What Is the Evidence for Parenting Interventions Offered in a Canadian Community?

John D. McLennan, MD, PhD¹

John N. Lavis, MD, PhD²

ABSTRACT

Background: The evidence supporting interventions offered in the community is often not examined. This study examines the evidence base supporting parenting interventions offered in a Canadian community and, in so doing, illustrates a community assessment mechanism that could be applied routinely for other psychosocial interventions.

Methods: An inventory of all manual-guided, group-based parenting interventions offered in a moderate-sized Canadian city was developed by reviewing existing community information guides and contacting key providers of parenting programs. Interventions offered between July 1, 2000 and June 30, 2001 were selected for evaluation. Evaluation reports for each intervention were assessed by two independent raters using a modification of the Effective Public Health Practice Project Quality Assessment Tool.

Results: Twelve parenting interventions were offered in the study community. Only three (25%) had been evaluated with at least one randomized controlled trial. No evaluation identified an *a priori* primary outcome measure to assess effectiveness. Multiple statistical testing without including a correction factor limits confidence in the robustness of the small number of positive results. Under-powered evaluations were common. Three interventions had only post-intervention client satisfaction data. The study community used none of the existing parenting interventions that are supported by extensive empirical evidence of efficacy.

Interpretation: There is a substantial research-practice gap in the parenting interventions offered in the study community. Similar community assessments could be used to spur debates within other communities about how best to reduce the research-practice gap.

MeSH terms: Evidence-based medicine; child; evaluation studies; health services; parenting

La traduction du résumé se trouve à la fin de l'article.

1. Departments of Paediatrics, Psychiatry and Community Health Sciences, Faculty of Medicine, University of Calgary, Calgary, AB

2. Departments of Clinical Epidemiology & Biostatistics and Political Science, McMaster University, Hamilton, ON

Correspondence: John D. McLennan, Community Health Sciences, Faculty of Medicine, University of Calgary, 3330 Hospital Drive NW, Calgary, AB T2N 4N1. Tel: 403-210-8673, Fax: 403-270-7307, E-mail: jmcleenna@ucalgary.ca

Acknowledgements: Thanks to Ms. Sandra Micucci for evaluation scoring; Dr. Mita Giacomini, Dr. Charles Cunningham, and Ms. Michelle Caza for comments on earlier versions of this paper; and the Hamilton Health Sciences Foundation for funding this study. McLennan is supported by the Alberta Heritage Foundation for Medical Research and the Canadian Institutes of Health Research. Lavis receives support as the Canada Research Chair in Knowledge Transfer and Exchange.

Expectations for using an evidence-informed approach to public health initiatives are increasing.¹⁻³ Yet there is a notable absence of efforts to determine the strength of evidence supporting the psychosocial interventions offered in the community to improve health status. Filling this gap requires moving beyond systematic reviews of the effectiveness of an array of interventions in achieving a single outcome and instead undertaking reviews of the effectiveness of *offered* interventions in achieving a broad array of relevant outcomes. A systematic assessment of the evidence base supporting one type of service – parenting interventions – offered in a community was undertaken as an illustration of such a community assessment approach.

Parenting interventions were chosen as an example as they are one of the most commonly used strategies for improving child health. In Ontario, for example, public health units are mandated to provide group-based parenting interventions to provide information and develop skills.⁴ The focus for parenting interventions can be diverse and include a variety of important public health practices such as dietary changes to address childhood obesity, safety practices in the home such as infant sleep positions, and disciplinary practices for disruptive behaviours in children.⁵⁻⁷ While some parenting interventions have been shown to improve parenting practices and child outcomes in well-designed studies,⁷⁻⁹ little is known about whether efficacious parenting interventions are being widely used in the community.

Researchers have examined the evidence supporting other types of interventions offered in the community, such as child mental health treatment services. Moderate-to-large effect sizes have been found in meta-analyses of trials of psychotherapeutic interventions for children, whereas some studies of psychotherapeutic interventions typically provided in community clinics have found little to no effect.¹⁰⁻¹⁷ The failure to use efficacious interventions may be one of the key factors contributing to the disappointing impact of community-based services for child mental health.¹⁸

METHODS

The setting for this study was a moderate-sized Canadian city, with a census metro-

TABLE I

Characteristics of the Parenting Interventions Offered in the Study Community

Intervention Name	Target Population	Child Age (Years)	# of Sessions
Parent-Child Mother Goose	Low-income, poorly educated, socially isolated mothers	0-2	10
Right from the Start	At-risk infants	0-2	8
Early Learning Canada	Child at risk for language/literacy delay	0-6	8
Nobody's Perfect	Low-income, socially isolated mothers	0-6	7-8
Language Instruction for Newcomers to Canada (LINC) Parenting Program	New immigrants	>0.5	7
COPEing with Toddler Behaviour	Challenging child behaviour	2-3	3-5
Community Parent Education Program (COPE)	Challenging child behaviour	3-12	4-12*
COPE for ADHD	Child with ADHD	3-12	10
Intergenerational Trauma Treatment Model (ITTM)†	Child experienced a trauma	3-18	6
Families and Schools Together (FAST)	Socially isolated/at-risk families	4-9	8
Under 12 Outreach Program (ORP)‡	Child engaged in delinquent behaviour	6-11	12
COPEing with Challenging Adolescents	Adolescents with ADHD or other behavioural problem	12-18	10

* The number of sessions depends on time of year (4-session courses offered in the summer).

† The group-based parenting intervention is the first of this three-part intervention.

‡ The group-based parenting intervention is one of several components of the Under 12 Outreach Program (ORP).

politan area population of between 500,000 and one million inhabitants. Like many Canadian communities: i) there is no systematic community-wide process ensuring that interventions are supported by evidence; ii) the community is influenced by provincial and federal government initiatives; and iii) the community has a number of parenting interventions offered by agencies that have no links to academic institutions.

An inventory of parenting interventions offered in this city was developed by reviewing an extensive listing of programs detailed through a citywide community information service and a detailed brochure identifying most parenting programs offered in the city. In addition, providers of parenting interventions were questioned about any additional parenting programs that were offered in the city. To be eligible for this study, the parenting intervention had to be 1) manual-guided, 2) offered as a group program, 3) delivered between July 1, 2000 and June 30, 2001, and to have as at least one aim 4) to improve child health or development through changes in parenting practices.

The following search strategies were used to identify evaluation reports and studies for each of the selected parenting interventions: 1) a literature search of MEDLINE (1966-2004), PsycINFO (1967-2004), HealthSTAR (1975-November, 2004), and CINAHL (1982-2004) using each intervention name; 2) an Internet search using the search engine Google and each intervention name; 3) requests for information from local providers of the intervention; and 4) contact with intervention developers.

Only the most rigorous research designs for each intervention were considered. For example, only randomized controlled trials (RCTs) were included for interventions that had been evaluated by both an RCT and a pre-post evaluation that lacked a comparison group. Two raters independently classified characteristics of the evaluation and the results using a modified version of the Effective Public Health Practice Project Quality Assessment Tool 2002.¹⁹ This tool identifies key methodological variables to rate (e.g., methodological design, participation rates). The main modification of the instrument was the addition of questions about the types of measures used (e.g., observation measures, teacher reports), sample size, and correcting for multiple statistical testing. This tool has been used for a number of systematic reviews in public health in Ontario, including the evaluation of parenting groups with professional involvement.²⁰⁻²² Disagreements between the two raters were resolved through consensus following a joint re-review of the evaluations. One rater had been trained earlier and had previously used this instrument; the other had experience with critical literature review and required only brief orientation to the tool.

RESULTS

Twelve parenting interventions met the inclusion criteria for this study (Table I). Target populations for these interventions included at-risk children based on such factors as the family being socially isolated and/or low-income or the child demonstrating early emotional or behavioural

problems. Two of the parenting interventions were embedded within larger multi-component interventions (i.e., the Intergenerational Trauma Treatment Model (ITTM) and the Under 12 Outreach Program (ORP)).

Only three of the interventions had evaluation reports based on RCTs (Table II). Only one, Families and Schools Together (FAST), was assessed through independently replicated RCTs. One additional intervention (Parent-Child Mother Goose) was evaluated using a quasi-experimental design. The remaining interventions were only evaluated with pre-post designs with no comparison groups (n=5) or with non-standardized post-intervention parent satisfaction surveys (n=3) (results not shown).

The majority of the interventions (n=8) were evaluated using standardized measurement tools with at least some reported psychometric properties. Those evaluations using standardized measures typically only collected parent reports of child behaviours. Only the Community Parent Education Program (COPE) evaluation reported outcomes of independent observational measures and only the ORP and FAST studies included teacher ratings.²³⁻²⁷ Those not using standardized measures typically only collected post-intervention parent satisfaction data.

Many of the evaluations assessed multiple outcomes using multiple statistical tests and small samples. None of the evaluations identified *a priori* primary outcome measures. Corrections were not made for multiple statistical testing, increasing the chance for a type I error of falsely concluding that there are differences between groups. Most evaluations had inadequate

TABLE II

Key Characteristics of Parenting Intervention Evaluations

Intervention Name	RCT	Comparison Group	Used Published Measures	# of Statistical Measures	% of Positive Statistical Tests	Sample Size*	% Attrition†
FAST							
Post-intervention ²³	Yes	Yes	Yes	36	6	50/50	0-62
9-12 mo follow-up				27	7		48-82
Post-intervention ²⁴	Yes	Yes	Yes	NR‡	NR	207/200	2-6
1-yr follow-up				47	9		4-25
Post-intervention ²⁵	Yes	Yes	Yes	13	8	272/201	1-2
2-yr follow-up				13	8		24-37
COPE							
Post-intervention ²⁶	Yes	Yes	Yes	9	0	48/56§	24
6-mo follow-up				9	11		24
ORP ²⁷	Yes	Yes	Yes	27	19	16/16	13
Parent-Child Mother Goose**	No	Yes	Yes	6	0	39¶	23
Right from the Start ²⁸	No	Yes††	Yes	5	60	12/5	NR
COPEing with Challenging Adolescents ²⁹	No	No	Yes	4	75	107	61
ITTM ³⁰	No	No	Yes	9	33	52	48
COPEing with Toddler Behaviour‡‡	No	No	Yes	4	25	19	16
Nobody's Perfect							
Post-intervention ³¹	No	No	No	0	NA	103	10
6-mo follow-up							24
LINC-Parenting Program	No	No	No	NA	NA		
COPE for ADHD	No	No	No	NA	NA		
Early Learning Canada	No	No	No	NA	NA		

* First number, sample size of intervention group; second number, sample size of comparison group.

† Attrition rates are reported as a range as these varied across outcome measures.

‡ NR, not reported.

§ Group-based intervention vs. no intervention (did not include comparison with individual intervention as in original study).

|| Whole intervention evaluated together, not just the parenting component.

¶ Total sample was 39 (breakdown not given): 13 in experimental and 13 in control group completed.

** Lottridge C, Hamilton D, Shewchuk D, Knott T. [personal communication, October 30, 2002].

†† Though this study had a comparison group, the statistical analysis was pre-post (number of positive tests per group were compared).

‡‡ Niccols A. [personal communication, McMaster University, May 28, 2002].

power to assess multiple independent outcome measures if a correction factor such as the Bonferonni multiple-comparison procedure is used. In lieu of correcting the significant values, the percentage of positive tests at a p value of less than 0.05 out of the total number of outcome tests was calculated for each evaluation report (Table II).

The most rigorously evaluated interventions (i.e., those with RCTs) all had a large number of outcome measures and a low percentage of positive tests having statistical significance (0-19%). The majority of outcomes were not statistically significant in a positive direction. There were some examples where outcomes were significantly worse in the intervention groups. The only exceptions to this pattern were two evaluations using non-RCT designs in which the majority of outcomes were statistically significant in a positive direction (i.e., Right from the Start and COPEing with Challenging Adolescents).

As some of the sample sizes for the evaluations were quite small, the probability of falsely concluding that there are no differences between groups (a Type II error) increases, though this was not clearly articulated in the evaluation reports. In addition,

as Table II shows, attrition rates were substantial. Further, only two evaluations (both for FAST) used a conservative intent-to-treat analysis.^{24,25}

DISCUSSION

A substantial research-practice gap exists in the parenting interventions offered in this moderate-sized Canadian city despite the increasing availability of empirically supported interventions and increasing demands for the use of efficacious interventions. This community offered none of the parenting interventions supported by the highest levels of research evidence. For example, the community offered none of the Blueprints for Violence Prevention interventions, nor those rated as Exemplary I by the Strengthening America's Families program.^{32,33} Parenting interventions rated by these organizations, which include the Incredible Years, Preparing for the Drug Free Years, and the Strengthening Families Program, demonstrated strong positive results based on replicated RCTs. The parenting interventions that were offered in the study community were supported by no or weak evidence. Shared characteristics between this

community and many others suggest that this pattern likely exists elsewhere.

Four characteristics of our approach and the implications that follow warrant further discussion. First, the appropriateness of giving preference to RCTs could be questioned. There is the potential for an overemphasis on RCTs within the evidence-informed public health agenda; however, these concerns are typically raised with regard to complex interventions or interventions that do not lend themselves to evaluation through RCTs.³⁴ Manual-guided, group-based parenting interventions can be evaluated through RCTs. The Basic parenting intervention of the Incredible Years has been evaluated in multiple randomized controlled trials and the results have been consistently positive.³⁵⁻³⁷

Second, requiring *a priori* primary outcome measures for all intervention studies could be questioned. Although most of the evaluations considered in this report identified at least some positive results, failing to designate *a priori* primary outcome measures or correct for multiple statistical testing is a serious concern. Designating a single *a priori* primary outcome measure (or more if the study is adequately powered)

should be the standard in psychosocial intervention trials as it is for medication trials. Secondary outcome measures can be considered exploratory and thereby generate hypotheses for further study. However, segregating the few positive results from a multitude of nil effects in order to endorse an intervention seems inappropriate.

Third, proposing that under-evaluated novel interventions not be disseminated in the community prior to completion of rigorous evaluation trials could also be questioned. Three of the parenting interventions offered in the study community are presently being evaluated in larger and more methodologically rigorous research designs. Pilot evaluations using weaker designs and smaller sample sizes were the only evaluations available at the time of the study. In contrast, we did not include one parenting intervention that was being evaluated in a trial in this community during the inquiry as it was not offered outside of the trial. Restricting the offer of novel interventions to those enrolled in trials prior to the intervention being shown to be efficacious requires a choice between imposing restrictions that could impair the creation of novel interventions that may need a period of development and refinement prior to rigorous evaluation and disseminating potentially inefficacious, or in some cases potentially harmful, interventions.

Fourth, a call for taking care in using evidence from one intervention to support a related intervention could also be questioned. The study considered only evidence derived from the evaluation of each specific "packaged" parenting intervention and not indirect evidence, such as from evaluations of component parts or from similar parenting interventions. For example, the COPE program has significant overlap with the Basic program of the Incredible Years. Both interventions suggest similar parenting strategies, use videotaped examples, employ modelling, and assign homework. In addition, they are both informed by experimental evidence for component pieces (e.g., use of the time-out procedure).^{38,39} Some have accepted evidence derived from one intervention to support the use of a similar intervention, such as the Hawaiian task force commissioned to develop recommendations for improving Hawaiian child

mental health services.⁴⁰ However, others have criticized this approach because of the potential heterogeneity among interventions and the lack of knowledge around which components are critical in achieving positive outcomes.⁴¹ The dissemination project of the Blueprints for Violence Prevention insists on a high degree of fidelity for the implementation of specific evidence-supported interventions because of concerns over potential loss of effectiveness if variations from the original intervention are allowed.⁴²

Different beliefs on these four points may partially account for agencies within a community adopting interventions lacking in evidence and failing to adopt interventions supported by evidence. Several additional factors may underlie this pattern, including 1) lack of access to, or understanding of, findings from empirical studies or findings from systematic reviews of parenting interventions produced by the Cochrane Collaboration^{43,44} and other groups,^{32,33} 2) lack of evidence-based interventions or systematic reviews of interventions that address the specific aims or mandates of key decision-makers and/or their agencies, and 3) the high costs of some evidence-based interventions relative to agencies' budgets.

This type of community assessment is applicable for evaluating simple, structured community interventions, such as manual-guided, group-based parenting interventions, but it may be less applicable for evaluating complex multi-component and/or unstructured interventions. As suggested by characteristics of our approach and the implications that follow from our approach, these assessments do raise thorny issues. Despite these challenges, there is still the opportunity to move forward to determine how to increase the extent to which existing efficacious interventions are adopted and to increase the extent to which novel community interventions are rigorously evaluated. Not to do so risks communities offering potentially ineffective interventions and thereby incurring substantial opportunity costs.

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Received: June 1, 2005

Revisions requested: November 10, 2005 and March 17, 2006

Revised mss: February 6, 2006 and May 2, 2006

Accepted: June 8, 2006

RÉSUMÉ

Contexte : Il est rare que l'on examine les données probantes sur lesquelles reposent les interventions communautaires. C'est pourquoi nous avons examiné les données probantes à l'appui des cours d'enseignement du rôle parental donnés dans une ville canadienne. Notre étude présente par la même occasion un mécanisme d'évaluation communautaire qui pourrait s'appliquer systématiquement à d'autres mesures d'intervention psychosociale.

Méthode : Pour dresser un inventaire complet des cours d'enseignement du rôle parental reposant sur un manuel et offerts en groupe dans une ville canadienne de taille moyenne, nous avons examiné les guides d'information communautaire existants et pris contact avec les principaux fournisseurs de programmes d'enseignement du rôle parental. Notre évaluation a porté sur les cours offerts entre le 1^{er} juillet 2000 et le 30 juin 2001. Les rapports d'évaluation de chaque cours ont été examinés par deux noteurs indépendants à l'aide d'une version modifiée de l'outil d'évaluation de la qualité du projet EPHPP (Effective Public Health Practice Project).

Résultats : Douze cours d'enseignement du rôle parental avaient été offerts dans la ville à l'étude. Trois seulement (25 %) avaient fait l'objet d'au moins une étude randomisée et contrôlée. Aucune de ces études n'avait défini au préalable de mesure primaire des résultats pour déterminer l'efficacité du cours. Or, l'exécution de plusieurs tests statistiques sans facteur de correction fait en sorte qu'on ne peut se fier complètement au petit nombre de résultats positifs enregistrés. De nombreuses évaluations accusaient des faiblesses importantes sur le plan méthodologique. Pour trois des cours, nous n'avons trouvé que des données sur la satisfaction des clients, recueillies à la fin du programme. Dans la ville à l'étude, on n'a utilisé aucun programme d'enseignement du rôle parental dont l'efficacité était démontrée par des preuves empiriques.

Interprétation : Il existait un écart considérable entre la recherche et la pratique dans les cours d'enseignement du rôle parental offerts dans la ville à l'étude. On pourrait utiliser des évaluations communautaires semblables pour susciter des discussions dans d'autres collectivités sur les meilleurs moyens de réduire l'écart entre la recherche et la pratique.