Title	Barriers and facilitators to the implementation of a community-based, multidisciplinary, family focused childhood weight management programme in Ireland: a qualitative study
Authors	Kelleher, Emily;Harrington, Janas M.;Shiely, Frances;Perry, Ivan J.;McHugh, Sheena M.
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University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Supplementary Material 1: Completed TIDieR checklist

The TIDieR (Template for Intervention Description and Replication) Checklist

Information to include when describing an intervention and the location of the information

Item number	Item	
	BRIEF NAME	
1.	Provide the name or a phrase that describes the intervention.	*'W82GO-community'* – a multi-component, family-focused childhood weight management pilot programme delivered in the community setting.
	WHY	
2.	Describe any rationale, theory, or goal of the elements essential to the intervention.	The *W82GO-community* programme is a family-focused programme grounded in behavioural change theory (transtheoretical model and social cognitive theory) and aims to reduce obesity in children with BMI ≥98th percentile, improve children's dietary intake, physical activity levels and weight status while also increasing children's quality of life and psychosocial health. During initial assessments the families' attitudes and behaviours related to health promotion are identified and specific and achievable goals are set. In attaining these goals, a number of sub-behaviours are promoted including self-efficacy, self-monitoring and self-management. At every stage of the process the team aims to empower the family to recognise and make the necessary changes to bring about positive lifestyle changes and motivate them to maintain these changes.

	WHAT	
3.	Materials: Describe any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers. Provide information on where the materials can be accessed (e.g. online appendix, URL).	The *W82GO-community* programme includes: (1) The *W82GO-community* pilot programme was delivered by a multi-disciplinary team using a manual developed to support community-based healthcare professionals to deliver the programme in their area. It does so through the provision of a guide to setting up a team and preparing the delivery of the programme; a framework for individual sessions that allows for session preparation and planning including programme presentations on disc; materials, including template letters and evaluation forms that can be adapted to suit the local context and information on additional resources that are available to support the team (2) W82GO leaflet outlining the programmes goals and core elements to be distributed to families during recruitment (3) W82GO family information booklet including goal setting and additional resources and tips were distributed to all families attending the programme
4.	Procedures: Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.	Recruitment: heights and weights were measured in school by public health nurses (PHNs) using standardised procedures. Weight and height data was subsequently used to calculate body mass index (BMI) and children were classified as obese if their BMI plotted ≥98th BMI percentile for age and gender using the UK90 recommended cut-off points for treatment or referral which are currently used in Irish practice. Parents of children meeting this eligibility criterion were contacted by their school PHN to inform them of their child's weight status and those who indicated an interest in attending the

		programme were subsequently invited to attend an initial screening assessment. This individualised initial assessment assessed eligibility before programme commencement. This assessment was carried out by a multidisciplinary team to rule out underlying medical conditions. In addition, indicators of health literacy, health beliefs and physical and environmental variables that might act as barriers to change were recorded. Following the initial assessment six group sessions took places over six weeks and group booster sessions occurred at three, six and nine months. During these group sessions parents and their children received an educational session for the first hour. Children were taken out to complete physical activity for the last 30 minutes while parents received an extra educational session. At 12 months another individualised final assessment took place to document any changes and make plans for sustainment.
	WHO PROVIDED	
5.	For each category of intervention provider (e.g. psychologist, nursing assistant), describe their expertise, background and any specific training given.	The W82GO community-programme was delivered by a multidisciplinary team of community health professionals including dietitians, physiotherapists, public health nurses, psychologists, health promotion officers, area medical officers, administrators and local area management. These health professionals had varying levels of experience of dealing with childhood obesity and as a result were invited to take part in a training programme prior to programme commencement. Training included a needs assessment, a one day educational training course and two days of clinical shadowing with an experienced *W82GO* programme practitioner at Temple Street Children's University Hospital in

		Dublin, Ireland. Each community practitioner was also supplied with a user manual which outlined the programme and detailed the content for both phases. Public health nurses in one of the sites received motivational interviewing training specific to childhood obesity as part of routine training in the area already being conducted in that area.
	HOW	
6.	Describe the modes of delivery (e.g. face-to-face or by some other mechanism, such as internet or telephone) of the intervention and whether it was provided individually or in a group.	The W82GO-community programme involved face-to-face sessions and included a mixture of group and individualised sessions as outlined above.
	WHERE	
7.	Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.	Initial assessments took place in community healthcare offices. Subsequent group sessions were delivered on weekdays in the afternoon at a local sports or community centre.
	WHEN and HOW MUCH	
8.	Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity or dose.	The programme was run in two sites (Site A and Site B) over 12 months. The individual assessment lasted approximately one and half to two hours. The initial intensive phase consisted of 6 weekly group sessions for both the child and his/her parent/carer and these occurred over one afternoon a week and lasted approximately one and a half to two hours. The three booster sessions at three, six and nine months lasted approximately one to one and a half hours. During these group sessions parents and their children received an educational session for the first hour. Children were taken out to complete physical activity

		for the last 30 minutes while parents received an extra educational session. Upon completion of the 12 month programme children and their parents/carer return for a final assessment lasting approx. one and half to two hours. This model of implementation is in keeping with the transtheoretical model of behaviour change.
	TAILORING	
9.	If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when, and how.	All families received the same intervention.
	MODIFICATIONS	
10.‡	If the intervention was modified during the course of the study, describe the changes (what, why, when, and how).	Two sites delivered the pilot programme to their respective communities. Site A decided to separate children and parents from the start of the group sessions because they felt children of this age would not gain anything nor were likely to understand the educational sessions. Children received a full physical activity session instead while parents received the educational session alone. Owing to low numbers attending the programme in Site B programme staff chose not to go ahead with the final assessment at 12 months and instead conducted the final assessments during the third booster session.
	HOW WELL	
11.	Planned: If intervention adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them.	Fidelity of intervention delivery was assessed using trainer self-reports and exit interviews.
12.‡	Actual: If intervention adherence or fidelity was assessed, describe the extent to which the intervention was delivered as planned.	In Site A, the programme was delivered in a more interactive manner (i.e. without the use of programme slides). Site B followed the manuals as planned.

** **Authors** - use N/A if an item is not applicable for the intervention being described. **Reviewers** – use '?' if information about the element is not reported/not sufficiently reported.

† If the information is not provided in the primary paper, give details of where this information is available. This may include locations such as a published protocol or other published papers (provide citation details) or a website (provide the URL).

‡ If completing the TIDieR checklist for a protocol, these items are not relevant to the protocol and cannot be described until the study is complete.

* We strongly recommend using this checklist in conjunction with the TIDieR guide (see *BMJ* 2014;348:g1687) which contains an explanation and elaboration for each item.

* The focus of TIDieR is on reporting details of the intervention elements (and where relevant, comparison elements) of a study. Other elements and methodological features of studies are covered by other reporting statements and checklists and have not been duplicated as part of the TIDieR checklist. When a **randomised trial** is being reported, the TIDieR checklist should be used in conjunction with the CONSORT statement (see www.consort-statement.org) as an extension of **Item 5 of the CONSORT 2010 Statement.** When a **clinical trial protocol** is being reported, the TIDieR checklist should be used in conjunction with the SPIRIT statement as an extension of **Item 11 of the SPIRIT 2013 Statement** (see www.spirit-statement.org). For alternate study designs, TIDieR can be used in conjunction with the appropriate checklist for that study design (see www.equator-network.org).