Summary of the UK WMP pilot feasibility study 2024

Watch Me Play!: A pilot feasibility study of a Remotely-delivered Intervention to Promote Mental Health Resilience for Children (age 0-8) across UK Early Years and Children's Services

Authors: Elizabeth Randell, Claire Nollett, Vaso Totsika, Eilis Kennedy, Sean Johnson, Lena Meister, Kim Smallman, Rachel McNamara, Jeremy Segrott, Jenifer Wakelyn, Angela Casbard, Kathy McKay, Ekaterina Bordea, David Wilkin, Ema Mortimer

Funder: What Works for Children's Social Care
Sponsors: Tavistock and Portman NHS Foundation Trust in collaboration with University College London and the Centre for Trials Research (CTR) at Cardiff University.

Final report completed 31/3/2024; available from 7/11/2024 here:
https://foundations.org.uk/wp-content/uploads/2024/11/watch-me-play-final-report.pdf

Background

Half of mental health problems are established by the age of 14 years (Public Health England, 2019). Early intervention and prevention of mental ill health is therefore vitally important. However, access to child mental health services is often restricted to those in severest need: in 2019-20, only a quarter of children estimated to need help received it (Children's Commissioner, 2021). Difficulties accessing treatment remained a key concern in 2021 (BBC, 2021a) (BBC, 2021b). Those not offered help include children at higher risk of developing problems later and those with problems that do not meet service thresholds (Crenna-Jennings & Hutchinson, 2020). Important opportunities for prevention and treatment are therefore missed (Colizzi et al., 2020).

Watch Me Play! (WMP) is an intervention for caregivers with their babies or young children that aims to enhance child development and caregiver-child relationships by promoting individual attention and age-appropriate stimulation. WMP involves a parent/carer watching their child play and talking with their child about their play for 5 to 20 minutes. Some sessions are facilitated by a trained practitioner who joins the parent/carer in watching the child or baby and talking to the child about their play, providing prompts to the parent/carer where necessary. Caregivers have reported improvements in their relationship with their baby or child, in parenting confidence, and in children's play skills, communication, and behaviour. The approach was found helpful during the pandemic when WMP was delivered online or as a combination of online and face-to-face sessions.

The importance of child-led play for development and learning is widely attested (DCSF, 2009; Sunderland, 2007). Discovery through play is linked with the development of social-emotional and problem-solving skills and school readiness (Broadhead, 2004; Fabian, 2009; Yogman et al., 2018; Slade 1994). Providing attention to a child's play and putting their play

into words has been found to enhance confidence, self-efficacy, imagination, self-esteem, concentration, regulation and co-ordination. Benefits have also been reported in the attunement and sensitivity of the caregiver (Panksepp, 2007; Sunderland, 2007; Dozier et al., 2009; Ayling & Stringer, 2013).

About the study

This study, the first to evaluate the feasibility of WMP in early years and family services in England, was a non-randomised single group study with parents/carers with children aged 0 to 8 years. Its primary objective was to explore the feasibility of further evaluation of WMP.

The primary objective was to assess the feasibility of providing WMP to families with babies and children aged 0 to 8 years referred to early years and children's services in the UK.

40 staff in 16 early years, children's health services and social care services took part in training. Participants included early years practitioners, early years mental health practitioners, social workers, therapeutic social workers, placement team senior practitioners, theraplay therapists, counsellors, specialist health visitors, clinical psychologists, assistant psychologists, educational psychologists, child and adolescent psychotherapists, and a dramatherapist. All practitioners had at least two years' experience working with families referred to early years and children's services.

WMP training consisted of two 3-hour online interactive workshops. Practitioners received a resource pack and from July 2023, were given access to a WMP website. Once recruitment began, practitioners were expected to take part in four or more 75-minute small group work discussion style supervision meetings for each intervention. Practitioners were invited to use a case discussion template to present a detailed account of interactions with the parents/carers and the child and to complete and discuss the WMP Practitioners' Checklist.

For the study intervention, practitioners were asked to provide an introductory session to explain the intervention and then offer five facilitated sessions with parents/carers. Parents/carers were also asked to complete an additional 10 independent sessions themselves. The aim was for the whole intervention to be completed in five weeks.

The study was interested in whether online sessions would be acceptable to families and could facilitate accessibility; sessions could be in person (in clinic or in home visits) or online as needed.

Methods

The following measures were obtained from the parent/carer at baseline and at follow-up (3-months post-recruitment):

Child Behavior Checklist; CBCL (Achenbach, 2011); Strengths and Difficulties Questionnaire; SDQ (Goodman, 2001); Vineland Adaptive Behavior Scale 3; VABS (Sparrow & Cicchetti, 2016); Parent Stress Index-Short Form; PSI (Abidin et al., 2006)(Haskett et al., 2006); Being a

Parent scale; BAP (Johnston & Mash, 1989); Mothers' Object Relations Scale-Short Form; MORS-SF and MORS (Child) for 0-4 years (Oates et al., 2018) (Simkiss et al., 2013), Child-Parent Relationship Scale-Short Form (CPRS-SF) for 4+ years (Driscoll & Pianta, 2011), and the frequency of parent-child activities (Parent-Child Activity Index; CPAI (Totsika, 2015).

Parent/carer Health Related Quality of Life and Quality-Adjusted Life Years and Service use for the child were also measured using the EQ-5D-5L (Herdman et al., 2011) and a modified version of the Child and Adolescent Service Use Schedule (CA-SUS) (Byford et al., 2007).

Parents/carers were also invited to consent to take part in a 20-minute videotaped free play interaction between the parent/caregiver and the child to assess the feasibility of using video material to assess Parent-child interaction in a future study.

Qualitative semi-structured interviews were conducted to explore the experiences of parents/carers and practitioners.

Recruitment

Sixteen practitioners from seven services participated in the study. There were 2-3 practitioners per service and they each provided 1-2 interventions.

Services shared a brief information leaflet about the study with parents/carers; those interested in taking part or knowing more were invited to use a link to the participant information sheet and online consent form, or to contact the research team. Those who provided informed consent were then screened for eligibility.

37 families were assessed as potentially eligible during a 5-month recruitment period; 21 (57%) provided informed consent. 20 families completed the screening questionnaire and all were eligible to take part. 12 families reached the 3-month timepoint and 8 (67%) completed at least one follow-up measure.

13 families (65%) reported their child having a neurodevelopmental disorder (either diagnosed or under assessment); **s**even families (35%) reported being in contact with a social worker because of their child.

80% of respondents achieved the expected 10 out of 15 sessions; only 42% of recruited participants reported on their session completion.

Fidelity to the intervention model was assessed using checklists completed by practitioners: 68 checklists were returned, with 52 (76%) containing complete data. The median total fidelity score of the completed checklists was 13 (out of a maximum of 15).

The expectation to provide weekly sessions did not prove realistic in many cases, but the possibility of offering some online sessions sometimes made weekly sessions more feasible.

Costs

The cost of delivering the intervention, depending on the mode of delivery, ranged from £209 to £418 per family.

The estimated cost per family of an intervention with a similar theory of change targeting child mental health (6 sessions of VIPP-SD) is £1466 (O'Farrelly et al., 2021).

The approximate total cost of introduction training and supervision per practitioner was £400.

Acceptability of the intervention to parents/carers

Interview data indicate that the WMP model was broadly acceptable.

Parents/carers saw WMP as an opportunity to access support and were motivated to try something that could make a difference.

"I thought, oh, it could be beneficial for, for my son, and … we could start right away…" (P0203)

One parent/carer described how they jumped at the opportunity to access WMP support, having had no support or help for 2 years:

"[…]*we had nothing else to um, I mean to go to, as a, as a help, as a support*" (P0601).

For many parents and carers, initial hesitancy or worries about the approach reduced as sessions progressed and positive outcomes were seen:

"… the first session I was a little bit nervous, cos I didn't really know what to expect, obviously, it'd all been explained to us. Um, but you don't know til you get in there … but it was … nothing to be worried about, it was absolutely fine." (P0102)

"… it was more time for me and [child's name] as well, to have that time together and kind of, let [child's name] take control and things, and she really enjoyed that." (P0102)

The one-to-one time and undivided attention facilitated within the intervention was valued; the intentional nature and focus of the time together seemed to provide a special quality to this interaction.

"I think it was special that … we made an effort to have … one on one time … just two of us." (P0203)

"I just get quality time with them and … it's hard when I've got, when you've got more than one child, to … focus that attention, just on that one." (P0102)

Parents recognised that it took some adjusting to not direct the child's play and commented on having a different experience when the play is led by the child:

"… it was really nice, and now I know that … child led plays, are really, really important, because I used to just like, teach them, and I led the play, … I'm more like, happy to um, let him make his own decisions, because I know it's important." (P0203)

"… the whole process, has been quite a big one for us, unlearning what we'd learnt before, and learning to be more free, and just playful with him." (P0602)

Parents/carers also commented on interacting with their child as they play, rather than watching silently:

"… I didn't know that that was what I was supposed to do in the beginning … like oh, let [participating child's name] lead, let [child's name] lead, and … I will just lay back and watch and I felt like, oh I'm not doing anything you know, but over the sessions, I learnt that I can interact, you know, as long as he's leading." (P0203)

Online delivery proved unsuitable for some families, but was more acceptable to many families than practitioners had expected. For parents for whom online sessions worked well, the accessibility and flexibility of this way of working was valued:

"it was more useful for me to have them online, because with work and stuff, it was just, it literally was half an hour out of the morning and that is it." (P0102)

For some children, including those with autism or neurodevelopmental difficulties, online sessions in the home were better than travelling to a clinic:

"But then we started having the online sessions, we were able to um, play here and do the Watch Me Play online, that worked really well, cos he was more comfortable at home …." (P0203)

Outcomes reported by parents/carers

Parents described improved relationships:

"… we noticed that he's more close to us[…]" (P0601)

"… our interaction with [child's name] has changed so much, … it's just been a really nice way to … just be more present with him and more interactive … it's just been a massive change, it's been a good one." (P0602)

Some parents linked a closer relationship with their child with an increase in their confidence and feelng less stressed

"… the difference is that we're, we're definitely closer and it's not as frustrating as before..." (P0601)

Some parents reported that their child's communication had improved:

"Before he couldn't really tell us what he wanted, um, but now, he's able to, like, he can tell us what he wants, and stuff, so, that's good." (P0203)

Parents also reported having a better understanding of their child and their needs:

"It's like, it's just shown us so much more, that my child is, what she needs help with, what she struggles with and like it's helped massively." (P0102)

"I've noticed a lot more of [child]'s struggles. So, I've been able to go to (school), and say, kind of, look, I understand now what they say." (P0102)

Some parents/carers described going on to apply the approach with their child in other settings and with other children within the family.

"… I've gone took from doing it with just [child], to … all of us have that time now, doing Watch Me Play, with each other and I let them choose what they want to do and I just kind of, follow their lead and they really enjoy it." (P0102)

"While eating, while we're playing, it's not about just Watch Me Play, it's about watch me …" (P0602)

Acceptability of the intervention, training and resources to practitioners and services

There was a high level of buy-in from service managers and practitioners. WMP was seen as a valuable intervention that fitted well with the needs of families and with other treatments offered by services. Training and supervision provided as part of the trial was an incentive to take part in the study.

"… a really positive way of interacting, … I can't think of any way that I would change it." (P0602)

" … it's a good fit with the clients that we work with." (0201)

"… it's so simple, in its outlay and approach, that it's a really good tool that anybody could use, with the right training". (0201)

Some practitioners were already familiar with the approach:

"it was one of the first interventions I learned in perinatal." (1103)

"(As a Child and Adolescent Psychotherapist) Watch Me Play! was part of the training … I liked it right from then." (0101)

Practitioners commented that it can take a few sessions for the parent to appreciate that WMP that the play in the session is led by the child rather than by the parent.

"… we did have a follow-up phone call where I explained it again… I don't know if I didn't explain it well enough … or she just didn't quite understand … It took a while for her to … kind of grasp what it was." (0602)

"… what's different is including the parent as a joint partner, so we're both observing the play, and commenting and talking about it. Which some parents find much easier than others, because … it's very difficult if you're used to teaching a child, or asking them to find you the yellow thing, or the blue thing." (0201)

"It's quite hard connecting that … quite hard for different parents, and I think with the training of Watch Me Play, we're taught to be very gentle about how we sort of redirect. … you know, isn't it difficult, isn't it hard to not teach, which is really helpful most of the time, but just for this special time, we … we'll do it this way." (P0201)

The flexibility of offering in person sessions in the home or in clinic or online sessions was valued; many practitioners expressed a preference for face-to-face work but there was an openness to working online:

" … I was surprised by how well it worked, and I would guess that it depends on the families that are able to use it, as well…" (0201)

Practitioners described the fidelity checklist as a useful tool for reflecting on practice:

"… it helped me to … reflect on whether I'd been doing the intervention properly or if there's things I need to work on. … it was really useful and it was quick to do as well." (0602)

"… it does just draw your attention back to … perhaps actually next time, I need to do a bit more of that or, it helps … me reflect at the end of the session. … I found it really helpful." (0202)

The average attendance for the supervisions was 5 meetings.

Barriers for practitioners and services

Barriers to recruiting families for the study related to delays between training and recruitment of families, staffing capacity to continue working with a family following WMP support and to undertake additional research related tasks.

In most services WMP support was offered only to families already known to them; as a result the study was not able to explore the potential of the approach for parents/carers on waiting lists. Prioritising continuity of clinician may conflict with the potential to provide WMP as a first line intervention for families on waiting lists, some of whom have fed back that brief WMP support would be better than nothing.

Barriers to using WMP related to work with families with complex needs, where other work may be needed alongside or following WMP support.

For a future study

WMP may have the potential to address the need for a low intensity, scalable, preventative intervention that can be offered by practitioners in NHS, Local Authority and Voluntary Sector settings. It has the potential to address key challenges for children's mental health identified in the 2021 Children's Commissioner's report of increasing access to intervention for children and broadening the 'system of support' across a range of services (Children's Commissioner, 2021).

The diversity of services recruited to the current study (in terms of geography, type of clinical service and population served) gives confidence that a future evaluation of WMP could appeal to a wide range of early years and family services across England and Wales.

Findings indicate parents/carers would value access to WMP support as early as possible.

Treatment As Usual is likely to be sufficiently different from WMP to serve as an appropriate comparator in a future trial.

A future study should:

- offer all modes of delivery to meet the needs of families and service patterns of working: in clinic, home visits, online

- capture a smaller number of measures, with the SDQ as the primary outcome measure; the VABS, if used, may need to be completed in an interview with the parent/carer

- explore the feasibility of recruiting families from waiting lists;

- explore the feasibility of scaling up training to include wider range of services

- tailor the intervention 'dose' (number of sessions) according to need;

- assess the willingness of families and services to randomisation;

- make the practitioners' fidelity checklist an electronic form.

Watch Me Play! Logic Model