



# Common components of parenting programs for children birth to eight years of age involved with child welfare services<sup>☆</sup>



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## ABSTRACT

Parent training programs have a long history of use in children's mental health and child welfare services. Several prominent models have more than 30 years of development and considerable data backing their effectiveness. Many agencies are intently seeking to provide evidence-based parenting interventions. Relying on ratings from the California Evidence-Based Clearinghouse for Child Welfare, this paper reviews the highest rated parenting interventions for children ages birth–3 and 4–8. The data show that the interventions for children birth–3 have less robust evidence behind their effectiveness but that higher rated programs share some emerging principles and a few common components. Programs designed for children 4–8 have considerably more evidence and appear to have substantial convergence of principals and common components. The authors propose that the use of the common components of parenting interventions for children 4–8 is likely to yield success even without a specific, manualized intervention that has previously been rigorously tested.

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## 1. Introduction

Although parent training has more than a 60-year history, many parents have been trained with programs that have very little supporting evidence (Barth et al., 2005; Haskins & Adams, 1983). Notwithstanding, parent training programs have broad use and are a well-established component of family support, education, and children's mental health services. As many as 800,000 parents receive parent training per year for prevention, intervention and reunification purposes, under child welfare service auspices, alone (Barth et al., 2005).

Interest in effective parenting interventions is likely to accelerate with growing evidence that parenting mediates the effects of pre-natal exposure to cocaine (Fisher, Kim, Bruce, & Pears, 2011) and methamphetamines (Twomey et al., 2013). Scott (2012) asserts that harsh parenting may even have a trans-generational impact through influences on gene expression and that this makes the delivery of effective parenting interventions even more critical. The success of parent training and the findings that the family environment have such a broad impact on children help explain why parenting interventions are broadening to new outcomes like literacy and obesity.

The logistics of a transition to more robust and evidence-based parenting programs are sometimes daunting because child welfare agencies have generally had a low budget for parent training programs (which are not, largely, reimbursed by the federal government). Parent training programs have relied on a history of having local practitioners develop and deliver home-grown group programs or programs that can be easily ordered from publishers and self-trained (Barth et al., 2005). Many social service agencies, both private and public, continue to struggle to meet the demand for evidence-based interventions. Evidence-based early childhood parent training models are lacking in number and the more tested and demonstrated programs for older children have significant logistical challenges including non-trivial start-up costs when working with manualized programs.

Research on parent training for children ages 4–8 has been conducted, and rigorously evaluated, for over forty years to achieve the efficacy needed to meet new expectations for effectiveness (Eyberg & Johnson, 1974;

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Patterson, Reid, & Jones, 1975). Research on early childhood—i.e. birth to three—parenting programs is, comparatively, underdeveloped. With this population being so vulnerable and due to the high rates at which they are experiencing child maltreatment and infant mortality—no less entering foster care—the need to accelerate the uptake of effective parent training programs for younger children is great.

This review focuses on the use of parent training as relevant to child welfare services and, specifically, for parents caring for younger children. The justification for this focus arises because young children have the greatest vulnerability, spend a higher percentage of time being raised and taught by their parents, and because of a longer history of parent training work with younger children. A significant proportion of child welfare services also involve children who are likely to be quite young, as 42% of the children identified as abused in the U.S. in 2011 were 7 or younger at the time of the report (US DHHS, 2012). As evidence of their greater vulnerability, slightly more than 90% of the more than 1200 child fatalities recorded by states were among children ages birth to 7 (US DHHS, 2012).

The goal of this paper is to identify common components of effective parent training programs for young children. Previous efforts have been made to try to categorize components of parenting interventions and tie these to effectiveness. Geeraert, Noortgate, Grietens, and Onghena (2004) conducted a meta-analysis of 40 child abuse and neglect prevention programs for families with children birth to three years of age. The interventions were assessed based on the reduction of effects of abuse and neglect, improvement in parent and child functioning, and parent-child interaction. Overall, family functioning and family context were also outcomes measured. Programs in the review focused on the prevention of physical abuse and neglect.

Geeraert et al. (2004) research synthesis also required that the evaluation study uses a comparison group or pre/posttest design. These programs were noted to include six common dimensions. The studies typically used either attachment, ecological, or learning theories as foundation for the intervention. Interventions varied in frequency from weekly to bi-monthly. Educational preparation of parent interventionists ranged from para-professional to master's prepared clinicians. Geeraert et al. (2004) found a small positive effect in abuse and risk reduction. The meta-analysis also demonstrated that interventions were followed by a significant reduction in abuse and neglect as well as child conduct issues. The approach to knowledge aggregation employed in Geeraert et al.'s (2004) review differs from this review insofar as the review that follows is about a decade more current, summarizes the components of interventions that have at least one randomized control trial, and relies on interventions that have been evaluated by the *California Evidence Based Clearinghouse for Child Welfare* (CEBC4CW).

The current study also has some similarities to the Kaminski, Valle, Filene, and Boyle (2008) review of 128 parent-training studies that ultimately examined the efficacy of 18 program components and delivery strategies. Kaminski et al. (2008) included quasi-experimental studies—spanning from 1990 to 2002—of parenting programs, for children ages 0–7. The outcome was effect sizes of changes in measures of parenting behavior and child externalizing behavior. Program components consistently associated with larger effects included increasing positive parent/child interaction and emotional communication skills, teaching parents to use time out, stressing the importance of parental consistency, and requiring parents to practice new skills with their children during parent training sessions.

## 2. The language of practice components

Evidence-based practices have, typically, been implemented and tested as a whole curriculum—often with a highly detailed manual which controls the order and duration of the presentation of treatment elements. Very few dismantling studies have been done to determine which elements are most important. Yet, these elements are often drawn from existing manuals for evidence-based interventions that

may have included them in a very different order or for a different population or outcome of interest. Advances in making effective parent training programs more available to the public may depend, in part, on finding a way to give aspiring parent trainers a set of treatment components that they can use flexibly without having to learn an entire manual.

A little attention to nomenclature will facilitate the analysis—at least four terms are in common use and warrant differentiation. *Common elements*, as defined by Chorpita, Daleiden, and Weisz (2005), are elements of interventions commonly found among effective treatments. These elements cannot be said to be necessary for an intervention to be effective only that the element is frequently observed in the winning arm of randomized clinical trials. If an element was in a high proportion of winning interventions, and a low proportion of losing interventions, this suggests the importance of their presence in an effective treatment model. Examples of *common elements* are exposure, response prevention, cognitive restructuring, relaxation, and psychoeducation (Chorpita et al., 2005).

A desired element for an effective intervention is an *active ingredient*. This is an element of treatment, which has been found to make a reliable positive difference. Determining whether an element is an active ingredient requires affirmative findings from comparative studies that differ only in the presence of a single item—sometimes known as dismantling studies. An active ingredient would, in the strictest use of the term, have been tested, identified and determined to be necessary to meet the goal of an intervention because interventions that lacked this element would have significantly diminished impact. Yet, there are many much less disciplined uses of the term—including a recently funded US DHHS national center on child welfare and evidence based practices that will “support the child welfare workforce to understand the effective interventions and the active ingredients of those interventions and to ensure that children and families receive those interventions” (ACF, HHS-2013-ACF-ACYF-CT-0595, April 25, 2013; p. 8).

An *essential component* refers, in the language used by the CEBC4CW, to describe an element provided by treatment developers, as something that makes the program unique and is required by the developer to deliver their program with fidelity.

*Common components* is a term coined for this review to describe frequently seen components in promising and effective parenting programs (as defined by clearinghouses and, in our review, requiring that the parent program has been evaluated using a randomized controlled trial (RCT) and found to make a difference). This label does not suggest that these components are active ingredients but rather are identified as essential components by the program developer of an evidence-based practice. By including the developer's perspective this approach adds a critical element. The CDC has also embraced the concept of obtaining developer input in funding adaptation guides for EBPs that require that adaptations of existing EBPs do not include what the developers define as “core components (which) are the essential pieces of a curriculum that are responsible for its effectiveness” (Lezin et al., 2011; p. 6). Although this definition of core components implies that these core components are active ingredients.

A fifth term, *kernel* (Embry & Biglan, 2008), describes fundamental units of behavioral influence that appear to underlie effective prevention and treatment for children, adults, and families. Kernels cover a much larger span of interventions than parent training or psychotherapy components and will not be further discussed, here. They warrant this brief mention, nonetheless, because they are also addressing the shared concern that “for now most daily practices that influence human development will fall outside the scope of existing programs” (p. 76). Embry and Biglan discuss the parenting procedure known as “time-out” as a seminal example of a kernel because it is “a staple of nearly every evidence-based prevention program for parenting...” (p. 79).

The goals of this article are to (1) describe existing evidence based parenting programs listed on the California Evidence-Based Clearinghouse (by two age groups), (2) identify common components of these

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