# *Lifestyle Triple P®* in the ACT: Key pilot findings

**December 2013**

ACT Government

# ABBREVIATIONS USED IN THIS REPORT

ACT – Australian Capital Territory

ACU – Australian Catholic University

BMI – Body Mass Index

CSD – Community Services Directorate

EIPS – Early Intervention and Prevention Services, Community Services Directorate

HIB – Health Improvement Branch, Population Health, ACT Health

WA – Western Australia

# CONTENTS

# INTRODUCTION

In recognition of an existing gap in services in the ACT to support families tackle childhood overweight and obesity, ACT Health (Health Promotion, Health Improvement Branch) funded a pilot of *Lifestyle Triple P®* for an 18 month period within the 2010/12 budget years under the ACT Government *Healthy Kids – Healthy Futures* initiative. The pilot was coordinated by the Early Intervention and Prevention Services (EIPS) within the Community Services Directorate (CSD), with program groups delivered through the Child and Family Centres program.

*Lifestyle Triple P®* was developed by the Parenting and Family Support Centre at The University of Queensland and tested through a randomised control trial over 2005/06 (West 2007). The program aims to address behavioural and emotional problems in children, but also provide parents with information and practical strategies for promoting healthy eating and increasing physical activity in their family.

The ACT decision to pilot the program was also informed by the promising results stemming from a Western Australian pilot of *Lifestyle Triple P®* in the community health setting. The impact evaluation for this WA pilot showed small but positive effects for both parents and children who completed the program, including: a decrease in the use of ineffective discipline strategies; an increase in parents' confidence to manage lifestyle behaviours and disruptive behaviours in children; and a reduction in child Body Mass Index (BMI). (CACHP 2011)[1]

Evaluation of the ACT pilot was coordinated jointly by EIPS and the Health Improvement Branch (HIB), informed by a range of qualitative and quantitative data collected pre- and post-program. Six month post-program data was also collected to potentially inform the impact evaluation, but the sample size was too small to provide meaningful findings and this data has therefore not been included in the analysis provided. This report describes the pilot process and impact evaluation findings – at end of program.

As detailed in this report, despite significant effort put into promoting *Lifestyle Triple P®* by both ACT Health and CSD, recruitment was challenging and participant numbers were low. Based on this, in early 2012, HIB made the decision not to fund *Lifestyle Triple P®* beyond the allocated funding period (ending 30 June 2012). At this point, HIB began planning for a new intensive healthy eating program for families, which is currently delivered by ACT Health community health dieticians. This program – *Healthy Families, Healthy Kids*[2] – will continue to be funded and refined under the ACT Healthy Children's Initiative under the Council of Australian Governments' *National Partnership Agreement on Preventive Health* (2011/18).

The evaluation findings within this report will inform the *Healthy Families, Healthy Kids* program, as well as future health promotion programs involving families progressed under the ACT Healthy Children's Initiative. The findings also have the potential to inform future primary care initiatives aimed at supporting vulnerable ACT families with children who are overweight or obese.

---

[1] Since this WA pilot, *Lifestyle Triple P®* has been funded under the WA Healthy Children's Initiative to run in one regional centre (one course per year) until June 2015. The WA Department of Health is currently undertaking a procurement process for delivery of an alternative family based childhood obesity intervention in the Perth metropolitan area. A less intensive, mainstream parent healthy lifestyle education program is also funded under the WA Healthy Children's Initiative. [Phone and email communication with Program Manager, Chronic Disease Prevention, WA Department of Health – 28 February and 13 September 2013]

[2] The name this program may change to align with broader health promotion campaigns being developed by the Health Improvement Branch, ACT Health.

# 1. THE INTERVENTION

## 1.1 AIMS, OBJECTIVES AND PROPOSED REACH

The aim of the *Lifestyle Triple P®* intervention is to prevent chronic weight problems by improving children's nutritional intake and activity levels, and increasing parents' skills and confidence in managing children's lifestyle behaviour. (West 2007)

The intervention objectives are:

- improving children's dietary intake, activity levels and weight status;
- increasing parents' skills and confidence in managing children's weight-related behaviour;
- reducing parents' use of coercive and permissive methods of disciplining their children; and
- reducing parents' stress associated with raising healthy children.

An added objective for the ACT pilot was to use a process and impact evaluation of *Lifestyle Triple P®* in the ACT to add to the local evidence base of programs that may reduce chronic weight problems for ACT children.

For the ACT pilot, it was anticipated that seven groups would be delivered by June 2012, with the first three to form the basis of this evaluation. It was proposed that these first three groups would be delivered between January and June 2011 and attract between 18 and 45 participants in total. Further, it was proposed that each group should have between six (min) and 15 (max) participants.

## 1.2 ELIGIBILITY AND RECRUITMENT

The eligibility criteria for families participating in the pilot was that they have a child between five and 10 years of age who had been identified as overweight or obese by the referring health professional, family or other referrer. The parent/carer was also required to commit to participate in the full 17 week program.

Although the program was open to any ACT family that met the criteria, the pilot aimed to particularly support disadvantaged or vulnerable families in the ACT. In line with this, the Early Intervention and Prevention Services Project Coordinator actively worked to recruit families that services typically find 'hard to reach' and who were likely to have poorer health outcomes based on the social determinants of health.

The program was also widely promoted, including through newspapers, schools, health centres, gyms, Government agencies, community services and groups, presentations at ACT Public Libraries (promoted in advance), nutritionists and dieticians, paediatricians, Maternal and Child Health (MACH) nurses, and child protection workers. Health professionals could also refer parents to the program; however this was not a requirement and self-referrals were welcome.

## 1.3 FACILITATORS

Twenty community workers from a range of agencies were trained as *Lifestyle Triple P®* facilitators in November 2010 to assist with the program delivery. Five of these community workers went on to be involved in the delivery of the program over the pilot period – co-facilitating sessions with the Program Coordinator or with each other (there being two facilitators per group). The small number of facilitators involved was due to a range of reasons, including a smaller number of groups than anticipated and difficulty engaging trained workers later in the pilot, in part due to staff movement.

The value of this training for the community workers involved is out of scope for this evaluation.

# 2. PROCESS EVALUATION KEY FINDINGS

## 2.1 AIMS AND METHODOLOGY

The aim of the process evaluation was to assess whether the program was implemented as intended, was appropriate and whether it is sustainable in a community-based setting.

The evaluation focused on parents and facilitators. It drew on data collected through a Client Satisfaction Survey conducted with parents at the last group session, a semi-structured parent telephone interview conducted post-program, and a semi-structured group facilitator interview.

If appropriate, parents withdrawing from the program were also invited to provide feedback, through a short telephone interview, on why they did not complete the program and suggestions for program improvements.

The group facilitator interview was conducted by the Institute of Child Protection Studies, Australian Catholic University (ACU). Ethics approval was granted by the ACU Human Research Ethics Committee (Register Number N2011 14) to undertake this group facilitator interview.

## 2.2 REGISTRATIONS AND RETENTION

Despite the ACT pilot program being widely promoted, interest and registrations were much lower than anticipated. In total, 19 families registered for the program, of which 15 went on to complete it. This compares to an anticipated reach for the pilot of 42+ families. As was its goal, parents registering for the program did include disadvantaged or vulnerable families.

Table 1 presents the high level characteristics of the children completing the program (N=15).

**Table 1: Characteristics of children completing program (N=15)**

| Mean age in years | No. Boys (%) | No. Girls (%) |
|---|---|---|
| 7.9 (range 3-11) | 9 (60%) | 6 (40%) |

Notes: One child younger than the eligibility criteria was included in the program (aged 3 years)

The socio-demographic profile of the families that withdrew from the program was found to be similar to the profiles of the families that completed the program.

The greatest number of participant registrations came through health professional referrals and self referrals prompted by Whole of Government email promotion of the program. Another recruitment strategy that showed promise, but was initiated late in the pilot period, was information sessions in ACT Public Libraries. Traditional means of promoting community programs, such as advertisements in local print media, were not found to be effective.

Facilitators reported that factors impacting on recruitment are likely to have included that:

- health professionals, including allied health, may be reluctant to discuss weight issues with parents or refer them to such programs;
- parental perceptions of 'natural puppy fat' and of children 'growing out' of being overweight may impact on parents recognising their child has a weight issue;
- parents can experience significant stigma around acknowledging and seeking help for obesity and weight gain issues; and
- the program required a significant commitment from participants which may not have been practical, especially for working families or those experiencing complex issues.

Due to the small participant numbers, only four groups were run over the pilot period rather than an anticipated seven. Only one of the four groups met the proposed minimum group size (of six) on commencement and only five participants within this group went on to complete the program.

In terms of retention, of the 19 families registering for the program one withdrew before the first session and one withdrew within the first few weeks after deciding they had sufficient support through their child's health professionals.

Of the remaining 17 families, four were experiencing significant vulnerabilities or access issues that made continuation with the group difficult. These families were therefore offered one-on-one delivery of the program in their homes to facilitate their continuation. Three families accepted this offer; however, one of these three then withdrew after a couple of home sessions due to experiencing serious family relationship issues (with referral made to Relationships Australia). Two families completed home delivery of the program.

In summary, 15 of the 19 registering families completed the program (a completion rate of 78.95%) – 13 families completing the group sessions and two completing the home sessions.

## 2.3 Evaluation Response Rates

Ten participants (parents/carers) out of a possible 15 completed the end of program Client Satisfaction Survey. The same number participated in the semi-structured telephone interviews post program. One parent/carer withdrawing from the program also provided feedback through a telephone interview. Of the five facilitators involved in the delivery of the program, four were invited to provide input via the group interview conducted by ACU – the remaining facilitator not being approached as they had moved interstate since the conclusion of the pilot. Of the four invited facilitators, two participated in the group interview. One of these participating facilitators was the Project Coordinator within the Early Intervention and Prevention Services, who had been most involved in the delivery of the program.

## 2.4 Participant Feedback

All participants reported being 'satisfied' (50%) or 'very satisfied' (50%) with the program, and reported a range of benefits. These benefits included increased knowledge of nutritional issues and learning practical strategies around dealing with behaviours (including what behaviours to expect from their children, and for how long, when parents introduce an eating change).

A key benefit reported by many participants was learning from and/or sharing with other parents – many stating that this interaction helped to validate the issues they were facing as parents and was a key factor for them deciding to complete the program.

Parents reported that their child's food intake and eating behaviours had improved at the end of the program, and that their child was spending less time on sedentary activity. All but one participant also felt that their child's level of physical activity had improved (the remaining respondent reporting no change). Half of the participants felt that their child's behaviour had improved.

Most participants found the venue and timing of the sessions to be convenient, however, a small number (in both evening and day sessions) found the timing difficult or suggested it may be problematic for other participants. Likewise, some participants found the small group size to be relaxed and valuable, whereas others suggested the small group size may be uncomfortable for some parents or may limit the possibility to share. A couple of participants pointed to the fact that the length of the program was a big commitment for them personally and the majority of participants suggested the length and/or timing of the program could be a barrier for other families participating in such a program (see more on this below).

One of the participants who completed the program through one-on-one support reported appreciating this delivery approach, which she found less confrontational than a group setting.

All participants felt that the program content was relevant and realistic for families generally (although the parent of the child with a disability did not think it suitable for her family's needs). They also reported that the program information was broken down well, was practical and could be implemented with some flexibility where necessary.

All participants, including a family for which English was their second language, found the resources helpful and easy to follow. (It should be noted, however, that facilitators reported that significant time and effort was required during delivery of the program for them to explain and make these resources accessible to all participants – see below.) One participant suggested that a copy of the program DVD be provided to each participant. Further, suggestions for new inclusions to the resources – around food "pyramids", recipes and cooking activities for children – were made by participants.

All participants felt that it was important that parents had a say in the content of the program and most felt they were given the opportunity to raise concerns and have their say. However, a couple of participants felt that either they were not adequately consulted on what they would like discussed or that it sometimes felt like they were being lectured to – suggesting more time be allocated to parent directed discussions.

Participants offered a range of ideas for improving the program, many of which were around the timing of sessions and increasing attendance, such as:

- making it an after school program;
- not running the program during school holidays;
- offering makeup sessions;
- reducing the length of the program or offering it as an intensive workshop; and
- providing a care worker or babysitter to mind participants' children.

Participant suggestions for improving the program marketing, content or delivery included:

- using positive language when promoting the program (e.g. 'healthy living' rather than 'weight management') and reducing the stigma felt by many parents in seeking help;
- running the program over Spring/Summer when it is easier to make changes;
- increasing session duration from 90 minutes to two hours to allow for more discussion (although this suggestion may conflict with feedback on timing);
- assigning 10 minutes at the end of every session for parents to identify, with the help of the facilitator, how best to achieve their homework over the coming week;
- including healthy food tasting or practical cooking activities; and
- including child participation, either as part of the existing program (e.g. home exercises involving children) or through activities run alongside the parent sessions (e.g. cooking or exercise groups).

Participant suggestions for improving post-program support included:

- providing someone for parents to ring for additional support to get back on track post program if needed;
- providing parents with information on ongoing services and supports at the end of the program; and
- establishing an ongoing support group for parents post-program.

## 2.5 Facilitator Feedback

In relation to pre-program assessments, facilitators noted that it was preferable for these to be conducted by a facilitator rather than the Project Coordinator where this Project Coordinator was not also a facilitator, as: 1) facilitators could use the assessment learnings to target the program to better meet participant needs; and 2) the process could assist in building rapport between the facilitator and participant pre-program. It should be noted that there was only one group for which the Project Coordinator was not also one of the group facilitators.

In terms of group sizes, facilitators reflected that it was advantageous that groups were not as large as originally anticipated (up to 15 participants) as the intensity of the program would have made it hard for large groups to cover the content and ensure all could participate. Facilitators also noted that very small groups impacted on how comfortable participants were to share and engage with each other.

Facilitators reported that the program content was mostly useful and positively received; however, suggested that many participants found it difficult to follow and process the material as quickly as was required by the program structure. Facilitators also suggested that the delivery of the content was not always systematic or cohesive, and that it was sometimes difficult to tie all the program components together for participants.

Facilitators highlighted that when they were working with particularly vulnerable families, it was often better to target strategies to particular behaviours than to provide one-size-fits all type programs. They reported that participants found strategies that highlighted the 'good' things about their children as very useful, instead of just focusing on responding to negative behaviours.

In contrast to feedback from participants, facilitators reported that although the program resources were mostly useful and appropriate for the purpose of the program, they were not always appropriate for the participants – particularly for those who might be identified as vulnerable. Facilitators suggested that participants with poor literacy skills found elements of the program difficult, as without these skills it was difficult for participants to engage fully with the program both at home and in the group.

In terms of enablers to program completion, facilitators noted that the most successful group was one conducted in the evening, with participants that were mainly well educated, middle income earners, with high literacy levels, who had support outside of the program and were well connected in their communities. As they did not have significant issues impinging on their lives (compared to some other participants and groups), these participants were found to be able to focus on the issues addressed as part of the program and to engage effectively with the content and each other.

Facilitators also highlighted a range of potential barriers to program completion, particularly for disadvantaged participants, including:

- the intensity of the program, which required a significant commitment from participants – participants dealing with competing issues in their lives and/or with having poor literacy skills struggled to stick with, follow and benefit from the program content. The program intensity was also found to be an issue for busy working families; and
- the program design lacking the flexibility to be tailored to the individual needs and learning skills of participants.

It should be noted that although there was a good completion rate of 78.95% (13 families completing the group sessions and two completing the home sessions), this was due to facilitator's providing significant additional assistance (including ongoing support and referrals to address emerging acute family needs) and/or flexible delivery options. Many of the more vulnerable families needed to complete the program through one-on-one support; however, this approach did not always guarantee program completion. In terms of improving recruitment, the Project Coordinator

reported that in order to try to overcome the stigma issue identified by both participants and facilitators, and attract more of the target group, the program changed its advertisements and flyers to emphasise the program's focus on healthy eating, rather than issues of weight and obesity. However, when this change was implemented, rather than attract more of the target group, parents of fussy or picky eaters enquired about the program.

Facilitators suggested that it may be more beneficial to work with existing groups and groupings within the community rather than expect families to refer themselves to programs.

Finally, facilitators discussed the skills and confidence they were required to have to deliver the program content and deal with the complex individual issues that arose through the program. Facilitators appreciated the co-facilitation model, which enabled sharing of experience and knowledge. The Project Coordinator noted the difficulties experienced in engaging facilitators after significant time has passed since their training, as well as issues around facilitators changing roles or moving interstate.

# 3. IMPACT EVALUATION KEY FINDINGS

## 3.1 AIM AND METHODOLOGY

The aim of the impact evaluation was to assess the effectiveness of the pilot *Lifestyle Triple P®* program when delivered in a community setting and where the target population included families from socially disadvantaged backgrounds across Canberra.

The evaluation was conducted as a one-group pre-program/post-program study design, where outcome measures were taken at two time points: before the program started; and after the program finished[3]. These measurements included children's weight status and parents' reports of their child's diet and activity levels. Parents also completed questionnaires on their child's problem behaviours, and their own parenting practices, styles and self-efficacy. These questionnaires are standard *Lifestyle Triple P®* tools with established terminology (as italicized below) and scoring systems for identifying clinical concern (significance). (See West & Sanders 2012)

Ethics approval was also granted by the ACT Health Human Research Ethics Committee (ETHLR.11.020) for the impact evaluation.

## 3.2 RESPONSE RATES

Of the 15 families that completed the program, 14 provided pre- and post-program data for the evaluation. Due to the small number of families that participated, the findings from the impact evaluation should be interpreted with caution. The number of participants in the evaluation was too small to produce reliable and robust statistics, therefore the findings cannot be generalised to the larger ACT population. For the same reason, statistical significance was not reported. Nonetheless, the evaluation provides some indication about the outcomes for the participants that took part in this particular pilot.

## 3.3 RESULTS

The impact evaluation results at end of program are set out below.

- Overall, children's weight status increased, rather than decreased as expected.
    - There was a small increase in children's BMI z-scores[4] of 0.11 from 2.57 (zBMI) at the start of the program to 2.69 (zBMI) at the end of the program. The change in BMI z-scores ranged from -0.12 to 0.73 for individual children.
    - Children's mean waist circumference increased slightly from 93.5cm to 94.4cms – a mean increase of 0.82cm over the course of the program. The change in waist circumference ranged from -6cm to 8.5cm for individual children.
- Overall, there were modest improvements in children's daily fruit and vegetable consumption.

[3] Six month post-program data was also collected to potentially inform the impact evaluation, but the sample size was too small to provide meaningful findings and this data has therefore not been included in the analysis provided.

[4] A BMI z-score (zBMI) indicates how many units of the standard deviation a child is above or below the average BMI for their age group and sex. BMI z-scores are considered a more appropriate measure to assess changes in a child's BMI as it accounts for age and sex. For this reason, children's individual BMI scores were converted into a BMI z-score for this evaluation.

- Parents reported a small increase in the mean number of daily serves of fruit eaten by children from 2.03 serves to 2.31 serves – a mean increase of 0.29 serves of fruit a day. The change in mean daily serves of fruit eaten ranged from -1 to 1.8 for individual children.
- Parents also reported a small increase in the mean number of daily serves of vegetables eaten by children from 1.14 serves at the start of the program to 1.34 serves at the end of the program – a mean increase of 0.21 daily serves. The change in mean daily serves of vegetables eaten ranged from 0 to 0.8 mean daily serves for individual children.

- There were modest improvements in children's physical activity levels.
  - At the end of the program parents reported that on average children increased the average number of days that they were physically active on weekdays (outside of school hours) from 2.7 days to 3.9 days.
  - Parents reported that children were being physically active for an additional 30 minutes a week (on average) on weekdays, compared to the start of the program – an average increase from 3 hours 48 minutes a week to 4 hours 18 minutes a week.
  - Parents reported that 80% of children were usually physically active on Saturday and Sunday over the weekend, compared to 50% of children at the start of the program. This equated to an additional 40-45 minutes (on average) of physically active on weekends.
  - Commonly reported types of physical activity children took part in were soccer, swimming, cycling, football and handball.
  - A reduction in average daily time spent on screen-based sedentary activity for entertainment was reported. However, as only eight families provided data for this outcome measure this finding should be interpreted with caution.

- Overall, there were small improvements in *weight-related problem behaviours* in children and parental *confidence* in dealing with these behaviours.
  - There was a reduction in scores for *weight-related problem behaviours* in children from a mean score of 114.2 at the start of the program to a mean score of 85.4 at the end of the program – a mean difference of -28.8. However, this improvement was not clinically significant based on clinical cut-off points developed for the *Lifestyle Triple P®* questionnaires by West & Sanders (2012)[5].
  - There was a small increase in parent's scores for degree of *confidence* in dealing with children's problem behaviours from a mean score of 129.1 at the start of the program to a mean score of 190.9 at the end of the program – a mean difference of 61.7. Again, this improvement was not clinically significant[6].

- The Strengths and Difficulties Questionnaire, which measures characteristics of children's behaviours such as *emotional symptoms, conduct problems, hyperactivity, peer problems* and *prosocial behaviour*, found a small reduction in the Total Difficulties mean score from 12.91 at the start of the program to 11.27 at the end of the program – a mean difference of -1.64. This reduction was not clinically significant[7].
- Overall, there was a small improvement in parent's *laxness* ('permissive, inconsistent discipline'), but no change in parenting practices regarding *over-reactivity* ('harsh, emotional, authoritarian discipline') and *hostility* ('use of verbal or physical force').

[5] Scores over 50 indicate clinical concern for *weight-related problem behaviours*.

[6] Scores below 204 indicate clinical concern for *confidence.*

[7] A total difficultly score of 17 or above indicates clinical concern.

- There was a decrease in scores for *laxness* from a mean score of 3.8 before the program to a mean score of 3.04 at the end of the program – a difference of -.76. This decrease was clinically significant[8].
- There was an almost negligible reduction in mean scores for *over-reactivity* after the program of -.1. Mean over-reactivity scores were within normal limits (less than 4.0) before and after the program (before: 3.54, after: 3.44).
- There was no change in primary caregivers' mean *hostility* scores before the program and at program end, with mean scores constant at 1.97.

[8] *Laxness* scores for primary caregivers of 3.6 or above indicate clinical concern.

# 4. RECOMMENDATIONS

The recommendations stemming from the evaluation findings are set out below.

## 4.1 *LIFESTYLE TRIPLE P®* SPECIFIC RECOMMENDATIONS

1. Should *Lifestyle Triple P®* be implemented in the ACT:

   1.1 additional assistance would need to be made available to meet the needs of participants from vulnerable families with complex needs or low literacy levels. These supports may include ongoing support by facilitators, referral to services to address emerging acute family issues and/or flexibility to provide the program one-on-one in the family home.

   1.2 where possible, initial (as well as follow up) assessments with families should be conducted by a program facilitator to allow for rapport and trust to be built and for facilitators to better target the program to meet participant needs (as identified through the assessments). This must be balanced with data quality control issues.

   1.3 program resources should be reviewed in light of pilot participant and facilitator feedback to:

   - add an A4 food plate (which has replaced the 'food pyramid') for parents to use with their children and for colouring in;
   - include recipes for families on a budget and for large families;
   - include recipe cards for participants to complete with a "tried and tested" recipes to be shared with the group;
   - add more cooking activities for children; and
   - be responsive to small group participant needs.

## 4.2 BROAD RECOMMENDATIONS FOR FUTURE INTERVENTIONS TARGETING PARENTS OF OVERWEIGHT AND OBESE CHILDREN

2. In terms of promotion and referral:

   2.1 Future interventions should consider how to optimise recruitment, noting that:

   - parents are more likely to participate if they already recognise that their child has a health issue and are already engaged with the health care system; and
   - health professional referrals, email advertisements and community information sessions at public libraries can be effective recruitment avenues.

   2.2 Further work is needed to address the various issues impacting on families seeking and participating in programs, which include:

   - parents being unable or unwilling to recognise overweight or obesity in children, including parental perceptions of 'natural puppy fat' and of children 'growing out' of being overweight; and
   - the stigma associated with obesity and weight gain issues.

   2.3 Further work is needed to increase the confidence and skills of health professionals to discuss weight issues with clients and make referrals to programs such as *Lifestyle Triple P®*.

2.4 Promotional strategies for future interventions should aim to balance the need to combat stigma felt by many parents in seeking help (e.g. by using positive language as well as personal success stories or testimonials) whilst still ensuring that the program reaches the target group and is not seen as a mainstream program for fussy eaters.

2.5 Future interventions should consider accessing families, especially vulnerable families, through existing community groups or settings rather than expecting families to refer themselves to new and intensive programs.

3. In terms of <u>content</u>:

3.1 Future interventions should include an element of parent interaction and sharing of experiences, where possible, given the benefits this provided participants of the *Lifestyle Triple P®* pilot.

3.2 Future interventions should be informed by, and provide strategies to combat, the barriers to making healthy changes reported by pilot participants, including:

- child opposition to healthy eating changes, including behavioural issues;
- issues around portion control and children stealing food;
- partners/family members not being on board with the messages or not acknowledging their child has a weight problem;
- lack of information about and/or referrals to post-program supports;
- family size – it being hard to please everyone with meals in a large family; and
- lack of time in relation to increasing physical activity.

Strategies to overcome many of these barriers are covered by the *Lifestyle Triple P®* content.

3.3 Future interventions should provide opportunities for parents to influence program content, where applicable – as was the case in this pilot.

3.4 Future interventions should aim to cover basic nutrition information as well as provide strategies for dealing with high risk eating times and unhealthy eating behaviours. Further, as was the case in this pilot, strategies should be informed by a strengths based approach – drawing on children's positive behaviours and traits rather than responding solely to children's negative behaviours.

3.5 Based on pilot participant feedback, future interventions should consider including:

- healthy food tasting or practical cooking activities; and
- child participation, either as part of the intervention or through activities run alongside the parent sessions (e.g. cooking or exercise groups).

3.6 In developing and implementing future interventions, further consideration should be given to the role of building parenting skills – particularly whether providing assistance with effective ways to be consistent, and in setting and enforcing (where necessary) appropriate boundaries, will help with child weight management.

4. In terms of <u>scheduling</u>, the timing and delivery of future interventions should be informed by suggestions from pilot participants, which include to:

- avoid running programs during school holidays to assist attendance;
- offer makeup sessions for participants who miss a session;
- offer intensive delivery options to reduce the length of the program;
- provide child minding options on site, where feasible; and
- assign time to assist participants to identify how best to achieve homework, if relevant.

5. In terms of groups:

   5.1 Future interventions should aim for optimal group sizes (possibly 5-8 participants), noting that larger groups may impact on the capacity to cover content, tailor the program to individual needs and ensure equal participation, and smaller groups may make sharing between participants uncomfortable.

   5.2 Future interventions should allow for flexibility in content delivery so that facilitators can tailor the content pace and flow to meet participants' needs. In addition, facilitators should strive to ensure presentation material is engaging for participants. This recommendation follows the principles of good teaching practice.

   5.3 Future interventions should ensure that the venue is child-friendly and welcoming for participants, and that facilitators are supportive and approachable – as was the case in this pilot.

   5.4 Future interventions should ensure that facilitators are confident and supported to deliver program material, noting that co-facilitation or access to a mentor can assist with this.

6. In terms of post-program support, future interventions should ensure that participants are provided information on and/or avenues for support post-program, with consideration given to the establishment of post-program support groups.

7. In terms of special needs:

   7.1 Future interventions targeting vulnerable families should avoid characteristics of *Lifestyle Triple P®* found to adversely impact on the ability of such families to benefit from and/or complete the pilot – including:

   - the intensity of the program and commitment required;
   - the resources being inappropriate for participants with low literacy skills, including those for whom English is their second language, without time consuming modification and explanation from facilitators; and
   - the program's one-size-fits all approach.

   7.2 Consideration should be given to the need for specific supports for parents of children with disabilities who are overweight or obese.

# 5. CONCLUSION

In summary, the program did not achieve its anticipated reach in terms of participant numbers, nor did it, in its original format, meet the needs of the most disadvantaged/vulnerable families involved. Those who completed the program were, however, satisfied with the program and reported benefiting from it in various ways. It also led to generally small improvements in most of the impact evaluation indicators; yet, these impacts are difficult to substantiate due to the small sample size and it is not possible to meaningfully review impacts six months post-program, as had originally been envisaged. Due to these limitations, it is not possible to assess the cost-effectiveness of the program.

The recommendations stemming from this evaluation are informing the development and implementation of alternative health promotion interventions for families within the ACT Healthy Children's Initiative – coordinated by HIB – including the current *Healthy Families, Healthy Kids* program. By sharing these evaluation outcomes with other agencies and service providers, the findings can also inform future primary care initiatives aimed at supporting vulnerable ACT families with overweight or obese children.

It is important to note that this evaluation also raised issues about the sensitivity of discussing weight with families, as well as the community attitudes and depth of knowledge individuals have about parenting and healthy lifestyles more generally in the ACT. Such issues have significant implications for the recruitment and retention of participants and ultimately the successful implementation of any program addressing childhood overweight and obesity. Within this context, it would seem that the most pressing task for informing the way forward is to explore how interventions may meaningfully source and engage families that need support without creating shame or stigma.

# REFERENCES

Child and Adolescent Community Health (CACH) (2011). *Lifestyle Triple P: Key findings WA Community Health Pilot 2010.* Department of Health WA

West F (2007). *Lifestyle Triple P: Helping Parents Raise Healthy Children*, The University of Queensland

West F & Sanders M R (ed.) (2012). *Facilitator's Manual for Group Lifestyle Triple P*. Triple P International, Milton QLD

# ACCESSIBILITY

The ACT Government is committed to making its information, services, events and venues as accessible as possible.

If you have difficulty reading a standard printed document and would like to receive this publication in an alternative format such as large print, please phone 13 22 81 or email HealthACT@act.gov.au.

If English is not your first language and you require the Translating and Interpreting Service (TIS), please call 13 14 50.

If you are Deaf, or have a speech or hearing impairment and need the teletypewriter service, please phone 13 36 77 and ask for 13 22 81.

For speak and listen users, please phone 1300 555 727 and ask for 13 22 81. For more information on these services visit http://www.relayservice.com.au.



Enquiries about this publication should be directed to ACT Government Health Directorate, Communications and Marketing Unit, GPO Box 825 Canberra City ACT 2601 or email: HealthACT@act.gov.au

www.health.act.gov.au | www.act.gov.au
Enquiries: Canberra 13ACT1 or 132281