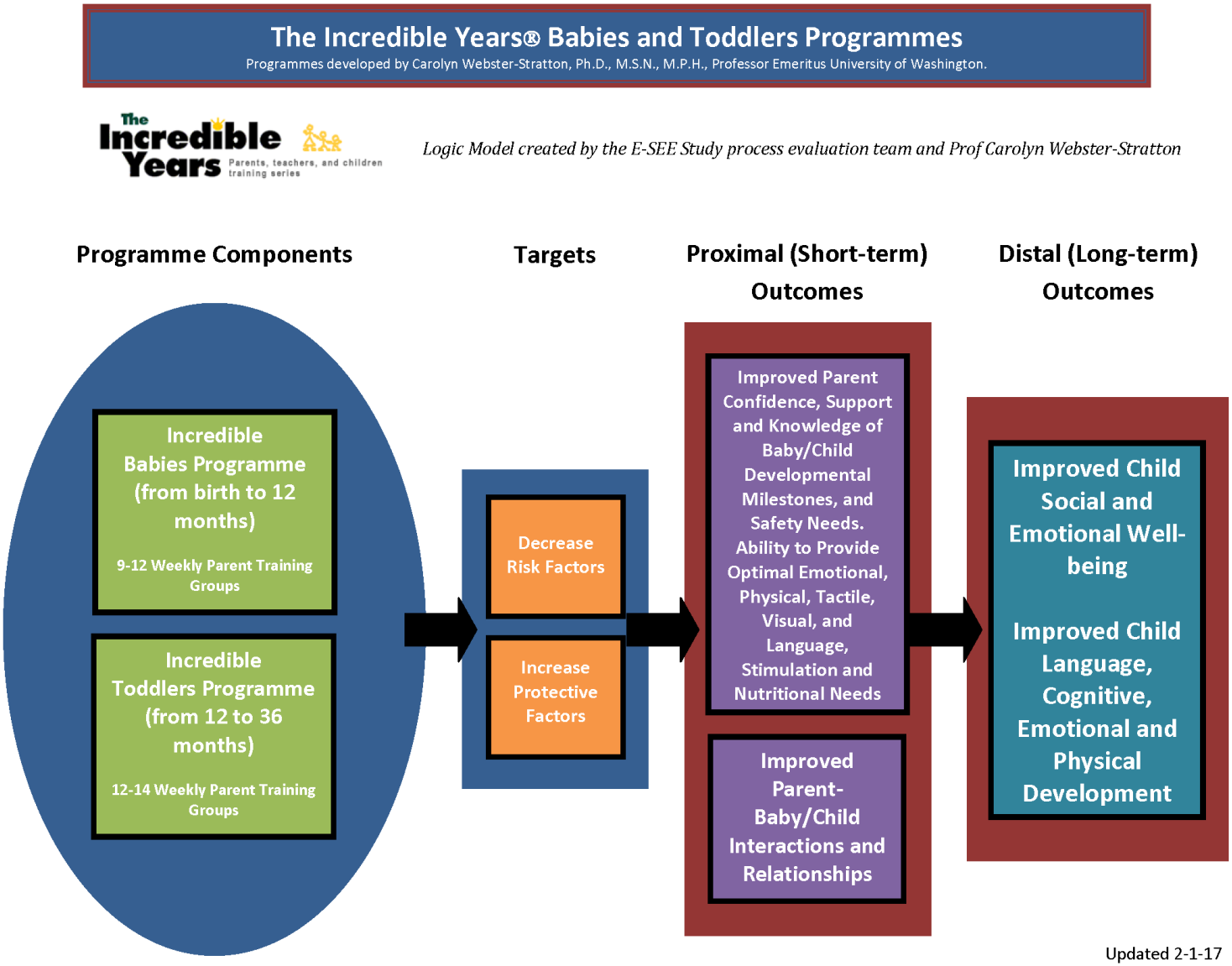


Figure 3. Detailed IY Baby logic model

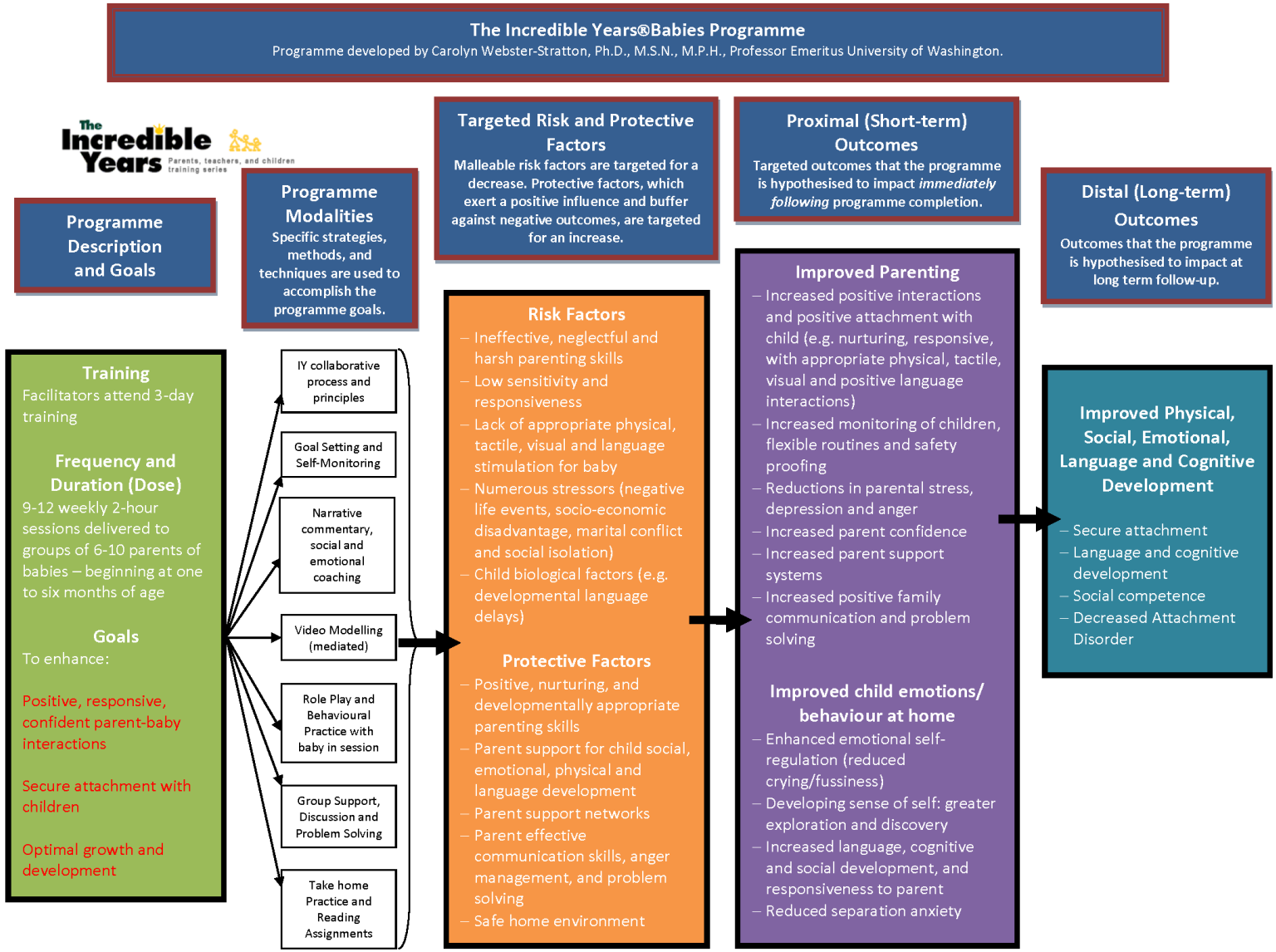
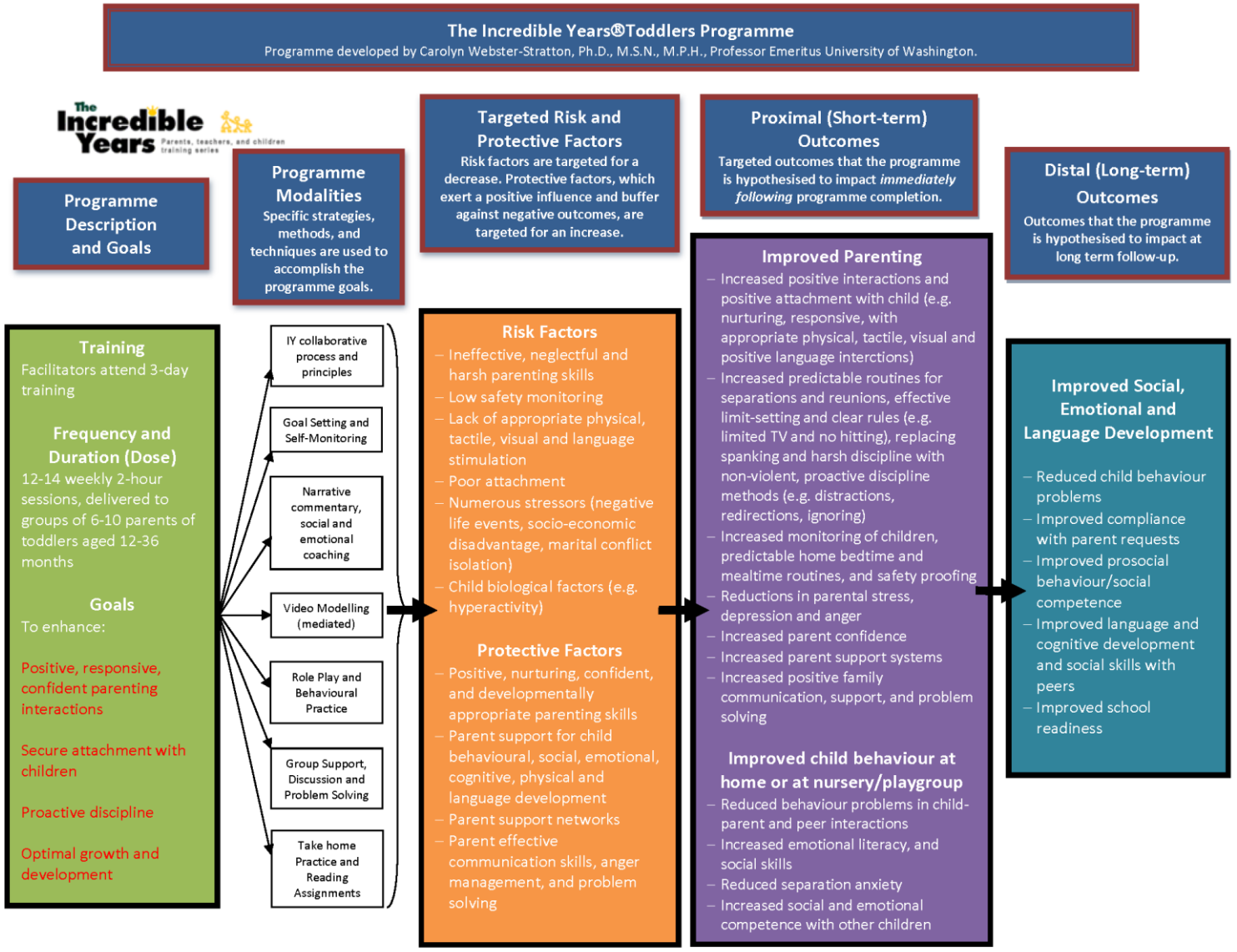


Figure 4. Detailed IY Toddler logic model



Evidence for the effectiveness or feasibility of Incredible Years

The IY series of interventions is one of the few potentially effective programmes for behaviour problems in children (75, 76). Evaluations of the programmes for children aged between 3 and 12 years have shown that IY produces significant improvements in the behaviour of children who received the programme compared with those who did not (76-79). Independent reviews have also found the IY programme to meet the highest standards of scientific proof (80).

The IY BASIC Parent Training Programme has been evaluated as both a treatment programme for children between 3 and 8 years referred with conduct disorders (78, 81, 82), and as a prevention programme with high-risk families (83). Outcome measures have included parent and teacher reports and direct observation of child behaviour and parenting style. When used as a treatment programme, results have demonstrated significant improvements in parent-child interaction, a reduction in parents' use of violent forms of discipline and a reduction in child conduct problems (78, 81, 82). Prevention-focused studies conducted in Head Start settings in the US with multi-ethnic, socio-economically disadvantaged families also demonstrated positive outcomes in terms of parent-child interaction, parental discipline strategies, parent involvement in the child's education, child conduct problems (both at home and at school) and child social competence. Using multiple report sources, a majority of the improvements were shown to be maintained one year post-intervention, particularly for parents who had attended at least six out of the 12/14 sessions (83). A similar study conducted in Sure Start centres in North and Mid-Wales for parents of children (aged 36-54 months) at risk of conduct disorder also showed significant improvements in parenting and child problem behaviours after attending an IY BASIC course, compared with a control group (37).

Further evidence for the effectiveness of the IY programme for children aged between 3 and 8 years comes from a Cochrane review on behavioural and cognitive-behavioural group-based parenting programmes for early onset conduct problems (84). Although this review was not limited to IY, nine of the 13 trials which met the inclusion criteria did involve evaluation of the IY BASIC programme. Results indicated that parent training does lead to a significant decrease in child conduct problems and a small, but significant, improvement in parental mental health. As the majority of included studies focused on the IY programme, the promising results were thought to be most applicable to studies in which the intervention components are similar to those used in IY (84).

Programme drop-out can be a significant problem in parent training interventions (85) and it is estimated that between 40% and 60% of families who receive treatment for child and adolescent conduct disorders fail to finish the programme (86). The effectiveness of the IY BASIC programme is further evidenced by programme retention rates of up to 88% with socio-disadvantaged families (87). A number of independent replication studies have also been conducted, evaluating the IY programme in both preventive and treatment contexts

and being delivered in a variety of settings including schools, Head Start centres and mental health clinics. These studies have been delivered with different ethnic populations and age groups in the US, Canada and the UK, and have largely supported the efficacy of the programme. A study to pool data from trials of IY programmes has been conducted, led by the University of Oxford. They identified 14 randomised trials from across the UK and Europe, totalling 1,799 families, with children aged between one and 11 years. The combined trial data showed a reduction in child conduct problems, parent-reported ADHD symptoms, and parental use of threats, shouting and corporal punishment, as well as an increase in the use of praise by parents. However, no evidence was found for the programme's effects on child emotional problems or parent mental health (88, 89). The study also investigated the influence of contextual moderators on programme impact, including child's age and gender, ethnicity and SES status. These results have yet to be published.

Evidence for IY Baby and Toddler

The IY Baby and Toddler programmes have been developed using the same format and infrastructure that was used in the programmes for older children, but they have not yet been evaluated in a targeted community-based trial. However, the early years are a critical period of development for children, during which responsive and empathic parenting can promote positive outcomes. Findings from a recent meta-analysis on the effectiveness of the IY programme suggest that the programme may also be beneficial to younger children and their parents because it is based on the premise that parenting behaviours influence children's functioning and changes in these behaviours will lead to sustainable changes for both children and their families (90).

One IY Toddler trial has been conducted to date in the UK (91, 92). It was delivered to parents of children aged between 12 and 36 months in eight disadvantaged 'Flying Start' areas in Wales and results demonstrated a positive impact on parent wellbeing and use of negative parenting practices. However, the sample size for this randomised controlled trial was small (n = 89) and no significant improvements in child development were evident in intervention children compared with controls (91). The IY Baby programme has also been trialled in Wales, in which pre- and post-course measures from 79 group participants showed improvements in parental mental health and parenting confidence. The IY Baby groups were offered in a 'real world' setting; that is, they formed part of the universal services offered to all parents of new babies. However, health visitors and other agencies did target the programme towards those with a higher need, resulting in more than half of parents attending the groups having a low level of parenting self-efficacy. Although the programme demonstrates support for the IY Baby programme in improving parenting confidence and mental health, because no control group was included the positive results cannot be fully attributed to the effects of the programme (93). There are a few experimental studies underway or recently concluded that begin to tease these effects

apart. A trial of the IY Baby and Toddler programmes is currently ongoing in the Republic of Ireland – the Parenting and Infant (PIN) programme is examining the effectiveness, cost-effectiveness and implementation of a range of group-based developmentally appropriate parent and infant support services, including the IY Baby and Toddler programmes (94). In addition, a recent small-scale trial of the IY Baby programme in Denmark found the programme to have no effects when delivered as a universal intervention, potentially due to the programme's focus on at-risk families (95, 96).

To date, IY has achieved significant success in preventing or tackling behavioural problems in older children, but the approach has yet to be rigorously tested and evaluated in the 0 to 2 years age group, and as such it is unproven what effect these programmes will have on the social and emotional health and development of young children.

Delivery of Incredible Years Baby and Toddler

Full details of the IY Baby and Toddler programme content and processes can be found in the licensed technical manuals and training, which can be purchased online (www.incredibleyears.com/). We summarise here the core components of delivery outlined in the logic models.

The group IY sessions aim to help parents learn to identify their child's cues and provide care that is nurturing and responsive, while developing their skills in observation and understanding of their child's needs. Throughout the sessions, they learn how to provide physical, tactile and visual stimulation, to talk to their babies and to establish predictable routines. The toddler programme extends this learning by including elements to develop child-directed play, promote language, social and emotional competence, and handle separations and reunions. The specific topics covered in each of the programmes are:

Baby

Getting to know your baby

Babies as intelligent learners

Providing physical, tactile and visual stimulation

Parents learning to read babies' minds

Gaining support

Babies' emerging sense of self

Toddler

Playing with your child

Supporting your child's social, emotional and language development

Using praise to encourage positive child behaviour

Reinforcing positive behaviour

Setting limits

Handling separations

Managing unwanted behaviour

For maximum effectiveness, each theme must be covered in the sequence listed in the programme manual and be based on the information in the manual, videotapes, and other resource materials. The Baby programme is reflected in baby building blocks (Figure 5), whilst a 'parenting pyramid' (Figure 6) is referred to throughout the Toddler programme, which depicts the parenting behaviours that should be used generously and those which should be used sparingly and appropriately.

Figure 5. Parents and Babies Building Blocks (www.incredibleyears.com)

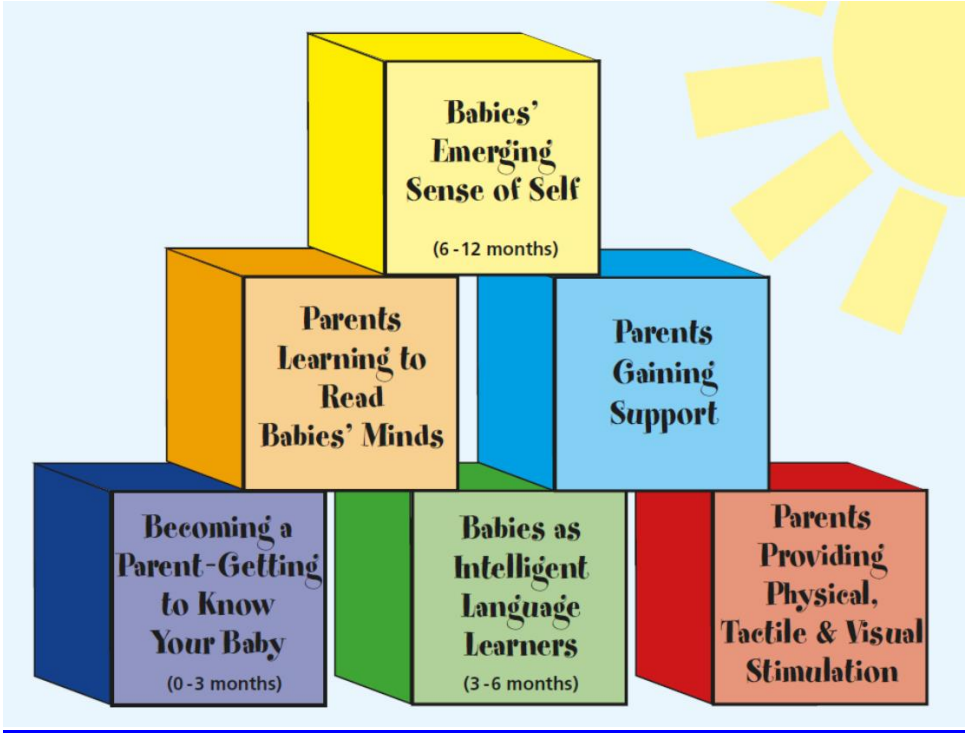
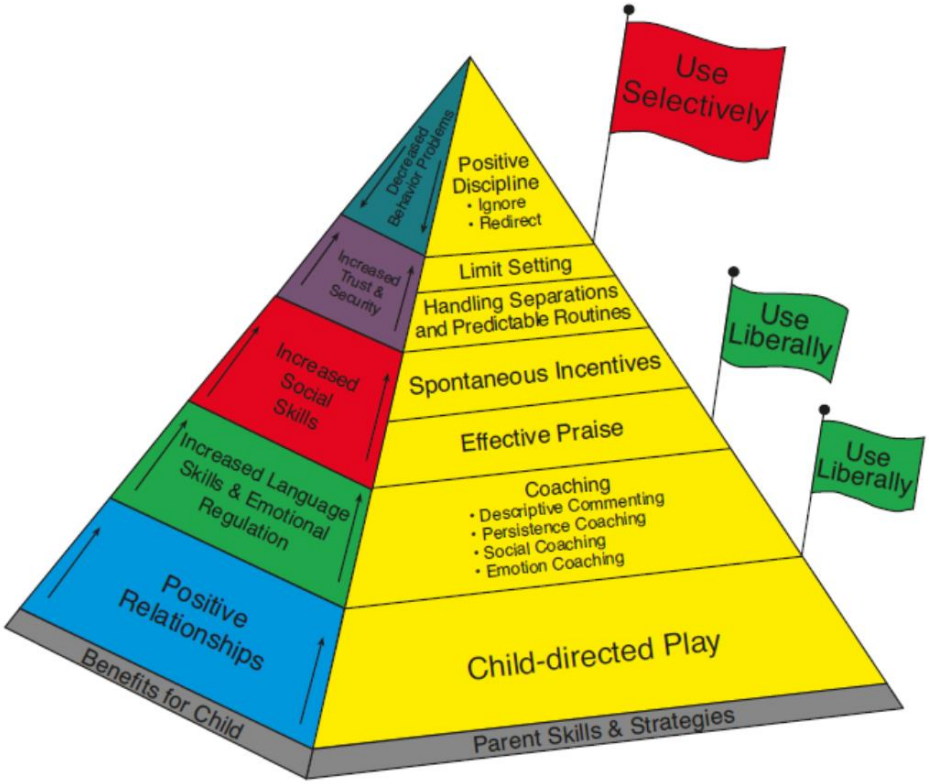


Figure 6. Parenting Pyramid Toddlers (1-3 years) (Webster-Stratton, 2011)



Both the Baby and Toddler programmes are accompanied by a parent book, which reflects the content of the programmes and includes activity and journal pages for parents to complete should they wish to. The IY programme relies on performance training methods, for example video-tape modelling, role play, and practice activities during the session and at home (discussed below), as well as feedback during the session from the facilitator and other group members. The objectives of the programme are to enhance positive relationships between parent and child and to help parents encourage appropriate social and emotional development in their children.

Performance training techniques

The IY programme aims to improve the skills and strategies – both cognitive and behavioural – that parents can use with their children. This is done by practising parenting techniques using video modelling, role-play and home exercises. Each group session involves around 60% group discussion (including role-playing), 25% video modelling and 15% teaching by the facilitator.

Video modelling

Video modelling involves watching video-tapes (referred to as 'vignettes') of parent-child interactions. The vignette settings include eating dinner, getting dressed in the morning and

playing. The video-taped examples are a mixture of positive, negative and neutral behaviours or interactions. The negative examples serve to illustrate that parents are not always perfect. After each vignette the facilitator asks open-ended questions about the scenes and there is discussion and role-playing of how the parent in the video might have handled the interaction more effectively. This approach is crucial in helping to enhance the confidence of parents in their ability to analyse inter-personal situations and to devise and practice an appropriate response.

The use of video-taped situations has the advantage of accessibility, particularly for less verbally-orientated parents. It also allows for better generalisation and longer-term maintenance because it shows interactions in a variety of situations and cultural contexts. The vignettes, which cover a range of situations, parenting cultures and both positive and negative examples, help to show parents how the strategies and responses they discuss and devise can be applied across situations and individuals.

Role-play

Role-playing is used in each session in order for parents to practice newly-learnt behaviours for interacting with their child. Facilitators are trained to help make people feel comfortable about role-playing and each session usually has about four or five brief role-plays. The advantage of role-play is that it helps parents to anticipate situations as well as demonstrating the consequences that follow from trying to solve a problem in different ways. In the baby programme, some of the role-play activities will involve parents practising techniques with their babies as they will attend the sessions together.

Home assignments

Home assignments are an integral part of the IY programmes. For parents, these assignments may involve observing their child's behaviour at home, recording thoughts and feelings, trying out an alternative parenting strategy or reading (or listening to an audiotape of) a chapter in the course book for parents.

The weekly assignments are designed to ensure that learning in the group sessions is transferred to the home and underlines the importance of practice as part of the training programme. At the beginning of each session, parents' experiences of home assignments are shared. In this way, the facilitator knows if the learning is being integrated into home life and parents can share strategies and solutions that they are using.

Barriers to treatment delivery

Much research has been conducted to examine the factors that present barriers to treatment delivery, such as parental factors (e.g. high parent stress), family factors (e.g. socio-economic disadvantage) and those centred on the child (e.g. comorbidity) (85). However, IY is based on a reframing of the problem of parent engagement programmes (87).

Instead of focusing on the characteristics of the family as the reason for programme failure, the programme developer sought to examine the characteristics of the programme and develop intervention characteristics that would enable families to remain engaged in the intervention and thereby benefit from it (87). The IY programme therefore encourages strategies that facilitate the engagement of socially-economically disadvantaged families, such as the provision of child care and meals or snacks, transport to and from parent groups, holding of groups in highly accessible locations (e.g. children's centres) and at convenient times (e.g. evening sessions). However, it should be noted that many of these strategies may be used as standard in the various delivery sites. In addition to these incentives, tangible benefits, such as prizes for attendance and completion of homework, are also incorporated into the weekly IY sessions.

Summary

The IY training series has been developed over the past 30 years to promote social and emotional health and wellbeing, prevent or reduce behaviour and emotional problems, improve parent-child interactions, and improve school relationships. The programmes for children aged between 3 and 12 years have been evaluated in several trials and demonstrated significant improvements in the behaviour of children. They have also been shown to meet the highest standards of scientific proof by independent reviews. The IY Baby and Toddler programmes were developed using the same format and infrastructure as the programmes for older children, but as yet have not yet been rigorously tested and evaluated in a targeted community-based trial.

The IY Baby and Toddler group sessions help parents to learn how to identify their child's cues and provide care that is nurturing and responsive, while developing their skills in observation and understanding of their child's needs through developmentally appropriate topics. The objectives of the programme are to enhance positive relationships between the parent and child, and to help parents encourage appropriate social and emotional development in their child. To do so, the programme relies on the use of performance training methods (for example video-tape modelling, role play and home practice activities), as well as feedback during the sessions from the facilitators and other parents. Strategies to encourage the engagement of socially-economically disadvantaged families, such as the provision of child care and transport, are also recommended by the programme developer.

E-SEE STEPS and its implementation

This section:

- Explains the 'logic' of the programme – how it will achieve the aimed-for improvements
- Describes who the E-SEE STEPS programme is targeted at
- Summarises the main components of the programme

A theory of change for E-SEE STEPS

A theory of change is essentially an overview of the steps required in order to reach a specified long-term goal. Figure 7 illustrates the theory of change for E-SEE STEPS.

More specific details about the implementation of E-SEE STEPS follow in the remainder of this section of the manual, which will add detail to the theory of change.

Several factors were identified earlier in this manual as affecting the social and emotional health and development of young children, including parental depression and, often related, unresponsive parenting and poor parent-child relationships. Additionally, social factors – such as deprivation, social class, education, parental job strain, and housing conditions – are also associated with children's social and emotional development. Although E-SEE STEPS is not equipped to change these social factors, their influence may be mediated by poor parenting and the parent-child relationship (40), which is being targeted by the intervention.

Figure 7. E-SEE STEPS Theory of Change

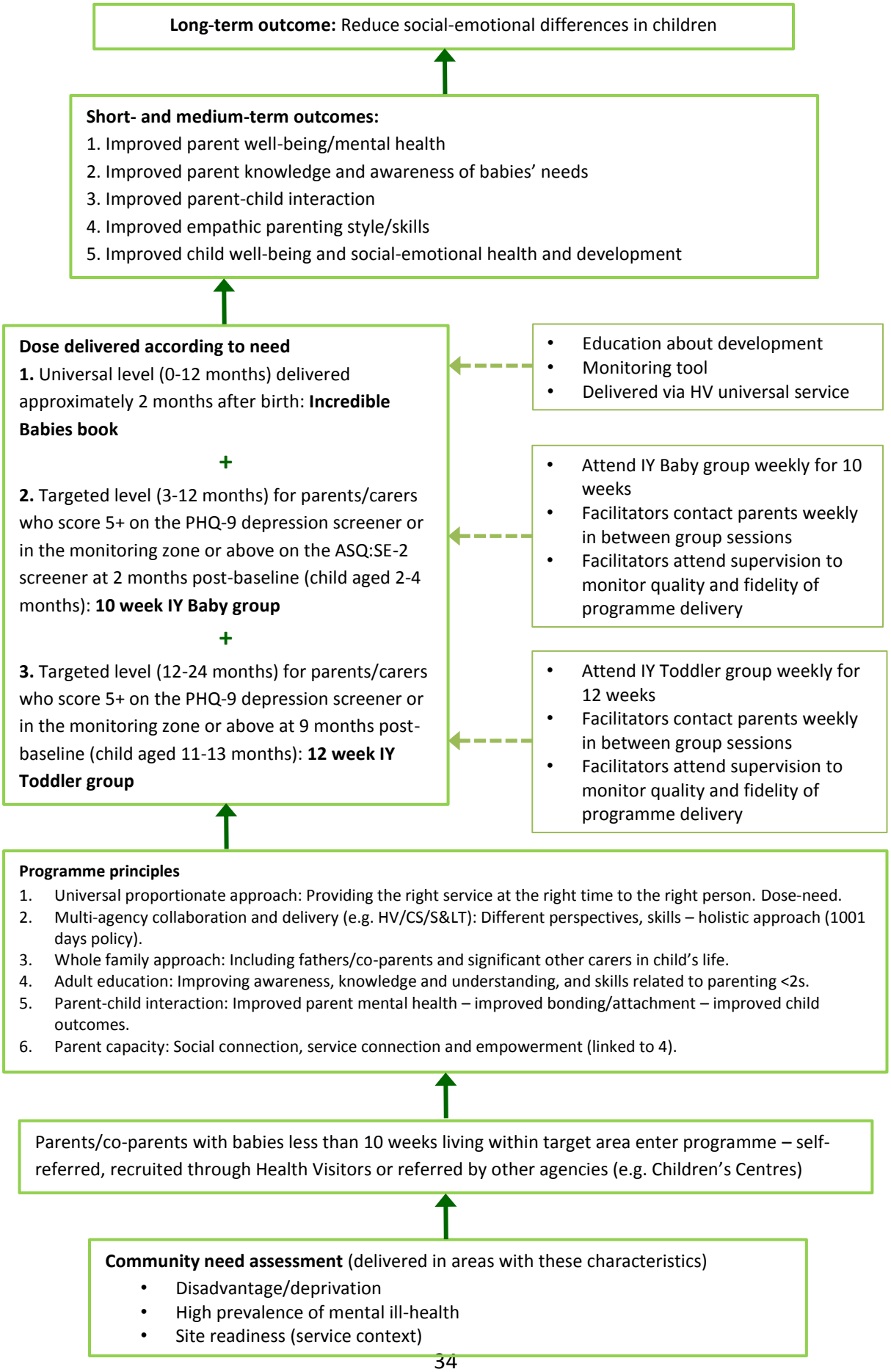
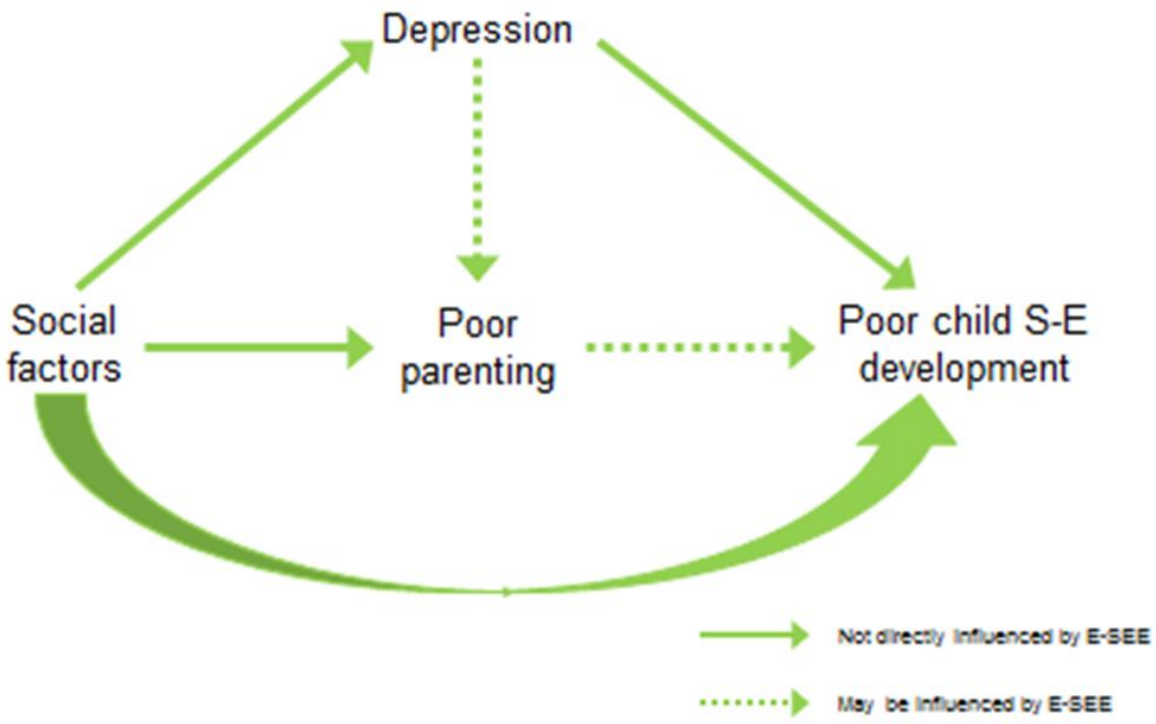


Figure 8 illustrates the pathways leading to poor social and emotional wellbeing in children. As the diagram shows, both depression and social/structural factors can have a direct influence on a child's development, but the effects of both variables may be mediated by poor parenting and consequently poor attachment. IY sessions delivered as part of the E-SEE STEPS model aim to equip parents with mild or above depression with the knowledge and skills needed to be effective parents, lessening the impact of depression on their parenting skills. By raising the quality of parenting, the child's social and emotional development should be improved. These pathways targeted by E-SEE STEPS are indicated by the dotted lines in Figure 8. Although not focusing on social influences, the group delivery of IY may also help to reduce the impact of social isolation on both depression and poor parenting by providing parents with a supportive social environment and the opportunity to meet other parents who face similar issues to themselves. As well as having positive impacts on child outcomes, group parenting programmes have also been found to improve the psychosocial health of parents, at least in the short term (71, 97), again lessening the impact of depression on poor parenting.

Figure 8. Pathways to poor child social and emotional development



Similarly, E-SEE STEPS cannot alter the dimensions of the parental relationship, which may impact on the quality of parenting and parent-child attachments. However, the inclusion of co-parents in the IY group sessions could potentially improve the quality of the relationship,

for example equipping both parents/carers with the same knowledge and practical skills may reduce conflicts caused by differing parenting styles.

Who E-SEE STEPS will target

The consequences of poor social and emotional development described earlier (and listed in Table 2, page 15), in essence, are what E-SEE STEPS is aiming to prevent through implementation of the IY Baby and Toddler programmes. The IY parent training programmes are universal programmes and can be delivered as a preventive measure to parents in order to improve their parenting skills. That said, they are likely to be of most use to those who find parenting a difficult or challenging experience. It is therefore appropriate to target the group session aspect of the programme at those who are most in need, for two reasons. First, it is ethically appropriate to help those who are already experiencing problems, prior to offering a preventive service to those who may be at risk of experiencing those problems. Second, it is an efficient use of resources to target interventions at those who are most in need, particularly when the target group is relatively easy to identify.

Initially, all parents of babies born in the specified date range living in the selected area/s will be informed of the programme and invited to make an application to take part. The inclusion criteria therefore consist of the following:

1. Primary carers who have a baby aged 8 weeks or under during the recruitment window.
2. Living within the specified geographic area and in the vicinity of one of the Children's Centres.
3. Parents are willing to receive the programme and will be able to attend the designated groups at the specified times for the duration of the programme, if invited to attend the baby and/or toddler group intervention.
4. Parents are willing to sign a consent form to acknowledge that they will be randomly allocated to one of two conditions and if allocated to the control group, they will receive no intervention but can access services as usual.

The first phase of the intervention is universal, i.e. every parent (randomised to the intervention group) will receive a copy of the Incredible Babies book. After this point, the intervention is targeted towards parents who score 5 or more on the Patient Health Questionnaire (PHQ-9) measure of depression, and/or a score in the monitoring zone or above on the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE-2). As the evidence presented in the previous chapters shows parental depression to lead to more negative outcomes for their children, this proportionate universalism approach is appropriate to deliver the level of intervention that is suited to the needs of the family. By improving the parenting competencies of these parents, they can help their babies and toddlers to achieve the developmental milestones of forming a secure attachment with their parents, language

and social expression, and beginning their development of a sense of self (4). Parents are also encouraged to develop support networks, for example with other parents in the group, which may have a positive effect on their own mental health.

Where E-SEE STEPS is being delivered and tested

The areas in which to implement E-SEE STEPS are decided based on several factors. Firstly, the evidence outlined above suggests that parent training interventions may be of most help to families living within areas of high deprivation and with a diverse population – the programme will therefore be delivered in areas that demonstrate higher than average levels of deprivation and diversity. The readiness of the local services to implement the programme, based on their identified need for it and its fit with their local priorities, and their experience of delivering the older IY programmes are also factors. The E-SEE STEPS programme will actively attempt to engage fathers, so the interest of the children's services in being more father-focused is a further consideration. Finally, the willingness of the health and children's services to work collaboratively together and with the universities involved in the programme is important in the decision making process.

The project began in 2015 and is due to be completed in 2020. It is envisaged that the programme will be implemented in two waves during this period as follows.

First wave: 2015/16 – 2017; ~18 months

The two pilot sites taking part in the first wave of E-SEE STEPS are Blackburn with Darwen in the North West and Devon in the South West of England. Two children's centres in each of these sites will run an IY Baby programme, and one or two (depending on the number of parents who score at 5+ on the PHQ-9 at follow-up 2) will run an IY Toddler programme. Both sites meet the criteria described above in terms of deprivation, fit with local service priorities, and the willingness of the health and children's services to work collaboratively with each other and with the universities involved in E-SEE STEPS.

Second wave: 2017/18 – 2020; 30 months

If the initial pilot in Blackburn with Darwen and Devon shows E-SEE STEPS to have a positive effect on parental mental health and child social and emotional development, and its implementation as set out in this manual is feasible, a full trial will be rolled out in four sites. These may or may not include the sites that took part in the initial pilot trial. The delivery model for the main trial will be refined based on the experiences of the pilot.

Selecting, training and supervising facilitators

All IY programmes, including the Baby and Toddler programmes, are manual-based. This means that they cannot be delivered without the manuals and other supporting documentation, which are obtained from www.incredibleyears.com/. Although use of the facilitator manual forms the basis of faithful delivery of the IY parenting programmes, the skills of the facilitator and co-facilitator in using the manual and materials in an appropriate way for each group are also crucial.

Facilitators play a key role in creating a therapeutic process that is warm, sensitive and caring while also being practical, problem-solving and collaborative. For this reason, the selection and training of facilitators is a crucial component in E-SEE STEPS. Facilitators need to have a natural aptitude for this work, such as good interpersonal skills, a positive problem-solving approach and an enthusiasm for working with parents. Previous experience of working with parents, particularly through the delivery of family support services in a health care or community setting, is advantageous.

Each group session will be co-facilitated by two people from different organisations, for example children's services, health visiting, or speech and language therapies. Managers of these services will be responsible for selecting facilitators and for ensuring that appropriate cover is provided to allow these staff members to: attend training; recruit and prepare parents for the parent training groups; prepare and deliver parent training groups; follow-up parents in between sessions; perform self-review and peer-review; and have time for supervision from their mentor.

The qualities required of facilitators are aptly summarised by the developer of Incredible Years as follows:

'Group facilitators' effectiveness is determined not just by their educational or professional background but by their degree of comfort with a collaborative process and their ability to promote intimacy and assume a mentor role with families – that is, the kind of leader who listens, asks for clarification, is reflective and non-judgmental, tries to understand what the parent is saying through empathy, is culturally sensitive, helps problem solve, and does not command, instruct or tell the parent or teacher how to parent or teach. At the same time, the group leader or facilitator must also be able to lead and teach – to explain behavioural principles and provide a clear rationale for them, challenge participants to see new perspectives, elicit the strengths of the group, and provide clear limit setting within the group when necessary.' (4:214)

To summarise, the key attributes, skills and experiences needed to be a successful Incredible Years facilitator are:

- good interpersonal skills
- a positive problem-solving approach

- an enthusiasm for working with parents
- previous experience of working with parents, particularly through the delivery of family support services in a health care or community setting
- a reflective and non-judgemental approach
- an understanding of parents through empathy
- the ability to help solve problems without commanding, instructing, or telling parents how to parent
- the ability to take charge, teach and confront – to explain behavioural principles and provide a clear rationale for them
- the ability to challenge families to see new perspectives
- the ability to manage a group – to elicit the strengths of the parents and provide clear limits within the group when necessary.

Training of facilitators

E-SEE STEPS IY Baby and Toddler facilitators are trained, over two or three days, to deliver the content of the parenting programme in a collaborative manner and to become proficient in using different methods for changing behaviour such as discussion, modelling, role-play, persuasion, brainstorming and homework activities. This training is delivered by a Certified Mentor who models a collaborative style of working and illustrates the various techniques that will be used in facilitating a group of parents.

Supervision of facilitators

The IY programme stresses the importance of supervision. Supervision for each programme begins after the facilitator has received the required training and starts to facilitate the first group. It is recommended that facilitators join a peer support group since peer support is key to the facilitators' continued learning and success at delivering Incredible Years, regardless of the degree of expertise they bring. In order to make the most out of peer support, it is recommended that facilitators make videotapes of their groups as soon as possible and have these reviewed by the peer group. These video-taped group sessions can also be self-evaluated and there are forms for doing this which cover areas such as group process skills, leadership skills, relationship-building skills, facilitator's knowledge, facilitator's methods, and parents' response. Both peer review and self-review help facilitators to identify their strengths and areas in which they could improve.

Facilitators are also encouraged to send a videotape of their group facilitation to their Mentor or Trainer at some point during their first group sessions and to schedule a consultation with the Mentor/Trainer once or twice a month when the group sessions are underway. For the E-SEE STEPS pilot, the initial Incredible Years Trainer will be providing this support to all newly practising facilitators.

The process of supervision, like the process of training, is designed to mirror the key principles and processes of the IY programme by being nurturing, caring and acknowledging the facilitators' strengths, in addition to practising different strategies to be used in the groups. At the same time, the process of supervision is also designed to promote fidelity to key protocols and sequences in the programme by respecting the order in which different topics are introduced and by maintaining the basic number and length of sessions.

The IY programme lays particular stress on training and certification whenever the programme is being evaluated. For this reason, any use of the IY programme for research purposes – such as evaluation – requires that it be implemented by certified facilitators. Following certification, facilitators are encouraged to be part of a peer support group within their agency – which would include peer review of videotapes of their work – as well as attending a consultation workshop every two years. However, the fact that IY has not been widely adopted by professionals or their agencies in the pilot sites means that group facilitators will find themselves acting in the role of 'early adopters' within their organisation and in the city as a whole. Supervision, both through peer support and consultation with mentors and trainers, will support these early adopter facilitators to become champions for Incredible Years and act as a source of ongoing training.

Specifically for E-SEE STEPS, the supervision arrangements for facilitators delivering IY Baby groups during the pilot phase will take the following format. This may be adapted for the main trial phase.

- 2 x face-to-face sessions plus 3 remote (Skype) sessions. The first face-to-face session will be at the start of the 10 week programme (for example, during week 1), and one half way through (for example, in week 5). Including preparation time, face-to-face sessions will last a maximum of 4 hours. Supervision sessions held via Skype will last a maximum of 3 hours, including preparation time (the exact split between preparation and call time to be decided between the Mentor/Trainer and IY developer).
- The IY developer, Carolyn Webster-Stratton, will have a debrief session with the Mentor/Trainer via Skype following their initial supervision session with the group leaders, plus another at a later date to be confirmed.
- The supervision sessions will involve discussion of the facilitators' experiences and a review of video clips from the sessions. Videoing of the sessions is crucial for supervision and certification. As supervision will be held in groups with the facilitators, the Mentor/Trainer will view the video clips prior to the session and have comments ready to give during the supervision. If there is not time for the Mentor/Trainer to review clips from all pairs of facilitators, the pairs that are reviewed in each supervision session will be alternated.
- Group leader checklists and parent weekly evaluation forms will also be shared with the supervising Mentor/Trainer.

Identifying and recruiting parents/carers to E-SEE STEPS (and the study)

The programme should be delivered to someone who has main caring responsibility for the child. In some cases this will not be a parent, but rather foster carers, kinship carers or even friends who have been given the responsibility through specialist services to look after a child. However, it will primarily be through the mother that researchers will recruit other carers.

Parents can be identified through referrals from Health Visitors, through Children's Centre staff and through self-referral. Parents/carers will complete an application form and give consent for the research team to contact them. Their details will then be passed on to the research team, who will make an appointment with the parent to do a baseline data collection visit. The study will be advertised across the delivery sites through posters (for example in Children's Centres, supermarkets, etc.), on Mumsnet and Children's Centre websites, and advertisements in the local media. Leaflets will also be delivered to family-populated areas within the area and awareness-raising stands will be held in the local areas, for example in supermarkets or community centres. Additionally, briefing sessions will be run with Health Visitors and Children's Centre staff involved in the identification and recruitment of parents/carers covering the application process and important information about the study.

It is also necessary to be clear to all delivery partners and parents that parents who meet the criteria for participation and who go on to attend a parent training group will need to be supported to attend and continue with the course to its completion. Delivery partners will be expected to provide practical support to deliver the programme, to identify parents likely to meet the selection criteria on screening and to provide on-going support to those parents.

The following process will operate to identify and recruit parents to the programme:

1. Children's Centres will send information about the study to all families with a child less than two months old born between the dates set for the site. This will also include an application form that parents can complete and return to the research team if they wish to be part of the study.
2. Health Visitors will be trained in the identification of parents and will tell parents about the study during the primary visit (10-14 days after birth). If the parent is interested in taking part, the Health Visitor will complete an E-SEE application form with them and get consent to pass their details on to the research team. If the parent does not wish to make an application at this time, the Health Visitor will leave the E-SEE information sheet and application form with the parent to self-complete should they decide to. Every Health Visitor will also be required to keep a log of parents who they have provided information to about the study, including dates and parent postcode.

3. Children's Centre staff will ask parents of new-born children if they have heard about the study and, if not, invite them to fill in an application form and give consent for their details to be passed on to the research team.
4. In addition, the programme will be advertised in the local area through Children's Centres, leaflet drops, and other popular community areas (for example supermarkets).
5. The paperwork included in the application packs consists of a brief information sheet for parents as well as an application form on which parents give written consent for the researchers to contact them about the study.
6. On receiving a completed application form, a researcher will contact the parent to arrange a time for a data collector to visit them at home, check eligibility (for example, age of child), give the parent more details about the trial and ask about their interest in taking part.
7. A data collector (researcher) will conduct a home visit with the parent, during which the researcher will give the parent a full information sheet and obtain written informed consent. (Baseline observation and questionnaires will also be completed during this visit – see 'Evaluating E-SEE STEPS').
8. After completing the home visit, the parents will be randomised to either the intervention or control group. The Trial Co-ordinator will inform the parent and the referrer of their allocation.
9. Parents in the intervention group will receive a copy of the Incredible Babies book (hard copy or audio) and, if found to have a score of 5 or above when the PHQ-9 is completed at the first follow-up data collection visit two months post-baseline, or a level of monitor or above on the ASQ:SE-2, will be offered a place on the Incredible Years Baby programme. Parents who have scores of 5 or above at the second follow-up time point nine months post-baseline will be offered a place on the Incredible Years Toddler programme. Follow-up 3 will be conducted 18 months post-baseline.
10. Parents allocated to the control group will be offered the normal range of family support services within each Children's Centre area, but not offered the Incredible Babies book or a place on either of the IY programmes.

Retaining parents/carers

It is now well known that getting parents/carers to stay involved with programmes often requires concerted efforts on the part of the programme providers. The following steps should be taken to encourage and enable parents to remain involved in the programme for its duration:

1. An on-site crèche should be provided free of charge for the children of parents attending the Incredible Years group sessions should they need it. For the baby groups, parents are expected to attend with their babies so that techniques can be practiced, but may also have older children who will be offered a place in the crèche.

2. Free transportation to and from the programme should be provided for parents who require it. This may involve refunding the cost of travelling on public transport or the transport being arranged by the delivery agency.
3. Refreshments (tea, coffee, biscuits, snacks etc) should be provided at the beginning of each group session, with a special celebration to mark the end of the programme.
4. As far as possible, group sessions should be arranged at a time and place to suit the majority of parents and will remain the same for all sessions.
5. Parents who miss a session should be contacted and offered a follow-up session at home, over the phone or at another convenient location and at a time that suits them so that they can catch up on the session content.
6. All parents receiving the group sessions should be contacted (telephone call, text, letter or home visit) by the facilitator or co-facilitator during the week in between every session to provide individual encouragement and support to continue with the programme. The parents/carers should also be asked about their feelings and thoughts about the previous session and how they are getting on with their home activities.
7. The principles and ideas developed by parents during the session should be typed out and circulated to parents. All parental homework needs to be reviewed and specific advice and feedback provided.
8. Procedures need to be in place for following up non-attenders. A telephone call on the day of the group and, where possible, catch-up sessions may be offered – including taking the DVDs out to families for them to watch. At a minimum, following the telephone call, the families who could not attend should be posted the relevant set of handouts.

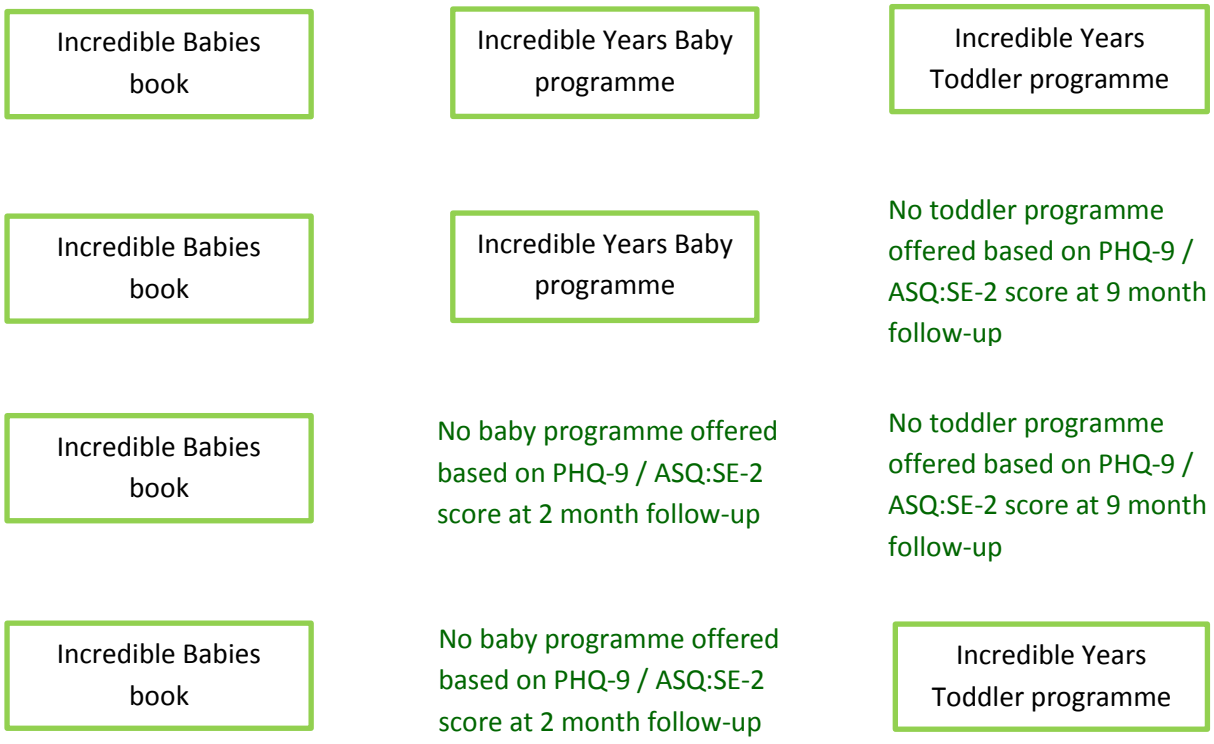
Implementation of E-SEE STEPS

The trial begins with the universal Incredible Babies book being given to all new parents who consent to taking part in the research. This book includes information and advice to help parents promote and understand their babies' physical, social, emotional and language development. All parents/primary carers will be screened for depression using the Patient Health Questionnaire (PHQ-9) at baseline and at 2 months, and parents whose score is 5 or above will be invited to attend practical parent training group sessions. In addition, children are screened using the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE-2) at baseline and 2 months, and children whose score is in the monitoring zone or above will also be eligible for the parent group sessions. These parents will be offered a place on the baby programme, which consists of 10 weekly 2-hour sessions involving facilitator-led group discussion, videotape modelling and rehearsal of taught intervention techniques. Programme content will focus on how parents can help their babies feel loved, safe and secure, and how to encourage the physical and language development of their babies.

Parents will be encouraged to take their baby along to the sessions with them to allow them to practice the techniques together.

All parents will then complete the PHQ-9 and ASQ:SE-2 again, 9 months post-baseline. Eligible parents, with scores above the cut-offs, will be offered a place on the toddler programme. This programme consists of 12 weekly 2-hour group sessions following a similar structure to the baby programme (discussion, video-tape modelling and role-play). Unlike the baby programme, the parents will not be able to take their toddler with them, although a crèche will be available on site for them to use. Throughout the toddler programme, parents will learn how to help their toddlers feel loved and secure, encourage the language, social and emotional development of their toddler, establish clear and predictable routines, handle separations and reunions, and use positive discipline to manage misbehaviour. Due to the offer of a place on the parent training groups being made based on the PHQ-9 score and/or the child's ASQ score, there are 4 potential scenarios (lines running across) for parents in this universal proportionate delivery model

Figure 9. Four potential scenarios for parents in the intervention group



These different elements of the programme recognise that some parents need more support than others. Some parents may also need assistance in linking in with other services; depending on their needs, assistance with this should be provided as part of the programme.

Group sessions and support

Parent training is delivered in groups and facilitated by trained facilitators. The group format has the advantage of reducing isolation and offering new sources of support to parents through building a parent support network. This support network is developed further using a buddy system, in which parents pair up and phone each other during the week to share their experiences of the homework assignment. Each parent's 'buddy' will change every few weeks.

Each group is facilitated by two people: a facilitator and a co-facilitator. The facilitator presents the content of the programme whilst the co-facilitator monitors and responds to the dynamic within the group. This requires a close and complementary working relationship between the facilitator and the co-facilitator. For example, the co-facilitator will observe if the group has spent enough time on a particular topic or exercise, if someone appears upset or distressed, if someone requires additional support, or if there is a need to explore a particular issue in greater depth for the group or for individuals. The effectiveness of each training session depends on there being a good match of skills and personalities between the facilitator and the co-facilitator. The facilitators are to alternate so that either: (i) one leads half a session and the co-facilitator leads the other half; or (ii) they take it in turns weekly. This is so that supervision can be delivered to all facilitators equally, thereby improving the chances of all of them reaching accreditation status by the end of the programme.

The group format helps parents to recognise that other parents often share their experiences, and allows them to explore different approaches to problem-solving. The facilitator or co-facilitator makes contact with each parent at least once a fortnight outside of the group sessions, either by phone (ideally once a week) or through a home visit, to ask how things are going and to see if they are having any difficulty with the programme. This not only helps to promote commitment from participants and prevent drop-out but it also allows for individual needs and requirements to be taken into account. If the facilitator or co-facilitator thinks it is necessary, there may be more frequent contact with parents, particularly where language or comprehension problems are affecting parents' attendance and understanding.

Working collaboratively with parents

A collaborative approach to programme delivery is fundamental (98) and the core theme is a reciprocal relationship between parent and facilitator. The facilitator seeks to utilise, equally, their own knowledge and the parent's unique strengths and perspectives. Respect for each person's contribution is paramount in order to foster a non-blaming relationship built on trust and open communication. Due to the reciprocal nature of the approach, both parents and facilitators have important roles in facilitating change and, consequently, a stake in the outcome (98). The facilitator and co-facilitator support this approach through:

- summarising the points made by parents while also reflecting, reframing and reinforcing them as required
- using role-playing exercises
- being supportive and accepting of all group members, while also displaying humour and optimism
- always encouraging participation.

This model of partnership is seen as restoring dignity, respect and self-control to parents who, because of their particular situation, may have low self-confidence and feelings of guilt and self-blame about their parenting.

Therapeutically, the collaborative approach is seen as improving parents' self-efficacy, motivation and commitment, which, in addition to promoting behavioural change, is also likely to reduce drop-out rates from the programme. The collaborative approach also allows the programme to be used flexibly and to be adapted to the particular needs of each individual and group.

Time considerations

The time to prepare the course must not be underestimated. In preparing for it for the first time, facilitators need to set aside a minimum of two days – preferably four half days – to go through the materials and familiarise themselves with the course content, vignettes and discussion ideas.

In the E-SEE STEPS model, facilitators are expected to contact parents prior to the start of the course. It is recommended that this be done by a home visit to explain the rationale for the programme and to provide a summary of the programme content. The amount of time involved with the initial home visits depends on the size of the catchment area from which the population is being drawn and the consequent travelling time.

Room preparation, including putting up agendas and principles, is likely to need around half an hour prior to the session. Half an hour afterwards is needed for room clearing.

Time should also be allowed for general administration, which includes photocopying course materials, writing letters to referral agencies and any other administrative requirements of the Children's Centres within which the Incredible Years groups are operating.

Language considerations

Some parents attending the group sessions may struggle to understand all of the verbal and written materials. Parents do not need to read anything in the sessions; they are reporting on what they have done in the previous week, watching video clips, discussing aspects of parenting and planning goals for the following week. There are handouts and record sheets if parents want to use them. Records can be completed at home using pictures, or written in poor English (spelling is not an issue). Alternatively, reflections can be audio-recorded.

The Incredible Babies book is available as an audio book, so parents can listen to it rather than read it. It is very helpful if parents can read or listen to the book, but they can complete the IY programme without it.

The IY 'fridge notes' are useful as they summarise the key points from each session. They can be translated, although of course this does not help parents who do not read in any language.

Groups can also be run in a language other than English provided that: (i) this is done by a trained facilitator; (ii) the whole group speaks the language in question; and (iii) the co-facilitator also speaks that language. For supervision, the facilitator would need to sit down with the supervisor and translate what he/she said on the videotape into English.

The IY programme materials can be translated but this is more complex: key principles have to be adhered to and there is a rigorous approval process for translating written and video materials, which requires collaboration with the Incredible Years head office in Seattle, US. The Incredible Babies book is being translated into an audio book in Urdu.

If required, interpreters need to be booked for the length of the programme (10 weeks for IY Baby and 12 weeks for IY Toddler). They should arrive ideally one hour before each session in order to run through the materials with the facilitator. There will usually be a short catch-up conversation for parents at the start of each session to go over things learnt in the previous session.

Implementation structure

Implementation of E-SEE STEPS involves the following groups of people:

1. Project Manager and Service Design Group
2. Service managers (e.g. children's services, health services)
3. Incredible Years Trainers/Mentors
4. Trained Incredible Years Baby and Toddler facilitators

Project Manager and Service Design Group

The Project Manager, with support and advice from the Service Design team, will support the implementation of IY by carrying out the following functions:

- Organise training and supervision for IY facilitators
- Train and support Children's Centre staff and Health Visitors to screen and recruit parents
- Train and support facilitators and other staff in retaining parents to the programme, including provision of training in father inclusion
- Help to establish peer support networks for facilitators
- Order resource materials for the facilitators to use

- Support Children's Centres in establishing parent support networks
- Be a central point of contact for staff involved in delivery to facilitate communication with the Evaluation Team
- Ensure the programme is delivered with fidelity and to a consistently high standard
- Promote awareness of the programme across the site.

Children's Centre and health service managers

Children's services and health service managers are key to the success of E-SEE STEPS. They will need to:

- Ensure that Health Visitors, Children's Centre staff (where appropriate), IY facilitators and partner agencies identify appropriate parents for the programme
- Identify appropriate staff from their own organisations to be trained as IY Baby and Toddler facilitators
- Support staff to deliver IY Baby and Toddler parenting groups, including providing appropriate rooms, finding staff cover if necessary and allowing time for delivery, preparation, reflection, supervision and peer-support activities
- Ensure that facilitators, Children's Centre and health service staff support parents to continue with and complete the programme
- Work closely with each other to ensure delivery is shared equally between the facilitators from different organisations
- Keep informed of the project purpose and developments and ensure that their teams and partner agencies are aware of the pilot project, its aims and intended outcomes.

Incredible Years Trainers/Mentors

Before IY can be delivered, group leaders will need to be trained in the Baby and Toddler programmes. Certified IY Trainers or Mentors will:

- Deliver 2-3 day IY Baby training to staff identified by service managers as potential group leaders
- Deliver 2-3 day IY Toddler training to staff identified by service managers as potential group
- Provide fortnightly supervision (face-to-face and/or telephone) to group leaders throughout the length of the programme for both Baby and Toddler programmes.

Trained Incredible Years Baby and Toddler facilitators

The successful delivery of IY will rest with the facilitators trained to deliver it. The success of the trial depends on the facilitators being adequately trained and supported to deliver IY Baby and Toddler programmes to groups of parents with fidelity.

The key functions of facilitators will be to:

- Deliver IY parent training groups with fidelity
- Encourage parents to complete the programme and make contact with them in between the group sessions
- Arrange and seek out supervision and opportunities for reflection on their delivery.

Ethical considerations for implementing E-SEE STEPS

Ethhical approval has been obtained from the Wales Research Ethics Committee (NRES REC number 15/WA/0178). The IY programme will be implemented in accordance with the following core values:

- Beneficence: a commitment to the well-being of programme participants, including a commitment to act with honesty and integrity as well as with compassion, empathy and care
- Non-maleficence: a commitment to do no harm and avoid any situations that may put programme participants in any physical or psychological danger through, for example, stress or inappropriate conduct
- Autonomy: a commitment to respect the dignity and rights of programme participants, including their right to confidentiality and to giving informed consent to participate
- Inclusivity: a commitment to promote participation in the programme by those parents who consent to participate but who may, due to personal or family circumstances, have difficulty in doing so.

Based on these core values, everyone involved in implementing the E-SEE STEPS model will:

- Have the necessary training and competence to do so, and will be given adequate support and supervision in order to optimise the opportunity for improving the well-being of participants
- Endeavour to identify and develop the strengths of participants. Equally, they will be aware of the vulnerabilities that can be exposed through sharing experiences of parenting with a group of other parents and will take all appropriate measures to ensure that participants feel safe and protected from harm
- Ensure that the needs of each individual participant are addressed adequately and that every effort is made to overcome barriers to participation
- Maintain confidentiality regarding information about participants. This principle can only be broken in exceptional circumstances where a child is considered to be at serious risk. In these circumstances, established guidelines at the Children's Centre/Family Hub for safeguarding children will be followed. This means that anyone who knows or suspects that a child has been harmed, or is at risk of being harmed, must report it through the local safeguarding channels.

- Follow the standard operating procedures (SOPs) when concerns arise, for example for suicide risk, severe depression and domestic violence. These have been developed in collaboration with service delivery partners
- Be required to be cleared by the Disclosure and Barring Service (DBS) before any work on Incredible Years parenting groups begins.

Information about participants will be stored as anonymised data, in accordance with the provisions of the Data Protection Act 1998, so that the data do not identify the person to whom they relate. Appropriate measures will be taken to store all data (both hard copy and computer data) in a secure manner, which includes the removal of identifiers, the use of pseudonyms, and other technical means for breaking the link between data and identifiable individuals. Extreme care will be taken when delivering or transferring any confidential material over computer networks in order to prevent data being published or released in a form that would permit the actual or potential identification of research participants. Similarly, arrangements will be made for the appropriate archiving or destruction of data when the evaluation is completed.

Everyone who is invited to participate must first be provided with information about the E-SEE study in order to give their informed consent. A leaflet containing information about the programme will be given to each parent. This leaflet will be supplemented by verbal explanations, and each person who is invited to participate will have an opportunity to ask questions and discuss their concerns. Prior to giving consent, each person will be informed of their right not to participate in the programme, including their right to withdraw from it at any time. Each participant who gives free and informed consent will be invited to sign a consent form.

Summary

E-SEE STEPS involves delivery of the IY Baby and Toddler programmes in a universal proportionate model, i.e. the dose delivered depends on the level of the families' needs.

Use of the facilitator manual forms the basis of faithful delivery of the IY parenting programme, but the skills of the facilitators in using the manual and materials in an appropriate way for each group are also crucial. Facilitators need to have good interpersonal skills, a positive problem-solving approach and an enthusiasm for working with parents. Previous experience of working with parents is advantageous.

Facilitators are trained to deliver the content of the parenting programme – separate training will be delivered for the baby and toddler programmes. In addition, the Trainer/Mentor will provide fortnightly group supervision sessions once the course commences. Videoing of the sessions is necessary for supervision and certification.

The recruitment process involves a combination of self-referral and applications through Health Visitors and Children's Centres. Parents must complete an application form and give written consent for their contact details to be passed on to the research team. A researcher will then contact the parents and carry out a baseline data collection visit before the parent is randomised into either the intervention or control group.

Concerted efforts should be made to retain parents during the programme, for example by holding the group sessions at a suitable time of day, providing transport, childcare and refreshments, and working to re-engage parents who are considering dropping out. Some parents attending the group sessions may struggle to understand all of the verbal and written materials. Parents do not need to read anything in the sessions and records can be completed at home using pictures, written in poor English, or audio-recorded. If interpreters are to be used in group sessions, they need to be booked for the entire duration of the course (10 weeks for the Baby programme and 12 weeks for the Toddler programme).

Evaluating E-SEE STEPS

This section:

- Describes the overarching design of the evaluation
- Outlines the main aims and objectives of the three strands of the evaluation – outcomes, processes and cost-effectiveness
- Lists the measures that will be used to assess parent and child outcomes and effectiveness of the implementation of the E-SEE STEPS model.

Introduction

The evaluation of E-SEE STEPS is to be conducted by randomised controlled trial (RCT), which is a method used to scientifically measure the efficacy or effectiveness of a service. It is an approach that remains fairly rare in children's services for a number of reasons, including the constraints of cost and practical obstacles but also owing to ideological resistance on the part of some policy makers and practitioners (99). While the aim should always be to select the most appropriate method for the question in hand, random allocation evaluations, used properly, are best-placed to identify the 'net effect' of an intervention (100). The considerable resources required to undertake such a study properly require clarity about what is being provided to whom and with what aim, and a clear understanding of the logic behind the intervention; it makes no sense, financially or ethically, to invest in an evaluation that potentially will be able to say very little that is conclusive about the impact of services on children's well-being. As well as quantitative approaches to assess change in measurable dimensions throughout the intervention, the evaluation will also include a qualitative element, in part to explore issues of implementation and process (to complement attention to impact).

The main research question for the RCT is:

To what extent does the E-SEE STEPS proportionate delivery model of Incredible Years enhance child social and emotional well-being at 20 months of age, and adult well-being, compared to services as usual (SAU)?

Intervention and control group allocation

Participants will be parents of children aged 8 weeks or less during the identification period, identified by children's centre staff, Health Visitors, other professionals, or through self-referral. Parents who are recruited into the trial will be randomly allocated to the intervention or control group on 5:1 ratio (3:1 in the pilot), stratified according to level of

need based on parent PHQ-9 scores or parent-child scores on the ASQ:SE-2, and the gender of the child and parent. Intervention parents will receive a copy of the Incredible Babies book (universal level). Dependent on the level of need at data collection points 2 and 3, parents in the intervention group may be invited to join an IY Baby programme (10 weeks, 2 hours per week) and/or an IY Toddler programme (12 weeks, 2 hours per week). Control parents will receive services as usual. IY Baby and Toddler will not be offered as part of SAU in participating local authority areas.

Aims

The need for the programme and the proposed delivery of the E-SEE STEPS model has been outlined earlier in this manual. This section will focus on the specific objectives of the research trial and the three elements of programme evaluation that will be conducted alongside delivery of the model, which focus on: 1) clinical outcomes; 2) processes; and 3) cost-effectiveness.

The three strands of the evaluation will help to answer the research question above by not only finding out if the programme is successful at improving child and parent well-being compared to services as usual, but also what contributes to the success, or failure, of the programme in different environments for different people, and how cost-effective it is i.e. whether or not the benefits of the programme for parents, children and services outweigh the costs required to implement it. Each element of the evaluation therefore has its own distinct aims and these are listed below.

1. Clinical outcomes evaluation

a) To what extent does the proportionate delivery model of IY (and each dose level) enhance child social emotional wellbeing at 20 months of age, and adult wellbeing, compared to services as usual (SAU)?
b) For whom are the cumulative/individual IY programmes most effective?

2. Process evaluation

a) Can a (multi-agency) service deliver IY in a proportionate universalism model, and what are the organisational, or systems-level, barriers and facilitators to delivering in this way with fidelity?
b) How acceptable and feasible is delivery of E-SEE STEPS for key intervention stakeholders, i.e. parents/co-parents, facilitators, heath facilitators, service managers?
c) How do organisations and facilitators engage with, and retain, fathers and other carers in the programme and in the services?
d) To what extent do process outcomes compare to a similar trial outside of the UK (to identify and explore transferable ‘lessons’ and transportability of IY Baby and IY Toddler)?

3. Economic appraisal/cost analyses

a) Is E-SEE STEPS cost-effective in enhancing child social emotional wellbeing at 20 months, and adult wellbeing, when compared to SAU?
b) Does E-SEE STEPS influence patterns of health and social service use in children and parent/s when compared to SAU?
c) Can we assess the likely long-term costs and benefits of the IY programmes?

Outcomes and measures

A suite of measures for children and parents/co-parents will be used to assess progress towards outcomes at various time points throughout the trial.

Child outcomes

The following measures for child outcomes will be administered at all data collection points – baseline, then 2, 9 and 18 months post-baseline – and independently completed by the parent or co-parent, unless otherwise stated.

Primary outcome

a) **Social and emotional wellbeing:** To establish effectiveness at each and all IY dose levels using the parent-report Ages and Stages Questionnaire – Social Emotional (ASQ:SE-2) (101-103). The co-parent will not be asked to complete this questionnaire.

Secondary outcomes

b) **Behaviour:** Strengths and Difficulties Questionnaire (SDQ) (104). Measured at 18 month follow-up only.
c) **Attachment:** Observational report of the parent-child dyad completed by the data collector using The CARE Index (105, 106).
d) **Cognitive development:** PedsQL Infant Scale (107). Measured at 18 month follow-up only.
e) **Health (quality of life):** PedsQL Infant Scale (107). Measured at 18 month follow-up only.
f) **Service use:** Client Service Receipt Inventory (CSRI) (108).

Parent and co-parent outcomes

The following measures for parent outcomes will be administered at all data collection points – baseline, then 2, 9 and 18 months post-baseline – and independently by the parent or co-parent, unless otherwise stated.

Primary outcome

a) **Depression:** To establish effectiveness at each and all IY dose levels, using the Patient Health Questionnaire (PHQ-9) (109, 110).

Secondary outcomes

b) **Carer-child attachment/interaction:** Maternal Postnatal Attachment Scale (MPAS) and/or Paternal Postnatal Attachment Scale (PPAS) (111). Measured at 18 month follow-up only.
c) **Parenting skill:** Parent Sense of Competence (PSoC) (112).
d) **Health-related quality of life (HRQoL):** European Quality of Life – 5 Dimensions (EQ-5D-5L) (113).
e) **Service use:** Client Service Receipt Inventory (CSRI) (108).
f) **Demographics:** A bespoke parent-/co-parent-report demographics form capturing key information on age, ethnicity, religion, income, marital status, and parent/co-parent education. The co-parent and follow-up demographics form are a shorter version than the baseline form.

Process evaluation

The process evaluation is a mixed methods study that will gather both quantitative programme delivery data as well as qualitative data about implementation, participant experiences and contextual factors influencing successful delivery.

The following quantitative fidelity monitoring data will be collected for each group programme delivered (IY Baby and Toddler):

a) ***Facilitators' adherence to core components:*** Assessed using the standard weekly-completed IY checklists that correspond with the components set out in the respective programme manuals. Adherence to an average of 80% of the content is generally considered acceptable fidelity.
b) ***Implementation fidelity:*** The IY group sessions will be video recorded and a random subset of both Baby and Toddler programmes will be used as observational data. The session videos will be observed and coded by two researchers using a tool developed by the research team – the Parent Programme Implementation Checklist (PPIC)(114) – which comprises indices for adherence, dose/exposure, quality of delivery, and participant responsiveness. Inter-rater reliability will be assessed and reported.
c) ***Parent satisfaction with the programme:*** Assessed using standard IY satisfaction questionnaires, adapted for use with parents with low literacy and for UK English language (originally US English). The weekly questionnaire will be completed by parents at the end of each group session and the end of programme questionnaires will be completed at the end of the baby and toddler programmes. These will supplement data

on retention rates over the course of the intervention to examine acceptability of the intervention.

d) ***Attendance:*** Facilitators will complete a weekly attendance log, developed by the research team, to record the parents/co-parents who attend each session. This includes space for the facilitators to include reasons for non-attendance, whether the parents received a catch up session, and how many crèche places and interpreters were required by the group each week.
e) ***Contact:*** Facilitators are required to contact parents in between each group session and a contact sheet, developed by the research team, will be completed weekly to record the number of each type of contact made (home visit, phone call, text and letter).

The process evaluation will also gather qualitative data from a series of focus groups and semi-structured interviews with key stakeholders in order to build an understanding of the acceptability and feasibility of the intervention, as well as the factors that influence successful implementation.

To avoid influencing the impact of the intervention, the focus groups and interviews will only be undertaken once intervention delivery is complete in each site. A total of 16 focus groups will be conducted; four in the pilot phase and 12 in the main trial. These will be divided between parents and co-parents participating in the intervention and facilitators leading the IY groups. The focus groups will explore:

a) Acceptability and usefulness of the Incredible Babies book as a universal intervention
b) Acceptability of a proportionate model with stepped intervention
c) Processes for identification, screening and recruitment
d) Strategies/approaches for engaging fathers and extended carers
e) Barriers and aids to attendance
f) Experiences of participation in the groups.

Where possible, a separate focus group with participating fathers and/or extended carers, such as grandparents, will be convened to explore item *d* above in more depth.

A total of 18 semi-structured interviews with health and children's services managers will be undertaken; six in the pilot phase and 12 in the main trial. This roughly translates to three interviews per site, to include at least one interview from a health services manager in each site. The interviews will explore the managers' views of:

a) Accommodations required/adaptations made to the existing service to enable delivery of E-SEE STEPS
b) System, organisational and team-level barriers and facilitators to delivery in their locality
c) E-SEE trial participation
d) Acceptability of study protocols, for example randomisation and screening.

Economic evaluation

Information will be collected directly from participants to establish access to health, social and educational services. Measures used to determine the cost-effectiveness of the trial will include:

a) Client Service Receipt Inventory (CSRI) – as listed for outcomes, the CSRI completed at each baseline and 2, 9 and 18 months post-baseline will be used to determine whether families' use of services changes over the course of the programme (reduced service use suggests reduced costs to health and/or children's services).
b) Assessment of social service and early educational service access to give a fuller societal picture for cost-analyses.
c) Use of participant health records to supplement, or compare to, the parent-completed CSRI.

Parent Advisory Committee (PAC)

An overarching Parent Advisory Committee (PAC) will be established with groups in each study region (two groups for the pilot and four groups for the main trial). Each group will contain 4-5 members drawn from the project sites with parents and co-parents who are similar to the potential research participants. This is to include mothers, fathers, stepparents and grandparents. Each PAC group will be contacted approximately four times during the set-up and pilot phase and five times during the main trial. The main roles of the PAC are to advise and support researchers on recruitment to the trial, advise on and assist with training in the measures to be used, advise on retaining parents to the trial, and on publicity and dissemination. PAC members will be trained appropriately with regards to their role on the committee. The handbook for the public engagement work will be on the E-SEE study website (http://e-see-trial.org/).

Summary

The main research question for the E-SEE STEPS trial is: *To what extent does the proportionate delivery model of Incredible Years enhance child social emotional well-being at 20 months of age, and adult well-being, compared to services as usual?* In order to answer this question, the evaluation of E-SEE STEPS is to be conducted by randomised controlled trial (RCT), which is a method used to scientifically measure the efficacy or effectiveness of a service.

Participants will be parents of children aged 10 weeks or less at baseline, identified by children's centre staff, Health Visitors, other professionals, or through self-referral. Parents who are recruited into the trial will be randomly allocated to the intervention or control

group on a 5:1 ratio. Intervention parents will receive an Incredible Babies book (universal level intervention) and, dependent on their level of need at the data collection points 2 and 3, may be invited to join an IY Baby group and/or an IY Toddler group. Control parents will receive services as usual.

The evaluation will consist of three strands: 1) clinical outcomes; 2) processes; and 3) cost-effectiveness. Put together, these three strands will help to answer the research question above by not only finding out whether or not the programme is successful at improving child and parent well-being compared to services as usual, but also what contributes to the success, or failure, of the programme in different contexts for different people, and how cost-effective it is.

A range of measures for child and parent outcomes will be administered at baseline, and then 2, 9 and 18 months post-baseline, including the *Ages and Stages Questionnaire – Social Emotional* (ASQ:SE-2) for child social and emotional well-being and the *Patient Health Questionnaire* (PHQ-9) for parent and co-parent depression. The IY interventions will be delivered in the interim periods between these data collection points. Additional quantitative and qualitative measures will be used for the process and cost-effectiveness evaluations.

A Parent Advisory Committee will be set up and consulted in each site, with the aim of supporting researchers on issues relating to the recruitment and retention of parents to the trial, training in the measures to be used, and on publicity and dissemination of findings.

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