Promoting evidence-based practice in the provision of health coaching interventions for parents of children with developmental disabilities

Systematic literature review

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BACKGROUND

• Parents of children with developmental disabilities (DD) are known to experience heightened levels of stress, mental/physical health issues, family dynamics disturbances, financial strains and coping in view of their child's emerging deficits and functional challenges.1

• Current health care service models are not standardized nor are they flexible enough to address these needs in a comprehensive manner, often requiring ongoing services, gaps and duplications in service delivery, and urging for more accessible and cost-effective delivery models. 2

• Health coaching (HC), defined as "a goal-oriented, data-centered partnership that is health-focused and occurs through a process of client enrichment and empowerment", 3 has recently emerged.4

• HC in children’s disability is increasingly being applied and advocated for as an alternative to the traditional health-care service models; however, the existing evidence under HC needs to be accumulated to guide clinical practice and research in that area.

• QUESTION: Among parents of children with DD, how does a HC program vs. no intervention/less intensive intervention impact parent-related outcomes?

RESULTS

• 13 RCTs (2002-2017: USA, Australia, Hong Kong, UK, the Netherlands, Japan)

• 15 non-RCTs (2002-2018: USA, Australia, UK, Hong Kong, Iran, China)

• QUALITY: RCTs: 11; 9 high; 2 fair; 2 low; non-RCTs: 6 high; 3 fair; 6 low

• TARGET AUDIENCE:
  o Parents (sample size range: mean ± SD in RCTs: n=30/80 / 84.7 ± 35.9; in non-RCTs: n=38/375 / 37.5 ± 130 of children) (age range in RCTs: 1.5-16.5 years; in non-RCTs: 3 months-17 years) with:
    • Autism Spectrum Disorder (ASD): 6 RCTs, 13 non-RCTs
    • Cerebral Palsy (CP): 1 RCT; 1 non-RCT
    • Intellectual disabilities: 2 RCTs, 2 non-RCTs

• HC FORMAT:
  o Individual: 9 RCTs; 4 non-RCTs
  o Groups: 4 RCTs; 11 non-RCTs
  o Face-to-face: 10 RCTs; 15 non-RCTs
  o Online/at distance: 2 RCTs
  o Combination of face-to-face and online formats: 1 RCT

• HC TARGET:
  o 68%: education and support: 7 RCTs, 12 non-RCTs;
  o 32%: manualized + education: 4 RCTs, 3 non-RCTs;
  o 2-22 sessions: (mean ± SD: 7.75 ± 3.80 sessions)
  o Child-targeted approach: 8 RCTs; 10 non-RCTs
  o Parent-targeted approach: 3 RCTs; 3 non-RCTs
  o Mixed approach: 2 RCTs; 2 non-RCTs

• HC PROVIDER:
  o 84%: trained and accredited health-care professional;
  o 12%: graduate students in the field of psychology and occupational therapy
  o 5%: mothers of children with ASD

• CHILD NETWORK

• Key Messages

  1. 3 HC approaches were identified: child-targeted, parent-targeted and mixed;

  2. Most commonly applied approach: child-targeted;

  3. Primarily implemented for parents of children with ASD;

  4. There is currently insufficient to limited evidence on the effectiveness of these approaches in improving parent-related outcomes;

  5. Components of successful HC approaches that lead to improvements in parent-related outcomes:

    1. One-on-one parent-targeted approach (e.g. problem-solving/goal-setting/action-oriented sessions);
    2. Group learning;
    3. Individual telephone booster follow-up sessions;
    4. Self administered online learning modules with telephone booster follow-up sessions;
    5. Higher frequency and longer duration;

  6. Future studies should focus on:

    1. Parent-targeted and mixed approach
    2. HC for parents of children with CP, mixed diagnoses and intelligibility disability

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