

# 'Getting Through the Day': An evaluation

Sure Start Annual Conference 2009

Kirsten Bland  
Clinical Psychologist  
NHS Lothian

# Outline

- Introducing 'Getting Through the Day'
- Why carry out an evaluation?
- Method
- Results
- Implications
- Reflections on conducting research within a community setting

# Introducing 'Getting Through the Day'

- Developed by John Rogers
- Foundation within attachment theory
- Delivered over 8-10 sessions
- Content includes:
  - Communication
  - Encouragement
  - Co-operation
  - Conflict strategies and behaviour management

# GTTD aims

- To promote parental self-efficacy and confidence in managing child behaviour
- To assist parents in becoming more child-centred
- Encourage play and listening skills
- Promote problem-solving

# Role of Parental Self-Efficacy

- Defined as the “extent to which a parent believes that they will competently perform the parental role” (Teti & Gelfand, 1991)
- Direct link between PSE and parenting behaviours (Weaver *et al.*, 2008) and negative child developmental outcomes (Coleman & Karraker, 2003)
- Complex mediating relationship with maternal depression (Weaver *et al.*, 2008)

# Evaluation

- Widespread West Lothian delivery:
  - Sure Start
  - Children and Young People Team
- Positive feedback from facilitators, parents and referrers but limited empirical support
- Emphasis from policy on evidence-based practice *e.g. Early Years and Early Intervention (2008), Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care.*

# Study design

- Hypotheses:
  - GTTD participants will show significant change as compared with control group participants across domains of:
    - parental self-efficacy,
    - parental mental health and wellbeing,
    - child behaviour

# Study design

- Control groups:
  - Original protocol included group control group and clinical waiting list control group
  - Final design included waiting list control group and 'healthy' school control group

# Study design

- Pre- and post-intervention questionnaire based assessments
- 10 GTTD groups ran between March-July 2009, composed of a total of 54 mothers
- Healthy controls recruited from 2 local schools – 340 initial evaluation packs distributed to parents

# Method

| <u>Area of Interest</u>              | <u>Measures</u>   |
|--------------------------------------|---|
| Parental Self-Efficacy               | Tool to Measure Parenting Self-Efficacy (TOPSE)<br>(Kendall & Bloomfield, 2005) |
| Parental Mental Health and Wellbeing | Hospital Anxiety and Depression Scale (HADS)<br>(Zigmond & Snaith, 1983)        |
|                                      | Parenting Stress Index (PSI-SF)<br>(Abidin, 1995)                               |
| Child Behaviour                      | Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1994)                  |

# Sample demographics

|                                   | <u>Intervention group</u> | <u>Healthy control group</u> |
|-----------------------------------|---------------------------|------------------------------|
| Child gender (% male)             | 55%                       | 32%                          |
| Mean child age (months)           | 54.43                     | 84.29                        |
| Mean mother age (years)           | 30.06                     | 37.59                        |
| Percentage single parent families | 37%                       | 21%                          |

# Sample numbers

|                  | <u>Intervention<br/>Group</u> | <u>Healthy<br/>Control<br/>Group</u> |
|------------------|-------------------------------|--------------------------------------|
| <u>Initial</u>   | 51                            | 34                                   |
| <u>Follow-up</u> | 24                            | 26                                   |

# Key results

- Significant improvement in GTTD participants as compared with controls in:
  - Parental Self-Efficacy (group\*time  $F(1)=9.930$ ,  $p<0.005$ )
  - Parental Depression (group\*time  $F(1)=7.303$ ,  $p<0.05$ ) and Parental Anxiety (group\*time  $F(1)=6.748$ ,  $p<0.05$ )  
with anxiety scores moving from clinical to non-clinical range
  - Parental Distress (group\*time  $F(1)=8.021$ ,  $p<0.05$ )
- Significance maintained even when discrepancies in baseline scores controlled for as a potential covariate

# Further results

- Child behaviour scores (as measured by SDQ) within the GTTD group also moved from clinical significance to non-clinical range
- However, significant improvements in child behaviour within GTTD group compared to control were no longer significant when initial score discrepancies taken into account

# Limitations

- Control groups
- Long term follow-up
- Engagement and retention (31% GTTD drop out)
- Mechanisms of change

# Implications

- Financially viable, community-based resource
- Significant impact upon parental factors with longer term impact upon parent and child still to be explored
- Tiers of parenting intervention resources for vulnerable families

# Research reflections

## ■ Challenges

- Engaging vulnerable parents (and facilitators!)
- Minimising impact upon programme delivery
- Selecting appropriate measures and design
- Establishing and maintaining culture of evaluation and research

## ■ Benefits

- Concrete outcomes for parents, facilitators and funding bodies
- Enhanced ability to tailor effective interventions for those families who need them
- Establish GTTD within parenting programmes forum

Many thanks for your time!

[kirsten.bland@nhslothian.scot.nhs.uk](mailto:kirsten.bland@nhslothian.scot.nhs.uk)