Adopting Parenting Interventions in a Canadian Community: Processes Contributing to Research-Practice Gaps

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ABSTRACT

With the aim of uncovering contributors to research-practice gaps in child mental health programming, this study sought to identify factors influencing the adoption of parenting interventions by community agencies. This qualitative case study with embedded units uncovered 3 key factors: resource demands of interventions, the fit of interventions with agency mandates, and the perceived needs of target populations. Autonomy of decision-makers within agencies was evident although curtailed by resource limitations. Although research evidence is valued, it does not appear to play a central role within the adoption process. How these factors may contribute to research-practice gaps is discussed.

Children's mental health services, as with most other health and human sector services, are purported to have worrisome research-practice gaps (Burns & Friedman, 1990; Graham, 2000; Lilienfeld, Lynn, & Lohr, 2003; Waddell, Lomas, Offord, & Giacomini, 2001; Weisz & Jensen, 2001). Interventions with demonstrated efficacy are frequently not adopted, and interventions that are employed by community agencies are frequently underevaluated or found to have little to no, and occasionally adverse, effects (McLennan, Wathen,

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MacMillan, & Lavis, 2006). In response, one approach is to "push" for increased uptake of evidence-based interventions. Some of these push efforts have been paired with investigations examining program uptake (Aarons & Palinkas, 2007; Chamberlain et al., 2008; Zazzali et al., 2008).

However, much less work has examined the naturalistic uptake of interventions within the community, that is, not restricted to specific push efforts of interventions deemed evidence-based. An exception is a study of HIV prevention program adoption by community agencies in the United States (Miller, 2001). This study identified compatibility with organizational philosophy; relevance to local context, which included filling service gaps; feasibility; and *evidence* as key factors influencing program adoption (Miller, 2001).

This and several other studies of psychosocial program adoption have been, at least in part, informed by the diffusion of innovation model (e.g., Freedman, 2002; Parcel et al., 1995; Rogers, 1995; Rohrbach, D'Onofrio, Backer, & Montgomery, 1996; Zazzali et al., 2008). However, there may be limits to the applicability of this model to *organizational* decision-making for *psychosocial intervention* uptake in contrast to the original grounding of this model in *individual* decision-making for *technological innovation* uptake (Baldridge & Burnham, 1975; Lundblad, 2003; Miller, 2001; Wolfe, 1994). Furthermore, Langley, Mintzberg, Pitcher, Posada, and Saint-Macary (1995) suggested that several assumptions compromise the literature on organizational decision-making, including the notion that decision-making can be isolated from its given contexts. This suggests that an inductive inquiry focused specifically on community organizations providing child mental health services may be particularly beneficial.

This study investigated the process of intervention adoption by agencies within a Canadian community by focusing on the uptake of parenting programs, one type of intervention relevant to child mental health. Within the repertoire of interventions offered by community agencies to improve child mental health, parenting programs are among the most common. However, parenting programs with the most empirical support are not necessarily preferentially adopted by community agencies. In one study of the evidence base of parenting programs offered in a Canadian community (McLennan & Lavis, 2006), a pattern was observed involving a failure to adopt interventions with the most substantial evidence base, and a tendency to offer programs with limited or no empirical evidence of effectiveness. The adoption of this same group of parenting programs in the same community became the focus for this inquiry. The intent was to determine the factors influencing the adoption of these programs, with the expectation of identifying factors that contribute to the development of research-practice gaps.

METHODS

Descriptive Case Study

This investigation used a descriptive case study, as informed by both Stake (1995) and Yin (1994). The case for this study is the adoption of group-based parenting interventions offered in one Canadian community. The cluster of factors influencing the intervention choice was the phenomenon of interest within the case. The adoptions of specific parenting interventions by specific agencies are considered embedded cases within this inquiry (Yin, 1994). This study focused on specific decisions, or more accurately, manifestations of decisions, rather than viewing innovation adoption as a general property of an organization.

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For the purposes of this study, a parenting intervention was defined as a structured service provided to parents in which at least one intention was to shift parenting practices to improve child outcomes. Furthermore, the sample was restricted to group-based, manualized interventions. Restriction to manualized and group-based interventions ensured that there was a specific and clear entity under question, which allowed for clear boundaries for the case versus inclusion of less defined interventions such as drop-in programs or individual counselling for parents.

A community was selected as the unit for this case because a substantial amount of specific child service planning appears to occur within the administrative boundaries of a community. The specific Canadian community in this inquiry was selected as (a) it contained a diverse range of agencies providing parenting interventions that provided a number of embedded cases for the overall case, and (b) the location was accessible to this investigator, which was essential to carrying out an in-depth inquiry.

Sample and Procedures

An inventory of parenting interventions offered in this community was developed through the use of community information services, intervention brochures, and personal contact with the major providers of services in the public and not-for-profit sectors; no private vendors were identified. The sample was restricted to interventions offered within a 1-year period, July 1, 2000, to June 30, 2001, and within the administrative boundaries of the study community. This approach identified 12 parenting interventions that met the inclusion criteria. These included a mix of prevention/early interventions and clinical interventions. The prevention/early interventions targeted high-risk populations such as low-income families, socially isolated parents, or parents of children showing early signs of behavioural difficulties. Clinical-type interventions focused on disruptive behaviour disorders or trauma-exposed children. Most of the clinical interventions focused on preschool or young school-aged children, although some covered adolescents.

Agencies offering these interventions were approached for participation in the study. Each agency was asked to identify at least one key participant who could speak to the parenting intervention and its adoption. Of the 12 possible agencies, 10 agreed to participate in the study and identified at least one key informant who subsequently agreed to participate in a face-to-face interview.

To counter the concern about pro-innovation bias raised by Rogers (1995), a "failed" case of adopting a parenting intervention was added. This additional example was the only known example within this community in which an agency had seriously considered adopting a parenting intervention with an extensive empirical evidence base. Ultimately, the agency did not offer this specific intervention. This agency was one of the 10 above and hence also had an example of a parenting intervention that had been adopted.

Each agency provided at least one participant for a face-to-face interview. Each participant was asked to nominate other possible participants from his or her agency or a partnering agency who could provide additional details on parenting intervention adoption. Most interviews were conducted one-on-one; however, a few agencies had two participants in the same interview. In total, 31 participants were interviewed. Participants held various positions within the agencies and included front-line providers who had some administrative roles in program adoption, program managers, agency managers, and a former executive director. Some participants had been directly involved in the decision-making process around whether to adopt a given

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intervention, while others provided important background concerning an agency and its decision-making processes with regard to intervention adoption.

A flexible interview guide was used for each interview. This included set domains with optional prompts. The interview was responsive to the participants' knowledge base and ideas that arose during the interview. In addition, the interview guide evolved over time to pursue concepts arising from the analysis of earlier interviews. The set domains within the interview guide included questions about the specific group-based parenting interventions that had been considered and adopted by the agency, how the intervention had been brought forward for consideration, what factors influenced the decision to adopt this intervention, and the key personnel involved in that decision. If not raised spontaneously, the role of research evidence was explicitly explored.

In addition to interviews, documents about the specific interventions and agencies were reviewed and the author's own observations and reflections as a participant observer in one adoption effort were studied. The documents were of public domain or internal to the agency, and included agency descriptions, intervention descriptions, evaluation reports, and intervention advertisements. Unfortunately, availability of internal documents varied across agencies. In particular, interventions adopted several years ago had few, if any, documents available for analysis. In addition, some agencies did not feel comfortable releasing potentially relevant but proprietary documentation.

Analysis

Interviews were audiotaped and transcribed verbatim. Analysis began when the first interviews and documents had been collected. This allowed for an iterative process between data collection and analysis, such that subsequent data collection was shaped by initial findings arising from the earlier analysis. As interviews and documents were reviewed, descriptive accounts of intervention adoption were constructed from the narratives. Texts were coded using an editing analysis style (Crabtree & Miller, 1992). Memos were used to analyze coded material and assist in the identification and elaboration of key constructs. Syntheses of the memos provided core material for the final text. Triangulation by data source was one key approach used in this inquiry (Denzin, 1978; Miles & Huberman, 1994). A summary of preliminary findings was circulated to participants for feedback. The qualitative software package NVIVO® (Qualitative Solution and Research Ltd.) was used for data management and to support the analyses.

Ethics

McMaster University Research Ethics Board approved this study. All participants signed informed consent forms. Specific findings are not linked to specific informants or their agencies to provide anonymity.

RESULTS

The Community Agencies

A mix of government and not-for-profit agencies from the health, mental health, education, and social service sectors had adopted parenting interventions in the study community. Participating entities included a

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hospital, agencies in public health, a community health program, religious and non-religious social services, a service club, a school board, a professional development agency, and an agency assisting immigrants.

The adoption of parenting interventions typically occurred through a subunit of these agencies, rather than as an agency-wide effort. The subunit was usually a division responsible for parent and child programs or community outreach. However, there were two examples in which the parenting interventions were offered through a multiagency partnership, as opposed to a single agency acting alone. In these examples, agencies as a whole played a larger role, with one of the agencies in the partnership playing a lead role.

Eight of the participating agencies had adopted one or more interventions developed external to the agency. Two had adopted parenting interventions developed by staff within their agencies. All the agencies offered services other than parenting interventions.

The following four constructs emerged from the analysis and will be discussed in detail: (a) the apparent extent of autonomy of local decision-makers within agencies, (b) the consideration of resource demands of the interventions, (c) the extent of fit of an intervention within a given agency and to the perceived need of the population targeted by the agency, and (d) the role of research evidence in influencing program adoption.

Autonomy of Decision-Makers Within Agencies

At least one key individual within each agency, and within the key subunit, appeared to play a major role in the selection and subsequent adoption of a given intervention in each embedded case. In the case of multiagency partnerships, the key individual came from the lead agency. There were additional individuals who played important supporting and, in some cases, essential roles in intervention selection and adoption; however, substantial decision-making appeared to be dependent on key local individuals within agencies.

Although the position of these key individuals in the organization varied across participating agencies, they were typically responsible for a specific division or clinic within an agency. They were not typically at the top of the administrative hierarchy in their agency; however, they were perceived as being appropriate experts within the agency for making decisions about specific interventions in their division.

These key individuals experienced substantial autonomy in intervention identification and subsequent adoption within their agency. As one decision-maker explained, “I guess I have final say, but the protocol is always that I share my decision-making with the agency.… They relied heavily on me making that decision.” Another commented that “they didn’t expect us to run by them new sorts of services. They … left that up to us to design and approve.” Local autonomy was also a key factor in the negative embedded case whereby one individual appeared to make the decision to discontinue the adoption process.

In most cases, the role of senior administrators in decision-making appeared to be minimal (beyond signing off on the chosen intervention). There also appeared to be few explicit policies on managing new intervention adoptions. As one decision-maker described, “We’d clear it with our clinical leadership.… I don’t know that the actual administration [clinical leadership] . . . would have much to do with it. I think it’s really our decision.”

Certain exceptions to this pattern emerged. In one embedded case, the leader of an agency was pivotal in intervention selection and adoption. Here the individual had a specific interest in a given intervention which,

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larger and more costly than most of the others, represented a major initiative for this agency. By contrast, the parent intervention adoptions in many other examples were minor relative to the agency's size. Another agency had an explicit internal policy and process for authorizing new interventions through a management committee. Here, a key informant felt that support at the management level had been essential in moving the adoption of the given intervention forward: "But the absolute major thing that made this happen was the manager was interested in it.… Without that it never would have gone anywhere."

Multiagency partnerships had a more complex process that perhaps curtailed the autonomy of key individuals within subunits. These multiagency efforts appeared to engage more senior administrators of participating agencies, and these interactions may have influenced the process and outcomes. One senior administrator recounted the adoption process to be "as much a political decision … as anything else. It was really to make sure that the community was all involved." However, in most multiagency cases, senior administration did not select specific interventions, but rather addressed issues of global concern, fund distribution and responsibilities across partnerships, and protection of agency resources. This may be the case not only in these partnerships. Another informant said that in her agency senior managers made "some decisions about program planning," including decisions about the issues just mentioned, but that junior managers were responsible for intervention adoption. For junior managers, "the issue is what should be the content of the programming, [rather] than will we have one or not, because … [that] decision has already been made. But now they're supposed to be deciding the content of it."

Resource Demands

The resource demands of an intervention appeared to be a central factor in considering and adopting given interventions. A relatively high cost intervention may be quickly eliminated from serious consideration. One informant noted, "So as soon as you put that price tag on it, they're just not interested." Similarly, another reflected that "the Cadillac version may be something that has lots of good evidence … but it's impossible to do here." Both these informants were referring to interventions that had a substantial evidence base but that were relatively costly.

Interventions must fit within the typically small budgets of the types of agencies considered in this study. In describing an adopted intervention, an informant commented that "the cost of the program for myself and the other facilitator to take the training was … [less than $200] a person, which was within our professional development budget."

Specific purchase costs are not the only resource consideration; other costs, such as clinician time, are also critical resource variables. An informant from the negative embedded case noted, "Partly it's a resource issue … our [staff] are swamped as it is, and I don't see us having the time to start up and run [this] parenting program without the support and participation of other programs." Furthermore, a trainer for one of the interventions noted that "everyone is excited about the training [but] when they get back to their agency it's all about dollars in terms of release time … they have to have replacement costs for staff." Another informant held a similar view: "If you think it's something that's needed and *it doesn't cost money* [emphasis added] and it's great for the community, then it's fine."

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Fitting into existing budgets was frequently emphasized. There was only one situation (the negative embedded case) where new funding clearly preceded the introduction of an intervention. Here, an evidence-based intervention was considered though not subsequently adopted.

Two multiagency partnerships undertook substantial efforts to obtain adequate funds to launch larger, more expensive interventions. Smaller interventions sometimes required procuring small grants for sustainment or expansion. In the case of the internally developed interventions, research funding allowed for development and expansion.

Fit With the Agency and the Perceived Need of the Target Population

Interventions had to fit with agency mandates and the perceived needs of the target populations. One of the local decision-makers noted that "this is the population we're dealing with anyway and we have a mandate to deal with these kids or with … [their] parents." Here the population was also the responsibility of the key decision-maker within the agency subunit. Another informant noted that "a lot of our choices are made on the population that we're servicing.… [This intervention] has been a good program for us to be using because it's with the higher risk population, low literacy, single, low income."

Not only must the intervention fit with the mandate of the agency, the area of responsibility of the key decision-maker, and the needs of the target population, it must also be consistent with the philosophical orientation and beliefs of the key individual and an agency bringing the intervention forward. As one informant noted about an intervention the agency had adopted:

> We liked that program because we liked the fact that it was very non-judgmental and that parents need to be perceived as coming to the table with skills. Sometimes I think that parenting programs that were offered here in the past were kind of a deficit-based program.… That doesn't really fit with my philosophy and/or with … [the agency's] philosophy.

Another informant noted that what they adopted was a good fit with their existing approach and "really consistent with what we were already thinking was good practice with this population."

Similarly, one informant from the negative embedded case suggested a particular intervention did not address the needs of the agency population and was not a good philosophical fit for her, despite the greater degree of empirical evidence supporting the intervention in contrast to the others that had been adopted.

A Role for Research Evidence?

Rarely was research evidence spontaneously mentioned by informants as a key factor influencing their adoption of interventions. However, when asked, all informants indicated they knew or assumed that evidence supporting the intervention in question existed. In most cases, informants spoke positively of research evidence and intervention evaluation, and endorsed the importance of evidence-based intervention selection. As one informant related, "Certainly given the research outcomes that we're hearing about from [city 1] and from [the program developer] and from some of our colleagues in [city 2], we thought this might be a program that would help the parents." Another informant for the same intervention but from a different agency noted, "We did look at the research that had been done [elsewhere] and they'd done quite a bit, and it looked fairly good."

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However, in other cases, informants did not portray research evidence as key in intervention selection. When asked, one informant noted that "no, they [supervisors] didn't ask me to look into that [evidence supporting the intervention]. I think probably because of the supporters and the funding, it appeared to have the reputation that it was working." Another informant concurred that research findings were not critical in influencing the adoption of the intervention: "I think there was a pilot but we don't know too much about that yet."

The intervention considered in the negative embedded case had an exceptional evidence base. This may have played a role in initial consideration of it for adoption but, in and of itself, was not adequate to support its adoption.

In some cases, rather than serving as a critical factor for adopting an intervention, outcome data may have just strengthened an existing position. One informant noted that the available outcome data "reinforced his [the supervisor's] support of it … [and acted as] a bonus."

Government funders did not appear to demand that agencies take into consideration any evidence of effectiveness of interventions. An informant from one agency receiving government funding stated, "Government departments, I find, are using traffic reports as outcome information. They want to know how many people in, how many people out, not too much about what did you do while they were in …[the] process." Furthermore, one informant suggested that merely labelling an intervention as "evidence based" may satisfy some funders.

As noted, some parenting interventions were developed within local agencies, and the agencies committed considerable time, energy, and funds to evaluate these interventions. However, the expansion of these interventions outside the originating agency did not seem closely aligned with evaluation activities. External agencies adopted these interventions before results were available from more rigorous evaluations. There appeared to be minimal scrutiny by outside adopters of the specific evaluation efforts. However, positive results from pilot work and the notion that research was or is being done may have increased the prestige of the interventions and may have aided the dissemination of these interventions.

DISCUSSION

This inquiry identified factors that appear to influence the adoption of interventions by community agencies and that may contribute to research-practice gaps found in some community programming. Understanding these factors may provide insight into the perpetuation of research-practice gaps in child mental health programming. The following is a consideration of how these identified factors may contribute to the research-practice gap and how they relate to other findings in child mental health service research and decision-making theories.

An unanticipated finding was the degree of autonomy of local decision-makers within agencies. Many appeared to have substantial discretion for decisions related to specific intervention adoptions. Additionally, senior managers and funders appeared to demand little for justifying the selection of an intervention vis-à-vis evidence of effectiveness.

Local autonomy, however, does not, in and of itself, determine a narrowing or widening of the research-practice gap. In some cases, the local decision-maker may champion an evidence-based approach, thus

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narrowing the research-practice gap. However, if an evidenced-based approach is not sufficiently valued at the local decision-making level, other layers of the system that could counterbalance to increase the role of scientific evidence in decision-making might not exist.

Resource limitations substantially curtailed the extent of discretion in intervention adoption by the local decision-maker. Key individuals in the adoption process appeared well aware of their funding constraints. These limits restricted which intervention possibilities could be entertained. Interventions perceived as financially prohibitive were likely not seriously considered. Hence local decision-makers committed to an evidence-based approach may be thwarted by resource constraints. Another child mental health study similarly found that interventions perceived as too costly precluded the adoption of evidence-based interventions (Walrath, Sheehan, Holden, Hernandez, & Blau, 2006).

Drawing upon the theory of planned behaviour (Ajzen, 1991), Breslin, Li, Tupker, and Sdao-Jarvie (2001) found that perceived control over barriers to implementation explained some of the variance in the use of an evidence-based intervention for treating youth substance abuse. Certainly, "prohibitive" costs of some of the evidence-based interventions represent a barrier and would presumably influence an agency's perceived control over an action. In this study, the multiagency partnership examples where substantial new funding was made available allowed agencies to purchase relatively expensive training and to adopt larger initiatives. Pooling resources and/or obtaining new funding may allow an agency or multiagency partnerships to adopt some evidence-based interventions that are beyond the capacity of individual agencies within their present resource allotment—although the availability of such resources is not a guarantee that the most evidence-based interventions will be adopted.

The multiagency partnership examples considered in this study did not have a clear mechanism to ensure a major role for research evidence, and the extant decision-making process "failed" to result in the adoption of the most evidence-based interventions. The need to accommodate the involvement and priorities of individual partners may compromise a prioritization of adopting an evidence-based intervention. Given a trend toward increased community partnerships in health and social service delivery, future inquiries should attend specifically to intervention adoption processes within these partnership entities.

Fit with the agency and the perceived needs of the target population may also contribute to the research-practice gap. For example, a correspondence to the organizational mission was found to be an important factor in the adoption of an evidence-based intervention, Functional Family Therapy, in community-based settings in New York State (Zazzali et al., 2008), and fit with perceived need was an important factor in the uptake of a case management approach, SafeCare, in one child welfare system in the United States (Aarons & Palinkas, 2007). Of note, "fit" may map onto "compatibility," a core innovation characteristic within the diffusion of innovation model found to influence innovation adoption (Rogers, 1995).

However, it may be rare that the availability of a specific evidence-based intervention aligns with the mandate and philosophy of a given decision-maker and her or his agency, as well as with the perceived needs of a given target group at a specific point in time when adequate funds are available. To obtain a "rational outcome"—that is, the adoption of an evidence-based intervention—"problems [need to] meet their solutions at the right choice opportunity" (Masuch & LaPotin, 1989, p. 41). This notion stems from Cohen, March, and Olsen's (1972) "garbage can model" used to describe decision-making within anarchic organizations

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marked by unclear preferences or goals and unclear technology, and variable participation by the actors, as well as disconnects between problem identification, solutions, and opportunities for making choices.

The variable role by which research evidence influences the selection of an intervention may also contribute to the research-practice gap. A central role for empirical evidence in intervention adoption was not evident in this inquiry. It may be unrealistic to expect that empirical research evidence will play the leading role in determining the adoption of child mental health interventions. Frameworks used to examine policy decision-making, such as the tripartite framework, identify research evidence as only one component of information that influences decision-making (Lavis, 2004; Lomas, 1997). However, the adoption of a specific entity, parenting interventions, was the focus of this study, rather than a more global or abstract direction, for example, choosing to target parents to improve child outcomes. In the former, one might expect a more direct relationship between research and practice, a so-called instrumental use of research. Lindblom (1959) proposed that a rational comprehensive method might apply to relatively small-scale problem-solving, in contrast to more complex and abstract problem-solving that requires a different model for explanation, such as the incrementalist model or an enlightenment model as suggested by Weiss (1979). The selection of specific parenting interventions presumably would be a relatively small-scale problem.

Limitations

The restriction of this study to what might be considered "minor" innovation adoptions may limit applicability to "major" or more complex innovation adoptions. Minor adoptions may fail to engage a range of actors and hence be less influenced by the power distribution within the organization as seen in the adoption of complex interventions (Denis, Hebert, Langley, Lozeau, & Trottier, 2002). However, complex innovations may be composed of multiple minor innovation adoptions; hence some of these findings may be relevant to aspects of more major adoption efforts. In addition, apparently "minor" aspects of larger interventions may be critical in cases where fidelity to component parts of an intervention is important for outcomes.

Finally, the methodological approach limits the conclusiveness of the findings. This was an exploratory case study relying on the reconstruction of intervention adoption processes. Decision-making processes are not precise events (Langley et al., 1995). Informants for this study were often immersed in the process and their ability to accurately and objectively recall the process is difficult to gauge. Limited available documentation hampered corroboration of informants' recollections, though where possible two or more persons were interviewed about each given intervention adoption. Nevertheless, this pattern of findings needs to be confirmed or disconfirmed in additional inquiries of other intervention adoption efforts. In addition, quantitative inquiries may allow the relative weighting of the different variables proposed to influence intervention adoption.

The decision to engage in an inductive inquiry not guided by pre-existing theory is another possible methodological limitation. Though this approach may allow the "discovery" of elements otherwise missed through the restrictive lens of an existing model, the approach is limited in its ability to explicitly confirm, challenge, or build on existing models.

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CONCLUSION

Although there is an increasing discourse on the use of evidence-based interventions in community-based child mental health services, additional strategies are required to increase the role played by empirical research in intervention adoption. This inquiry identified key factors influencing the adoption of a specific type of psychosocial programming in community agencies. At least some of these factors may contribute to the existing research-practice gap in other community-based services. Attending to these factors may enhance efforts aimed at reducing the gap.

RÉSUMÉ

Pour découvrir les éléments contribuant aux disparités entre la recherche et la pratique dans les programmes de santé mentale des enfants, cette étude a tenté d'identifier les facteurs influençant l'adoption des programmes d'intervention parentale par les organismes communautaires. Une méthodologie qualitative a identifié 3 facteurs-clés: ressources nécessaires aux interventions, concordance des interventions avec les mandats de l'organisme et besoins perçus de la population visée. Les décideurs principaux étaient autonomes, mais restreints par le manque de ressources. Bien que valorisées, les données probantes paraissent secondaires dans le processus d'adoption. L'étude a examiné comment ces facteurs influencent les disparités entre la recherche et la pratique.

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