

Comparing the results of an Australian efficacy evaluation and an effectiveness trial for parenting interventions aimed at reducing child abuse and neglect

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# Background & Rationale

Parent training is effective

- ❖ e.g., Incredible Years, Olds, Triple P

Ideal conditions

- ❖ Delivered by program developers
- ❖ “lab” style conditions
- ❖ Manualised, structured delivery
- ❖ Supervision & support

# Definitions

(Seligman, 1995)

- Efficacy
  - Ideal conditions
  - Narrow inclusion criteria
  - Excludes as much bias as possible
  - Tends to detect small effects of treatment
- Effectiveness
  - Everyday life or real world conditions
  - Broader inclusion criteria (or none)
  - Many confounders present

# Aim

To compare the results from the efficacy trial and effectiveness trial of two Australian parent education programs targeting child abuse and neglect.

# Parent Education Programs



**Parenting Young Children**  
A program for parents with learning difficulties  
Produced by the Parenting Research Centre



Child care skills &  
parent-child  
interaction

Home dangers, health  
& emergencies



# Parenting Young Children

A program for parents with learning difficulties

Produced by the Parenting Research Centre



## Efficacy Trial - Method

(Mildon, et al., 2008)

- Participants
  - N = 24 (Age range mothers 20-49; fathers 30-49)
  - Children aged 16 to 70 months
- Design
  - Single group repeated measures
  - Weekly visits of approx 90 minutes for 6 months (10-26 sessions)





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## Efficacy Trial - Method

(Mildon, et al., 2008)

- Measures
  - Parenting Daily Hassles Scale
  - Parenting Sense of Competence Scale
  - Eyberg Child Behavior Inventory
  - Home Observation and Measurement of the Environment
  - Contextual Fit Questionnaire
  - Satisfaction with intervention

# Parenting Young Children

## A program for parents with learning difficulties

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## Results of Efficacy Trial

	Pre-intervention	Post-intervention	3-month follow-up
	<i>M (sd)</i>	<i>M (sd)</i>	<i>M (sd)</i>
Parenting Daily Hassles Scale			
Frequency	45.7 (10.6)	42.4 (9.0)*	42.5 (11.8)
Intensity	54.0 (16.7)	52.7 (17.0)	50.2 (18.7)
Parenting Sense of Competence Scale			
Satisfaction	26.9 (10.9)	29.2 (8.0)	27.2 (10.1)
Efficacy	17.7 (9.3)	23.5 (11.7)	23.3 (10.0)
Eyberg Child Behaviour Inventory			
Intensity	133.5 (41.5)	117.8 (44.4)*	126.2 (45.9)
Problem	17.3 (8.8)	14.5 (11.5)	16.2 (12.2)
HOME			
Early Childhood	29.4 (11.1)	35.9 (8.0)*	32.4 (10.0)
Infant	25.8 (6.8)	30.0 (8.4)	33.4 (5.4)

\*  $p < .05$



## Efficacy Trial - Method

(Llewellyn, McConnell, Honey, et al., 2003)

- Participants
  - N = 45 parents (Mean age 32, range 22-45)
  - Children aged 0 to 54 months (Mean = 28 months)
- Design
  - Random allocation to H&S, visits only, booklets only or current services
- Measures
  - Home Dangers and Precautions Inventory
  - Health Knowledge and Skills Assessment



## Results of efficacy trial

- Sig. increases in parents' knowledge of:
  - Symptoms of health & illness\*
  - Skills to manage emergencies\*
  - Skills in visiting doctor\*
  - Skills in using medicine's safely\*
- Other conditions also led to increases in learning
- Many gains maintained at 3 month follow-up

National initiative aimed at building the capacity of practitioners to better support the needs of families headed by a parent with learning difficulties



Healthy Start



*Healthy Start*

What did we do?

- use of local opinion leaders
- built an active multi-disciplinary network based on Learning Hubs
- provided resources, training, and ongoing support



Healthy Start

A national strategy  
for children of  
parents with learning  
difficulties

## Effectiveness trial - Method

- Design
  - Multi-site trial
  - 3 phases of training
- Participants
  - 394 practitioners trained in 2006-2007
  - 87 began program with 1+ family
  - 36 completed program with 1+ family
  - 122 parents began program



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for children of  
parents with learning  
difficulties

## Effectiveness trial - Method

- Measures (H&S)
  - Home Dangers and Precautions Inventory
  - Health Knowledge and Skills Assessment
- Measures (PYC)
  - Parenting practices (LSAC)
  - HOME



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## Results of Effectiveness trial

- 28 completed PYC (18 follow-up)
- 21 completed H&S (5 follow-up)

\*  $p < .05$



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difficulties

## PYC - Effectiveness trial

	Pre-intervention	Post-intervention	3-month follow-up
	<i>M (sd)</i>	<i>M (sd)</i>	<i>M (sd)</i>
Parenting Warmth	7.25 (1.67)	7.52 (1.36)	7.68 (1.75)
Parent Involvement	1.13 (0.76)	1.24 (0.47)*	1.43 (.79)
Parent Efficacy	2.89 (1.07)	3.16 (.90)	3.64 (.74)
HOME - SF			
Early Childhood	18.25 (3.30)	20.29 (3.68)	21.24 (3.08)
Infant	12.30 (3.27)	14.33 (3.08)	14.0 (3.83)

\*  $p < .05$



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## H&S- Effectiveness trial

	Pre-intervention	Post-intervention	3-month follow-up
	<i>M (sd)</i>	<i>M (sd)</i>	<i>M (sd)</i>
Health comprehension	2.42 (.77)	2.56 (.73)	2.60 (.55)
Illness and symptom recognition	10.25 (4.07)	16.21 (9.46)*	19.0 (9.76)
Life threatening emergencies	3.44 (2.71)	6.94 (2.86)*	6.40 (2.70)
Going to doctor	3.67 (1.88)	5.63 (1.67)**	5.20 (2.17)
Using medicines safely	1.67 (1.53)	3.25 (1.34)**	2.80 (2.17)
Total dangers	40.0 (19.64)	32.15 (12.65)*	23.75 (10.14)
Total precautions	79.13 (32.81)	98.46 (33.11)	88.0 (46.12)

\*  $p < .05$ , \*\*  $p < .01$



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raising children well

	Efficacy	Effectiveness
PYC	<ul style="list-style-type: none"> <li>All measures changed for the better at post-test.</li> <li>Generally maintained at follow-up.</li> <li>Sig. decrease in parent stress.</li> <li>Sig. improvement in home (3-6 y.o.).</li> <li>Sig. decrease in disruptive child behaviour.</li> </ul>	<ul style="list-style-type: none"> <li>All measures changed for the better at post-test.</li> <li>Generally maintained at follow-up.</li> <li>Sig. improvements in parent involvement.</li> <li>Sig. increase in Variety at Home (0-2y.o.).</li> </ul>
H&S	<ul style="list-style-type: none"> <li>Sig. increase in knowledge of health &amp; illness.</li> <li>Sig. increase in knowledge of emergency management</li> <li>Sig. increase in visiting doctor skills.</li> <li>Sig. increase in knowledge about medicine use</li> <li>Generally maintained at follow-up.</li> </ul>	<ul style="list-style-type: none"> <li>Sig. increase in knowledge of health &amp; illness.</li> <li>Sig. increase in knowledge of emergency management</li> <li>Sig. increase in visiting doctor skills.</li> <li>Sig. increase in knowledge about medicine use.</li> <li>Sig. decrease in dangers in home.</li> <li>Variable maintenance at follow-up.</li> </ul>

If we are transferring and exchanging knowledge what effect are we trying to have?

# Training Transfer

So we know that these programs work,  
but we don't know whether they can be  
effectively used in practice

Training transfer = transfer of skills from  
training to the workplace that are  
sustained over time (Burke & Hutchins, 2007)

## Rate of training transfer

Previous studies have reported

- 40% of trainees fail to transfer skills immediately following training
- 70% fail to transfer skills one year later

Overall, only 50% of training investment results in behaviour change (Saks, 2002).

# Results of training

Training phase	Number of practitioners eligible	Places filled	Training uptake (%)
1: Pre-reading & MC test	810	464	57%
2: Face-to-face workshop	464	394	85%
3: Engaged with Phase 3 Program completed	394 295	295 37	75% 12.5%

295/394 commenced a program - 75% engaged with Phase 3  
37/394 completed a program – 12.5% training transfer

# Implementation of evidence based programs

Four most common reasons for discontinuation

1. Practitioner discontinued or could not be contacted - unknown
2. Practitioner changed job or moved to another workplace
3. Child no longer with family
4. Other family issues or family moved out of the area

# Implementation of evidence based programs

Least common reason

No response from family or family not  
at home for sessions



“Discovering what works does not solve the problem of program effectiveness. Once models and best practices are identified, practitioners are faced with the challenge of implementing programs properly. A poorly implemented program can lead to failure as easily as a poorly designed one”

(Mihalic, Irwin, Fagan, Ballard, & Elliott, 2004)

# Where does this leave us?

Explore alternative knowledge translation and exchange strategies to enhance evidence-informed practice in child and family services

Making use of the best implementation science related to practice, service, and system change

# Knowledge Translation and Exchange (KTE) strategies

Varying degrees of participatory KTE  
activities – fit for context

Co-production

Evidence-based kernels

# Evidence-based implementation: Core components

Staff selection

Pre-service and in-service training

Ongoing coaching and consultation

Staff performance evaluation

Decision support data systems

Facilitative administrative supports

System interventions

Fixsen & Blase (2009)



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