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Systematic Braiding of Two Evidence-Based Parent Training Programs: Qualitative Results from the Pilot Phase

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Abstract

An effective approach in early intervention for children and families, including child maltreatment prevention, is home-based services. Though several evidence-based programs exist, they are often grouped together, despite having different foci. This paper describes an ongoing cluster randomized trial systematically braiding two evidence-based home-based models, SafeCare[®] and Parents as Teachers (PAT)[®], to better meet the needs of families at-risk. We describe the methodology for braiding model implementation and curriculum, specifically focusing on how structured qualitative feedback from pilot families and providers was used to create the braided curriculum and implementation. Systematic braiding of two models at the implementation and curriculum levels is a mechanism that has the potential to meet the more comprehensive needs of families at-risk for maltreatment.

Keywords

home-based services; evidence-based practice; SafeCare; Parents as Teachers

Early intervention in the home creates the opportunity for enhanced child outcomes and improves general family outcomes.^{1–3} There has been a movement towards the exclusive use of evidence-based models delivered in the home; that is, practices rooted in scientific outcomes and found effective in rigorous research efforts.^{4,5} Large-scale trials of these evidence-based models have reported mixed outcomes^{6,7}; home-based services, determined to be an effective prevention strategy, have received substantial funding allocated from the Affordable Care Act.⁸ Despite increased funds, agencies often select only one model most in line with the needs of the families they will serve from the array of available models. Agencies may have providers trained in multiple models, but ultimately choose to deliver one model to the family at a time. Thus, model developers and researchers are challenged with assisting agencies and providing guidance on how to best choose and implement models despite the wide array of options available and wide range of family needs. One strategy used primarily in child mental health services is referred to as the *common elements* approach. Providers are trained on individual treatment components and then pick which components to deliver to a client.⁹ However, it is not known if the common elements approach can yield the same magnitude of results as a manualized evidence-based program.¹⁰ Another strategy to consider is “braiding” models together. That is, combining

two home-based models with complementary foci to increase the relevance of these models to particular families.

The purpose of this paper is to present data from the pilot phase of a cluster randomized trial that systematically braided two evidence-based home-based parenting models, SafeCare[®] and Parents as Teachers[®] (PAT). We hypothesized that braiding would create a new curriculum to more comprehensively address multiple needs of families, thus, enhancing child and family outcomes. To our knowledge, this was the first systematic braiding of two evidence-based home-based models though in practice, providers commonly deliver different models to different families or multiple models to the same family sequentially.¹¹ Our experience braiding these two curricula documented here provide lessons for others who may wish to conduct this kind of work.

Evidence-based practices in the prevention of child maltreatment

Home-based parent support programs have been used to impact multiple child and family outcomes, and are recognized for promoting children's social, emotional, and cognitive development, as well as for preventing child maltreatment.^{6, 12} Delivering services in the home eliminates the need for parents to arrange transportation or child care for clinic visits, but also allows for individualized service delivery.⁶ Service delivery in the natural environment, such as the home, is also more likely to lead to skill generalization.² The multitude of home-based models address the needs of at-risk families in different ways: child-focused or parent focused; differing child ages at entry into the program; or primary or secondary prevention focused. This project braided two of these home-based models, SafeCare and Parents as Teachers.

SafeCare[®]

SafeCare is an evidence-based behavioral parenting model for families at-risk or reported for child maltreatment with children ages 0–5 years old. Home visitors provide skills training in three modules: parent-child/infant interactions, child health, and home safety.^{13,14} The duration of the weekly visits is typically 60–90 minutes over the course of approximately 18 sessions (3 modules, 6 sessions per module); number of sessions per family is dictated by mastery of trained skills. Each module consists of a baseline assessment, several training sessions, and an end-of-module assessment to evaluate mastery of module skills. The home visitor first explains and models the desired behaviors, and then asks the parent to practice engaging in the behaviors through role-play or scenarios, followed by positive and constructive feedback.

SafeCare has been shown in research trials to improve parenting behaviors and reducing rates of recidivism in child welfare populations, including child neglect.¹⁴ In a recent state-wide randomized trial with a seven-year follow-up, SafeCare was found to significantly reduce recidivism of child maltreatment reports to Child Protective Services compared to home-based services that did not utilize the SafeCare modules.¹⁵ The unique aspects of the SafeCare model are the short duration of 'touch' a provider has with a client, the focus on reducing risk for neglect, and sessions directed at modifying parenting behaviors. Additionally, SafeCare notably uses intensive coaching following workshop training;

sessions are reviewed by a coach to ensure fidelity to the model and the coach serves as support to home visitors.

Parents as Teachers

Parents as Teachers (PAT) is an evidence-based model focused on parent-child interaction, development-centered parenting, and family well-being through: personal home visits; group connections; developmental, health, hearing and vision screenings; and resource networks.¹⁶ PAT serves families for at least two years beginning at pregnancy through the kindergarten year. PAT affiliate programs select the target population they plan to serve and the program duration. Affiliates may choose to focus services primarily on pregnant women and families with children from birth to age three; others may offer services from pregnancy through the kindergarten year. Enrollment typically is voluntary. Numerous studies have provided evidence of the program's positive effect on both child and parent outcomes relevant to children's school readiness.¹⁷ In contrast to SafeCare, the PAT approach has the potential for long-term involvement of a parent educator in a family's life – the educator is able to serve multiple children within a home and, thus, may be with the family until all children are over five years old. Additionally, the sessions are targeted at child outcomes of development and school readiness.

Current Project

Considering the barriers to implementation and constrained funding, there is a burgeoning movement to purposefully combine evidence-based practices to optimize resources to address families' needs. The current project, Parents as Teachers and SafeCare at Home (PATSCH), braided the implementation strategies and the curricula of SafeCare and PAT in a systematic manner and evaluated the effect on family outcomes. Specifically, we hypothesize that families who receive the PATSCH curriculum compared to PAT only will have: 1) lower risk of child maltreatment; 2) improved parenting outcomes; and, 3) improved child development and school readiness. In this article, we trace the phases of the braided implementation and curriculum development, from the initial method and development of the braided program to pilot testing to subsequent modifications and the final implementation strategy. The implications for this kind of research, including the potential outcomes gained, are also discussed.

Phases of PATSCH Development

The development of PATSCH occurred in non-linear phases¹⁵, depicted in Figure 1. The project was approved by the Georgia State University Institutional Review Board.

Phase 1: Initial Braided Presentation

Method—The initial idea for the project was a collaborative effort between a PAT State Leader and the developer of SafeCare, with the driving force being to more comprehensively meet the needs of the families routinely served by Parents as Teachers. Because this work brought together models with similar goals (e.g., to improve family outcomes through home-based sessions) that use different approaches (e.g., family-focused for a short-term number

of sessions vs. parent-child interaction focused serving multiple children in the home over many years), the first step in the collaborative process was to understand the intricacies of each model to determine what needed to remain intact from each model in the resulting effort. It was at this point the research team decided upon the term ‘braided,’ in contrast to blended or integrated. “Braided” best described the overall approach to this project; in a braid individual components are easily identified, but at specific places they overlap; a metaphor that guided the development process.

Two PATSCH project coordinators were trained in both curricula such that they would be capable of delivering the programs but did not attempt certification. PAT training was delivered by a National Trainer in primarily a didactic format over the course of 3 days to a group of more than 25 trainees with varying levels of experience. SafeCare training was delivered over the course of four days by a National SafeCare Training and Research Center Training Specialist following the explain, model, practice and feedback loop specified by the curriculum to a group of six trainees with varying levels of experience.^{11, 12} Following training, the PATSCH project coordinators outlined the specified goals of each program with the intent to identify places of overlap and gaps in each curriculum.

Concurrently, the research team met with potential sites already implementing PAT for a pre-implementation, recruitment-oriented meeting. At this meeting, the rationale and proposed implementation schema were introduced to six site supervisors and five parent educators; a convenience sample recruited by the PAT State Leader of Georgia.

Results—The overwhelming response from the 11 meeting attendees was concern over the number of sessions (18 SafeCare sessions) to be added on top of their already demanding caseload. The supervisors recognized the need for the additional content areas that SafeCare supplied in this braided program, specifically the health and safety modules, but perceived the added workload to be a serious barrier. Following this meeting, three of the initial six sites invited to the pre-implementation meeting remained interested in participating in the pilot study. The research team recognized the concerns expressed by the parent educators at this meeting and were responsive to their concerns in the next phase.

Phase 2: Braided Curriculum Development

Method—Phase 1 functioned as an impromptu focus group. If SafeCare was to be braided into the PAT curriculum, the SafeCare curriculum structure would have to be modified. In typical implementation, four of the six SafeCare sessions are focused on training to maximize the opportunities for parents to attain mastery of the trained skills. For this project, we believed that the existing relationships and rapport between parent and parent educators would support the reduction in the number of training sessions while maintaining the integrity of the SafeCare module content. The new condensed curriculum, now referred to as PATSCH, was also translated into Spanish.

Results—The SafeCare research staff addressed the concerns of the parent educators in the pre-implementation meeting by reducing the number of module sessions from six to four. The duration of the sessions was assumed to be slightly increased, but the overall time

commitment of providers and families was reduced. We believed this would address the concern of the demanding workload of parent educators that emerged from Phase 1.

Phase 3: Pilot

Method—A cohort of four pilot sites (the three sites that remained interested from Phase 1 and an additional PAT site that approached SafeCare for training) were randomized to receive training to implement PATSCH or to continue PAT services as usual. The two sites randomized to the PATSCH condition received SafeCare training at the National SafeCare Training and Research Center from two Training Specialists and the Associate Director for Training. The training was conducted as if the providers were to deliver the four session PATSCH curriculum without explicit instructions or suggestions for how to braid this curriculum with the PAT curriculum. We assumed that the parent educators would braid content on their own, and that they would easily see the way the two curricula were complementary. Following training, parent educators were assigned one module to implement with one of their existing families. As the modules can be delivered in any order, this assignment allowed the research team to evaluate each module concurrently. Additionally, bilingual parent educators and families participated in the pilot project to evaluate the translated materials.

It took an average of five weeks for parent educators to complete all four sessions with their respective families. When the family assigned to receive the Parent-Infant Interaction module dropped out of the PAT program, we asked another parent educator to provide this module to her family that had already completed the health module in the pilot phase. Following completion of all pilot modules, the participating families, parent educators and one site supervisor were interviewed individually by the two project coordinators. A graduate research assistant served as the translator for the bilingual interviews and subsequently translated the interviews into English.

Results—Parent educators implemented only one of the braided modules in the pilot phase with a previously enrolled PAT family. The research team had no input in the selection of the pilot families. The qualitative results of this phase are discussed by module.

Child Health and Parent-Infant Interaction: The mother who completed both the child health and parent-infant interaction modules during the pilot phase had two children, a 2-year-old son and a 7-month-old daughter. The parent educator had been visiting the family since the mother was pregnant with her first child, just shy of three years.

In the Health module, the parent received a comprehensive symptom and illness guide in addition to learning steps to decide the best course of treatment for her sick child (care at home, call the doctor, or go to the emergency department). The pilot mother spoke about her use of this material: *“Like, my baby had I think the diarrhea, and I didn’t really know what to do so I looked over the book and it kinda helped me out... I was home alone and I didn’t know what to do... the book helped me out.”* She said that she kept the health materials next to her bed so she knew where they were whenever one of her children should become injured or ill. In her individual interview, the parent educator shared: *“When I would tell her what we were going to do, she’d be like page 44. She already knew the page!”* When asked

about the value of the Health module, the parent educator noted: *“Most of my families will go to the emergency room; they will not go to the doctor’s office.”* She felt that this resource would encourage parents to schedule medical appointments instead of only utilizing the emergency department.

The focus of the Parent-Infant Interaction module is to increase positive interactions between parent and infant through the use of core bonding behaviors including looking, talking, touching, and smiling. Parents are also provided materials related to typical development and age-appropriate activities. The pilot mother spoke about her favorite part of the module: *“It helped me play with [my daughter] more. I liked that one. My favorite new activity was the babblin’ – trying to copy her sounds. I really couldn’t do it at first.”* The parent educator added: *“She is extremely shy, I could never get her to do patty cake with the baby [in front of me]. But, during this module I heard her singing with the baby, and I mentioned it to her. I’ve heard her do it since then, too.”*

Home Safety: The Home Safety module teaches parents to identify and eliminate hazards in the home. The pilot mother, bilingual in Spanish and English, who completed the Safety module had three children between 4 and 12 years old. She had received services from the same parent educator since her second child was born more than nine years earlier. When prompted to share her thoughts on the Home Safety module, the mother said:

It’s a big help for me because sometimes one doesn’t always detect like for example the hazards that are here at home. You just think ‘Oh it looks good there,’ but you don’t know that it’s a hazard for the child. With the [parent educator’s] help and the manual that was provided and the sheets, I began to guide myself to remove all the hazards that I had here in the home.

This parent expressed pride in how she removed hazards in the room and showed the interviewer how she moved the knives on top of the refrigerator so that her children could not reach them: *“Here in the kitchen I had my knife right there. In that countertop. I had them there. The teacher told me that I shouldn’t have sharp items there because the child [could] hurt or cut himself. So we decided to move it to the top.”* She walked through all of the different changes she made in her kitchen during the interview, clearly prideful in the work she did to make her home safe for her children. She did not express concern about the duration of the visits, repetition or the added sessions with her parent educator. In fact, this mother tried to recruit other mothers from her community into the project so they could be exposed to the safety module: *“I told her to do this program with me... I told her that she couldn’t keep those liquids down there... I told her that is dangerous because her kids might think that, if they see the colors they might think that its juice and they could drink it.”* When the interviewers brought this up with the parent educator, she expressed pride about the parent and said that because of this parent in particular she had recently added four new parents to her caseload.

Parent-Child Interaction: The focus of the Parent-Child Interaction module is to teach parents to provide developmentally appropriate and stimulating activities, increase positive interactions, and prevent challenging child behaviors. The mother who received the Parent-Child Interaction module in this pilot phase had three daughters and was pregnant with her

fourth child. She had been involved with PAT for five years and received visits weekly, but sometimes more depending on her needs. For PATSCH sessions, the mother commented that the parent educator was well prepared and did not have any concerns going through this different content because they had been working together for so long. She did say that the sessions were long and repetitive (e.g., practicing skills multiple times in one session); there was little new information from one session to the next and everyone, especially the children, became bored and lost interest. This mother spoke Spanish and was asked to comment on the translated materials. She did not identify any issues with the translation, indicated it was easy to understand, but suggested that new materials and activities should be given out at every session.

The parent educator who provided the Parent-Child Interaction module to this Spanish-speaking mother had been serving families at various agencies for approximately nine years at the time of the interview. This parent educator did not like that the sessions were so repetitive and that the parent was not allowed to direct what would be covered in a session, a stark difference from typical PAT implementation. She suggested that PATSCH might be better for families who were not “*as deep*” into the PAT program: “*She has been working with us for so long, so she was too far into the program in the things that we do.*” The skills repeated in training sessions covered content the parent educator believed she had addressed with this mother in PAT alone.

Additionally this interview uncovered two implementation issues: (1) a discrepancy in terminology between models regarding what age is considered infant versus child which was subsequently addressed in modifications; and, (2) a misunderstanding about the role of the coach. We learned that the parent educator who began delivering the Parent-Infant Interaction module was advised by her coach that she should have been implementing the Parent-Child Interaction module, and as a result started over with the Parent-Child Interaction module. This parent educator’s coach had not provided the level of support expected of a coach (e.g., not being available or proactive in helping the parent educator prepare for implementation). Likewise, coaching was a new level of implementation for the parent educator and it is possible the process was not explained in enough detail during workshop training.

Implementation Comments and Suggestions: The interviews with the parent educators centered upon their suggestions regarding training and implementation of PATSCH. As noted, training occurred over the course of four days at the National SafeCare Training and Research Center offices. Training was focused on providing an overview of the curriculum with the intention of using subsequent coaching to attain mastery. One parent educator commented on the duration of the training: “*I think it was a whole lot of information. Because really by the second day you hit the wall. And I think everyone else honestly did...I don’t know what I would say to do it differently because who wants to be at training for six days, but it is a lot to try and absorb.*” The site supervisor added, with regard to training: “*change always creates some stress right? I keep reminding them that when they first started PAT it was a lot of work and they had to learn, and now it’s a piece of cake.*” It is not uncommon for adult learners to feel the need to be competent immediately following training; however, the design of the SafeCare workshop is to provide foundational

understanding followed by support in the field to build competency. This is now better articulated in trainings.

Related, most parent educators commented on the benefit and importance of the subsequent coaching sessions as a resource for remembering what was covered in training. One parent educator discussed what it was like to practice a session on a coaching call: *"[My coach] is so calm if I miss anything in the book. She's just so calm. You can't help but feel good about things you did wrong. And she'll always be complementing me. And encouraging. And, I like that."* The coaching required for PATSCH certification was a unique component to these seasoned PAT parent educators and one upon which they seemed to not only rely for refreshers, but also enjoyed. Though the coach was providing most of the technical assistance, the supervisor we interviewed expressed interest in receiving some sort of overview, since supervisors did not attend training, so could support her parent educators. This was addressed in the subsequent phase by creating a supervisor specific training.

The initial group of sites approached for this project emphasized their concern about the added workload of PATSCH sessions. A parent educator who was not at the initial meeting had this to say in response to workload: *"I did SafeCare, PAT, then braid. It adds more time, definitely. If you're trying to cover more things. Like I said, we're in the learning stages and we don't breeze right through it....For y'all to expect us to do it all and get it all done, it's hard."* However, later on the same parent educator added, *"[The parents] are learning it and applying it. So we'll see how worth it all this work is."* A parent educator who attended the pre-implementation meeting shared her opinion following training: *"It's amazing how the parents involved with all these topics and say 'Oh wow, I don't know that, can you teach me more, can we do it?'"* She also said that she liked that she is able to give her families the knowledge they need to do what is best for their family without having to ask anyone else. Our research team concluded that though the parent educators confirmed the added workload of PATSCH, they also saw the benefits of their hard work.

In typical PAT delivery, the parent educator utilizes handouts to guide conversation, but the session is not manualized in the way that typical SafeCare is structured. A previous iteration of the PAT curriculum was more manualized, but in its present form it is parent driven and, as such, less scripted. The PATSCH curriculum, on the other hand, provides session outlines to guide the session and assist with fidelity. The transition to the guided approach was a shift for the parent educators. The parent educator who provided the health module had this to say with regard to the materials:

When I was doing the Health manual I had like three books laying out. And, all the little boy had to do was come by and hit the book closed. And, then I was like where in the world am I? And, I didn't want to sound like I was totally lost, because I wanted her to think that I did know what I was talking about. I had to look at all three of these. If it was all... let her keep her three books, but let me just have one so I can go down the line, like an outline.

Early on in implementation it is not uncommon for parent educators to use the session outlines as a script. However, over time, as they become more comfortable with the material, the outlines become more of a resource and less as a script.

Additionally, at this point, the outlines did not provide instructions for braiding or transitioning between the content of the two curricula. The parent educator whose family was to receive the parent-infant interaction module, but dropped out, was successful in completing one braided visit with the family. She shared this: *“I did a braid with the family and it went smoothly. We just went over things and did some activities with the PAT and then transitioned into... actually, I think I melded those things together. Because when we trained in health I was remembering something and would throw that in to the session. I don’t guess there is a right or wrong.”* This parent educator braided the Parent-Infant Interaction module with excerpts from the Health module, not the way in which we had envisioned braiding the sessions. Overall the interviews indicated the need for a clear session outline that included all aspects of implementation.

We were only able to interview one of the two PATSCH site supervisors. This supervisor had proactively contacted the research team about participating in the project, which set her apart from supervisors at other recruited sites. She had researched the SafeCare model because it supplied content in areas the PAT curriculum was, in her opinion, lacking, specifically the child health and home safety modules. She commented: *“[We have to be] responsive to the families we’re serving. And, I was really concerned with the level of risk of the families that we’re serving, and what their risk factors were. And, whether or not if PAT alone had enough teeth to it.”* This supervisor, without prompting, solidified the research team’s belief in this braiding methodology.

Phase 4: Modifications to Braided Curriculum

Method—Based on the feedback from the pilot qualitative interviews, the research team made considerable modifications to the braided implementation and curriculum. The most significant outcome from the pilot phase was the conclusion that the parent educators providing PATSCH wanted and needed more explicit braiding instructions. That is, instead of asking them to simply integrate the material themselves, it needed to be easy for them to see the overlap. Without guidance in braiding during the pilot phase, one parent educator braided the parent-infant interaction module with the health module content; it was evident we needed to be clear what content specifically should be braided and when.

To more effectively implement the braided and consolidated sessions, the research team solicited input from representatives from the National SafeCare Training and Research Center and the PAT National Center through routine conference calls and file sharing. As only the PATSCH project coordinators were trained in both curricula, their job was to balance the integrity of each program while trying to accommodate the modifications necessary as a result of the pilot work. It took several attempts to bring the appropriate “players” to the table; in the end the research staff, SafeCare training staff, PAT curriculum team, and PAT Director of Research had the final input on the braided curriculum.

Results—The braided sessions were set to be the second and fourth visits for each module based upon the amount of content covered in these sessions (see Figure 2). It was thought that the consistency in specifying where and what to braid would alleviate some of the concerns about workload and planning time, but also would provide some assurance for the

parent educators about what to do during each session. The braided components were color-coded in the session outlines and all PAT specific content was accompanied by the PAT logo (see Figure 3). The PAT National Center agreed to allow braided sessions to count toward the required number of sessions delivered to families. As such, the parent educators did not have to schedule PAT-only sessions, instead the research team explicitly integrated the three components of a PAT visit (development centered parenting, parent-child interaction, and family well-being) into PATSCH sessions. For example, in the Safety sessions, it was outlined when an activity could occur and what development-centered parenting handouts went along with the content covered (see Figure 3). It was assumed that with these modifications the parent educator would meet fidelity criteria for both evidence-based curricula without increasing pre-session planning time.

We specified what handouts went along with each session so that the parent educators did not have to engage in the extra work of finding what was complementary. The research team culled the available handouts from the PAT curriculum matching the content with specific sessions and reviewed handouts for repetition and inconsistencies.

Other modifications to PATSCH included creating supervisor training in which supervisors were given a binder that provided an overview of the content of each module so that they could have a common language with their staff who had been trained in this new curriculum. Additionally, the research team added an hour to the training on the last day in which they reviewed braiding-specific requirements and addressed questions generated throughout training. To complement this segment of training, and in recognition of the potential content overload of training, we created an implementation manual for parent educators to which they could refer back after training.

Phase 5: Trial Implementation

Method—Using the modified curriculum developed in Phase 4, a large cluster randomized trial began at extant PAT sites in 3 southeastern states. The sites were randomized (1:1 allocation ratio) to receive PATSCH training or continue providing services as usual. Our research team was concerned that if parent educators at a site were randomized to deliver different curricula, the potential for comparing and/or sharing materials or results would be too great. Thus, randomization occurred at the site level to eliminate contamination within sites.

Participants were families already enrolled in PAT services. The families were approached by the PAT parent educator with whom they had an ongoing relationship after they completed at least the first five foundational visits of the PAT curriculum. Additionally participants had to meet at least two of the following criteria: low income, low parental educational attainment, single-parent status, teen parent, or English not as a first language. Families who received PATSCH completed the three modules of the braided curriculum and subsequently returned to the PAT visits as usual with their parent educators. Families of the services as usual (control) sites continued to receive PAT sessions with the parent educators throughout.

Data Collection: Participants completed three research assessments at baseline (enrollment in PATSCH), 6-months, and 12-months post-enrollment conducted by a research team member, including locally hired data collectors in other states. The assessment was comprised of three components: a video recording of two rooms in the home from which an environmental scan was later scored with the Hazard and Accident Prevention Inventory (HAPI)¹⁶; a video-recorded parent-child interaction later rated with the Keys to Interactive Parenting Scale (KIPS),^{17,18} the Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO)¹⁹, and the Child and Infant Planned Activities Training Checklist¹⁶; and, a 242-item Audio Computer Assisted Interview (ACASI; Questionnaire Development System™) that evaluated dimensions related to the risk for maltreatment, such as the potential for abuse and neglect, child development, conflict tactics, and protective factors.

Results

PATSCH, in its entirety, consisted of 20 sites, including those that were trained and randomized but never began implementation. A long list of lessons learned from this pioneering effort were collected and could be useful for other efforts that seek to systematically replicate braiding or blending of evidence-based models. Those lessons will be discussed in future publication submissions.

Discussion

To our knowledge, this is the first effort to systematically braid two evidence-based home-based parenting models. As this paper illustrates, our research team has learned, through trial and error, strategies on how to approach this systematic braiding. National organizations, such as the National Institutes of Health and the Agency for Healthcare Research and Quality, have created goals and funding that focus on dissemination and implementation research, including a push for collaboration in order to “develop methodologies that allow us to...integrate the enormous amount of data becoming available” related to evidence-based practices.²² Future research in this vein will benefit from our pioneering effort as other braided curricula are implemented in the field of child maltreatment prevention.

In its final form, PATSCH involved braiding at two levels: model implementation and curriculum. Implementation evolved in two ways: 1) coaching was provided to parent educators who delivered PATSCH; and, 2) structured session guides were created such that fidelity for each model is maintained. The effect of braiding was most evident in regard to the curriculum: a separate toolkit (i.e., session guide) was created for PATSCH sessions and SafeCare modified the parent training structure (e.g., reduced number of sessions) to accommodate the existing rapport between parent educator and family. However, it should be noted that the pilot phase was conducted with a group of previously trained PAT parent educators whose experience with PAT largely informed the development of how the braiding should occur. It is possible that if the pilot was conducted with a group of new PAT parent, SafeCare providers, and/or new providers unfamiliar with either model, the braided curriculum, PATSCH, would be quite different.

Initial analyses indicated potentially significant results for home-based services and the importance of cross-model collaboration. An interim analysis of baseline data detected a modest correlation between counted hazards in the home and the potential for abuse in the sample population.²³ Other preliminary analyses explored the association between the potential for abuse and the quality of parent-child interactions.²⁴ Though only long-term analyses will confirm our hypotheses, based upon the qualitative feedback in the pilot phase and initial analyses, it appears that the braided approach is supported by the data, qualitative and quantitative.

Braiding curricula to better meet the needs of families at-risk for child maltreatment is a provocative step in advancing evidence-based practices and implementation research. If outcome evaluations support or partially support the hypothesis that PATSCH is superior to PAT alone, plans will need to be made through the PAT National Center and the National SafeCare Training and Research Center organizations for sustainability for PATSCH.

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Figure 1.
Phases of Braiding Progression

Session 1 [SafeCare only]	Session 2 [Braided]	Session 3 [SafeCare only]	Session 4 [Braided]
<ul style="list-style-type: none">• Baseline Assessment• Training	<ul style="list-style-type: none">• Training	<ul style="list-style-type: none">• Training	<ul style="list-style-type: none">• Training• End-of-Module Assessment

Figure 2.
Braided Curriculum Sessions

Session 2: Training (Braided)

PREPARATION FOR THE VISIT

Review the personal visit record and milestone form from the previous visit. Consult to seek information or guidance if necessary. Check in with the family to confirm agenda. Familiarize yourself with the session outline and pull the specified parent handouts.

Prepare for the Parent-Child Interaction component of this visit. Choose:

- A child development domain
- An age-appropriate parent-child activity page
- A parenting behavior based on activity page and/or discussion with parent
- Decide on appropriate handouts
- Read parent educator resources

Prepare for the Family Well-Being component of this visit. Based on knowledge of the family:

- Choose a Strengthening Families Protective Factor to focus on and any anticipated topic(s) that might be addressed
- Choose appropriate handouts
- Read parent educator resources
- Choose suitable personal or community resources
- Prepare discussion questions to get parent's perspective on the topic

INTENTION OF THE VISIT

- Assess retention of information and skills from preceding session
- Continue to assess and remove hazards from last session's room
- Assess and remove hazard from next room
- Encourage the parent to continue removing hazards
- Go over safety-related PAT handouts
- Go over Parent-Child Interaction and Family Well-Being handouts as they fit the family paying particular attention to the child's development

Figure 3.
Braided Safety Session with PAT Components