Public Health Ontario | Santé publique Ontario

ENVIRONMENTAL SCAN

Prioritization of Parenting Indicators for Ontario Public Health Units

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Key Findings

- Ontario public health units (PHUs) need local population-level data on parents and families to assess community needs. Building on a prior PHO scoping review of parenting measures and frameworks, this environmental scan and prioritization identify relevant parenting indicators at the local PHU level.
- Overall, the environmental scan highlighted limited availability of population-level parenting and early relational health data PHUs measure parent mental health and parent-child attachment domains with strong consistency, though the number and type of parenting domains and indicators varied across PHUs.
- PHUs reported a lack of standardized tools and inaccessible data infrastructure as major barriers to comparable, actionable parenting indicators. PHUs reported challenges such as inconsistent data collection, limited staff capacity, and inaccessible Healthy Babies Healthy Children (HBHC) program data, which prevents aggregation and provincial reporting despite widespread use of some tools.
- A practical set of 12 priority indicators emerged, led by prenatal mental health, but cultural inclusivity remained a significant gap. Population health indicators from the Better Outcomes Registry and Network (BORN), the Canadian Health Survey on Children and Youth (CHSCY), and the Canadian Community Health Survey (CCHS) were prioritized due to high scores on importance, actionability and data availability at a local PHU level. These 12 indicators span six key domains of parenting and early relational health.

Background

Supporting parents and young families is critical to healthy growth and development across the life course and a function of local public health agencies. Public health units (PHUs) in Ontario are required to support "positive parenting" in their local communities based on the 2018 Ontario Public Health Standards (OPHS) Healthy Growth and Development Guideline.[1] However, there is no standardized set of parenting indicators at the population-level that PHUs are regularly using to determine the needs of their communities for parenting-related supports. Population assessment and surveillance is a foundational standard in the OPHS,[2] however there are few routinely collected sources of data for the Healthy Growth and Development (HGD) programs in PHUs. Therefore, PHUs have relied on their own resources and capacity to identify, collect, and analyze data on parenting.

While “parenting” has traditionally been used to describe the behaviours and practices of caregivers, it can unintentionally place responsibility and pressure for child health and well-being solely on parents and reinforces a one-directional relationship from parent to child. In recent years, there has been a shift toward reframing this language to *early relational health (ERH)* which broadens the lens to include the dynamic, reciprocal interactions between children and their parents/caregivers, as well as encompassing the community supports and environments that enable healthy development.[3] This broader term also enables centering relational strengths, rather than deficits, and emphasizes the socio-ecological systems that shape early experiences and which are fundamental to all child health and well-being programs.[4] Although ERH focuses on ages 0-6 years, this work was expanded to include parenting indicators in the prenatal period and all of childhood, reflecting the scope of many PHU programs and the age range covered in population health surveys.

Moreover, this language supports a paradigm shift underway in pediatrics and public health, which increasingly recognize relational health as a biological necessity for lifelong development and a key moderator of adversity across the life course.[5,6] While PHUs support this new term, this project was originally proposed using the term *parenting*. As such, for the purposes of this report, and to maintain alignment with the current OPHS, the term *parenting* was used for consistency. However, as mentioned, future public health work is likely to transition to the use of ERH.

The purpose of this project was to understand what parenting indicators are currently used in public health practice for population assessment and surveillance, program planning, and evaluation, across 29 PHUs in Ontario. This work complements a previously published Public Health Ontario (PHO) report, Parenting Measurement Tools and Frameworks: a Scoping Review.[7] This review aimed to capture common concepts across universal public health positive parenting frameworks and measurement tools for families with young children in the published peer-reviewed and grey literature.

This project had three objectives:

1. To compile a comprehensive list of parenting indicators currently used in Ontario public health units.
2. To highlight data gaps for important parenting domains and indicators that are absent in routine data collection; and
3. To prioritize a core set of parenting indicators for public health practice.

Methods

We used a multi-stage indicator identification and prioritization process including three phases of work. Phase 1 involved a structured survey of local PHUs. Phase 2 involved extensive consultation with the Ontario Parenting Community of Practice (CoP), mostly PHU staff in HGD programs, to contextualize the survey results and compile a complete list of parenting indicators for Ontario. Phase 3 involved a prioritization exercise conducted with the Parenting CoP to finalize key indicators across domains.

Phase 1: Environmental Scan

A survey was developed using the Qualtrics™ platform to collect data from PHUs on current parenting indicators and conducted in September-October 2025. The survey had three sections: 1) general information, 2) use of parenting indicators, and 3) gaps and needs. In section one, data was collected on name of the PHU, the program completing the survey (e.g., HGD, Healthy Babies Healthy Children

(HBHC), or Population Assessment and Surveillance), and a dichotomous question on whether the PHU used parenting indicators (Yes/No). Section two asked PHUs to identify the parenting domains for which

they had available data (see Appendix for a Table of parenting domain descriptions). For each selected domain, respondents were then asked to report the specific tools, scales, or instruments used to assess that domain, as well as the child age group(s) to which they apply (e.g., 0–2 years, 3–6 years). PHUs were also given the option to upload parenting surveys or assessment tools created by their health unit that would not be available publicly. In section three, three questions were asked about the gaps and needs of the PHUs including: 1) *Do you feel that the current parenting indicators available to your health unit adequately reflect the needs of your population*, using a rating from "Not at all" to "Completely", 2) *Are there parenting domains you would like to measure but currently lack appropriate indicators or tools?* If yes, they were asked to identify them in an open-text field, and 3) *What challenges do you face in using parenting indicators in your practice?* Respondents were given a list of options to select all that apply including lack of validated tools and inconsistent data collection.

PHUs were asked to report indicators by parenting domains which were identified a priori based on a scoping review of existing parenting measurement tools and frameworks.[7] Domains including parent mental health, parent–child interaction, attachment and bonding, co-parenting/family functioning, parenting confidence and self-efficacy, and parenting skills and behaviours were derived from the existing evidence-base. A parenting indicator was defined as "any measure or value used to show a particular aspect of parenting" that could be collected from various data sources, such as: parent self-reported surveys, standardized screening or assessment tools with validated scoring, observation checklists used by practitioners during home visits or programs, or administrative data, such as referrals, attendance, or program engagement.

Multiple surveys per PHU were permitted, mainly if they were completed by different program standards (e.g., HGD, HBHC, population assessment and surveillance). An inventory of reported indicators was compiled by domain, measurement tool, and data source. Data were analyzed using descriptive bar graphs that illustrated the proportion of PHUs reporting indicators and measurement tools across each parenting domain and for each question in Section Three.

Phase 2: Public Health Expert Consultation

A provincial Parenting CoP, composed of 64 public health practitioners from 25 PHUs provided public health expertise in parenting in the refinement of reported indicators from the environmental scan survey. The purpose of the CoP is to bring together Ontario's local PHUs to collaborate and share best practices promoting and delivering services related to positive parenting. One of the CoP's main goals was to collaborate on developing provincial indicators for parenting and parenting-related activities (Parenting CoP Terms of Reference, unpublished internal document). The CoP meets every two months, with two additional meetings added in February and March 2026.

Once survey data was collated, a spreadsheet was circulated to CoP members to review the draft indicator set. During the regularly scheduled CoP meeting, results of the survey were presented to the group, and the CoP assessed:

- conceptual relevance of indicators to parenting,
- data accessibility across health units,
- opportunities to clarify domains and add subdomains,
- feasibility of generating indicators at population, program, and evaluation levels, and
- potential alignment with relevant frameworks.[8]

Discussions were facilitated using the draft indicator spreadsheet, which organized information by domain, measurement tool, indicator type (population, program, and evaluation), and data source. Indicators that lacked sufficient data accessibility, were overly subjective, required specialized training,

or were not generalizable across health units were flagged for exclusion. Conversely, indicators supported by reliable population-level data sources were prioritized for retention.

Concurrent Ontario Early Adversity and Resilience Indicator Development

The final source for indicator identification was from the Association of Public Health Epidemiologists in Ontario Adverse Childhood Experiences and Resilience Indicator Working Group (APHEO ACER WG), who were simultaneously identifying indicators to map onto the Ontario Early Adversity and Resilience Framework (OEAR).[8] The OEAR Framework has four focus areas, including "Responsive and Culturally Safe Parenting/Caregiving." To reduce duplication and align the two data projects, all indicators developed through the APHEO ACER WG were added to the Parenting Indicators Project compiled list for prioritization.

Phase 3: Prioritization

Members of the CoP rated each indicator during a live prioritization exercise via Mentimeter™ using Results-Based Accountability[9] criteria previously established across various public health topics.[10,11] These included communication power, importance/proxy power, data power, actionability, and cultural inclusivity. Communication power was defined as whether the indicator is easily understood by various audiences (e.g., Medical Officers of Health, Boards of Health, community partners); importance/proxy power was defined as how well the indicator reflects a key aspect of parenting and early relational health; data power was defined as the quality, availability, reliability, timeliness, and coverage across PHUs; actionability was defined as the extent to which PHUs can influence change based on the indicator; and cultural inclusivity was defined as the extent to which the indicator was culturally sensitive and avoided misinterpretation across diverse communities. Each indicator was rated on each criterion from 1 to 5 (strongly disagree to strongly agree). An average score across the five criteria was then calculated and indicators were ranked from highest to lowest overall and subsequently, by domain to ensure indicators represented as many domains as possible.

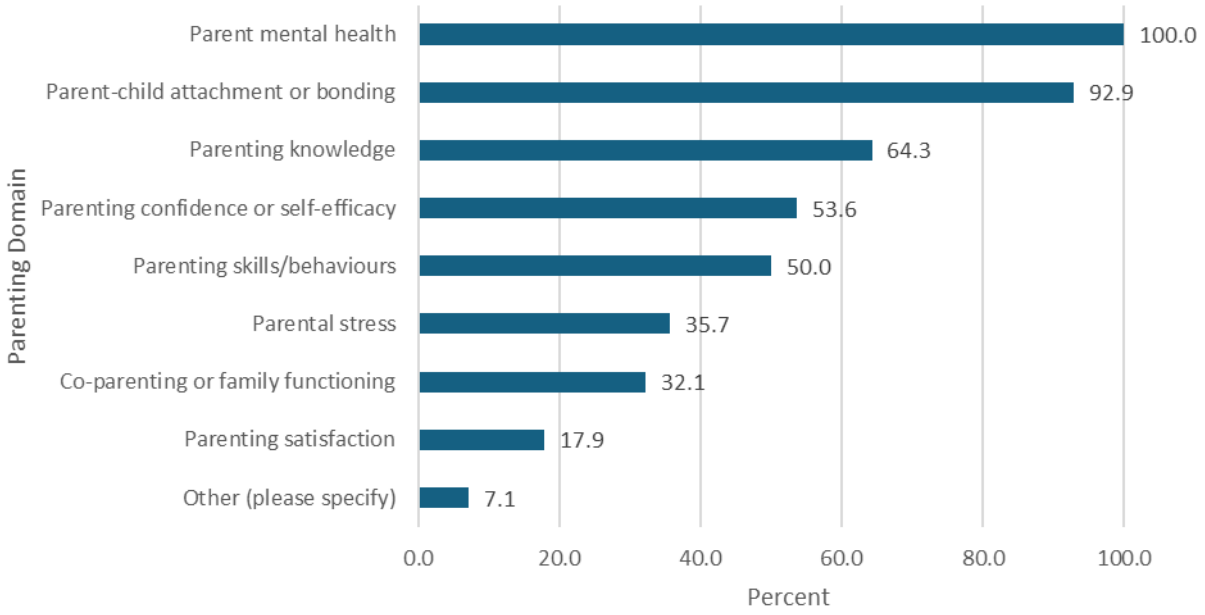
Results

Phase 1: Environmental Scan

There was a 100% response rate from PHUs, 20 PHUs submitted one survey and 9 submitted two or more, totalling 40 complete surveys. Partially completed surveys were excluded. Twenty-eight PHUs reported using parenting indicators and one PHU did not. The survey was completed predominantly by the Healthy Growth and Development divisions (27/29 PHUs) and Healthy Babies Healthy Children (HBHC) teams (17/29 PHUs). Two PHUs had only the HBHC teams complete the survey, and six PHUs included their Population Assessment and Surveillance teams.

The mean number of parenting domains reported by PHUs was 4.3 and the range was 1 to 8. Figure 1 presents the distribution of reported parenting indicators by domain; 100% reported parent mental health and 92.9% reported parent-child attachment or bonding (Figure 1). Two health units (7.1%) reported other domains including 'Infant Feeding' and 'Social Determinants of Health.'

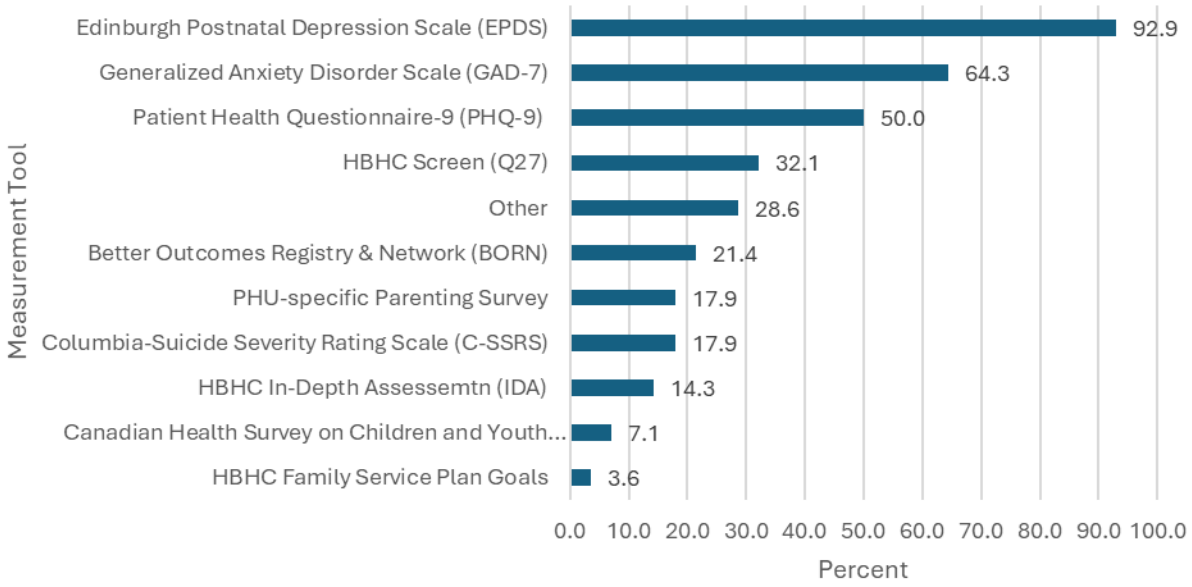
Figure 1: Percent of PHUs reporting on each parenting domain



Parent Mental Health Indicators (N=28)

To measure parent mental health, eight standardized measurement tools were reported by one or more PHUs (Figure 2). Overall, 92.9% of PHUs used the Edinburgh Postnatal Depression Scale (EPDS),[12] 64.3% used the Generalized Anxiety Disorder-7 (GAD-7),[13] and 50% used the Patient Health Questionnaire-9 (PHQ-9).[14] Often, PHUs reported using all three. Although these are standardized, self-reported assessment tools, many PHUs described the data collection as 'Clinical assessment by staff', meaning the tools were used in their one-on-one client services such as HBHC or perinatal mental health services. Five PHU's (17.9%) reported using their own questionnaire, and eight PHUs (28.6%) described other measurement tools (e.g., the Ontario Parent Survey,[15] Loneliness Social Isolations Scale,[16] PHO Snapshots[17]), 32.1% reported using question 27 from the HBHC Screen Questionnaire ("History of depression, anxiety or other mental illness?"). Only two PHUs reported using the parent self-rated mental health question from the Canadian Health Survey on Children and Youth (CHSCY) which asked "In general, how is your mental health? Would you say: excellent, very good, good, fair, poor."[18]

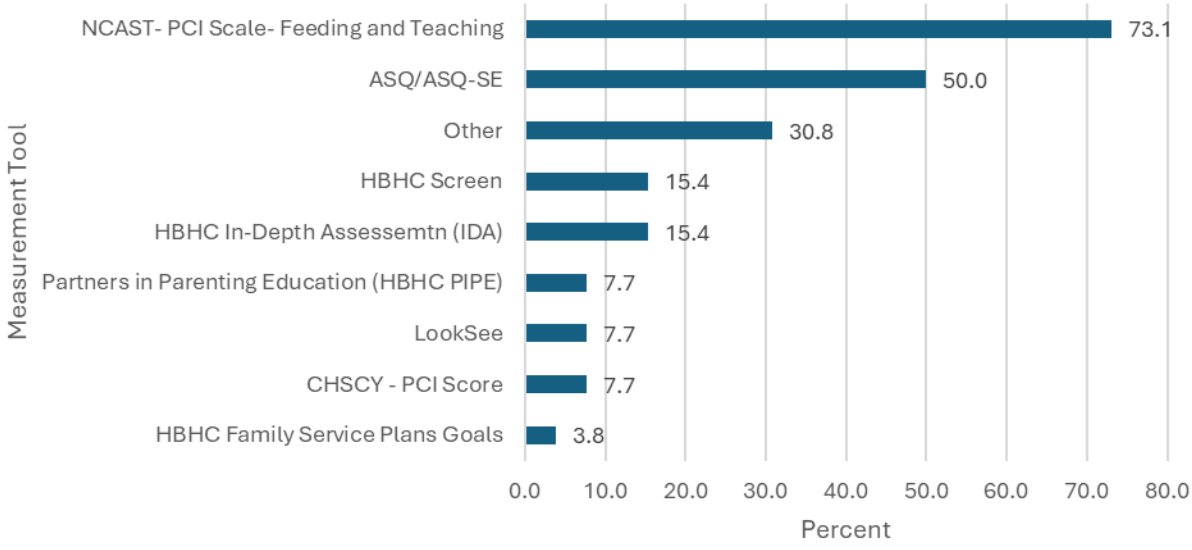
Figure 2: Types of measurement tools/data used to measure parent mental health



Parent-child Attachment or Bonding (N=26)

The second most reported domain was parent-child attachment or bonding, likely due to the standardized use of the Nursing Child Assessment Satellite Training (NCAST) Parent-Child Interaction (PCI) Feeding and Teaching Scales[19] used in the mandated HBHC Program (Figure 3). Similarly, 50% of PHUs reported using the Ages and Stages Questionnaire (ASQ)[20] to assess attachment and bonding, a questionnaire traditionally used to screen for developmental delay. The only representative population-level indicator reported by two PHUs was the parent-child interaction score from CHSCY.

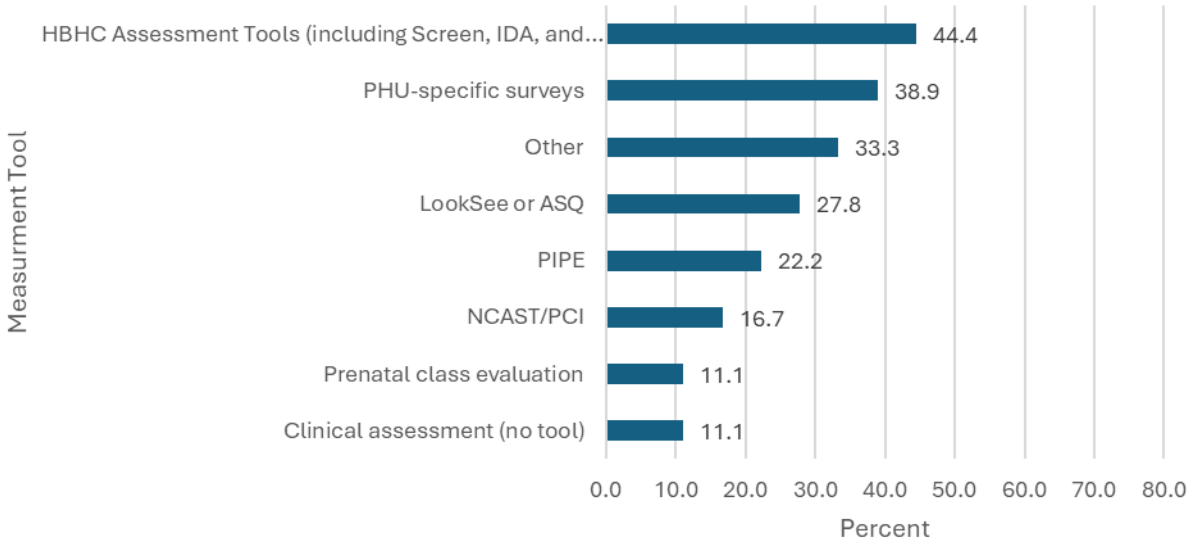
Figure 3: Types of measurement tools/data used to measure parent-child attachment or bonding



Parenting Knowledge (N=18)

To assess parenting knowledge, 44.4% of PHUs used the HBHC assessment tools and 38.9% used PHU-specific surveys designed for their local needs (Figure 4). Multiple PHUs also reported using pre- post-surveys from prenatal education programs (online or in-person) to measure gains in parenting knowledge that could be used for evaluation purposes. Several PHUs reported clinical assessments (e.g., ASQ, NCAST-PCI) to measure parenting knowledge, however like parent-child attachment these data are often collected on targeted populations in HBHC.

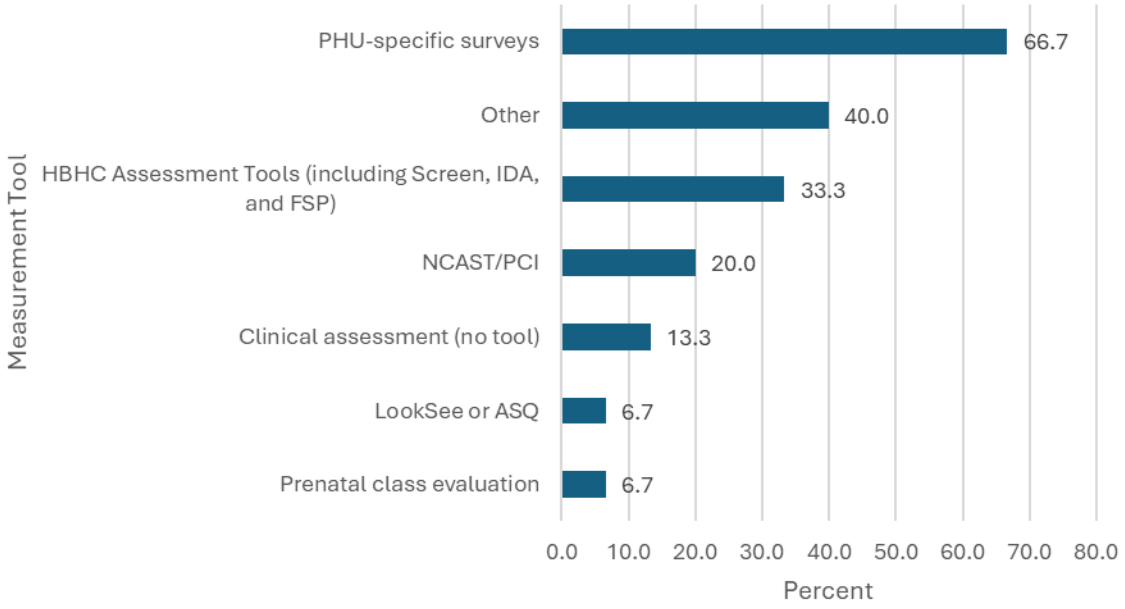
Figure 4: Types of measurement tools/data used to measure parenting knowledge



Parenting confidence or self-efficacy (N=15)

Fifteen PHUs reported measuring parenting confidence or self-efficacy, mainly through PHU-specific surveys (66.7%). Most of the other reported measurement tools were HBHC-specific assessments such as the HBHC In-Depth Assessment (IDA) and NCAST-PCI scales. No routinely collected, representative, and provincially available data sources for parenting confidence or self-efficacy were reported.

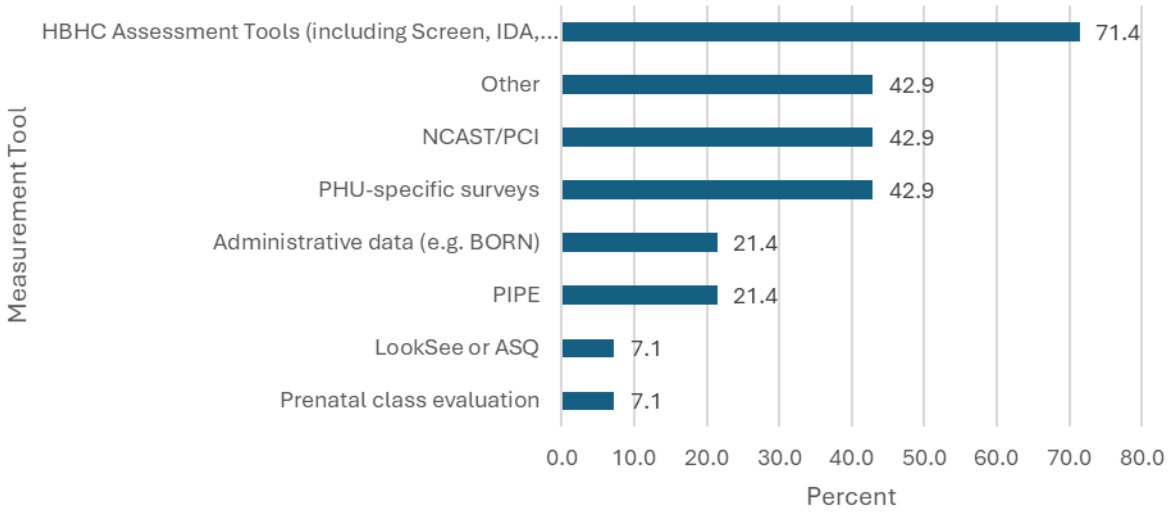
Figure 5: Types of measurement tools/data used to measure parent confidence or self-efficacy



Parenting Skills and Behaviours (N=14)

Parenting skills and behaviours were measured by 14 PHUs, predominantly through the HBHC program and PHU-specific surveys (Figure 6). Additional data sources included developmental screening tools (e.g., Looksee[21], ASQ), and prenatal class evaluations. Most of the measurement tools in this domain are completed by public health nurses in clinical assessments.

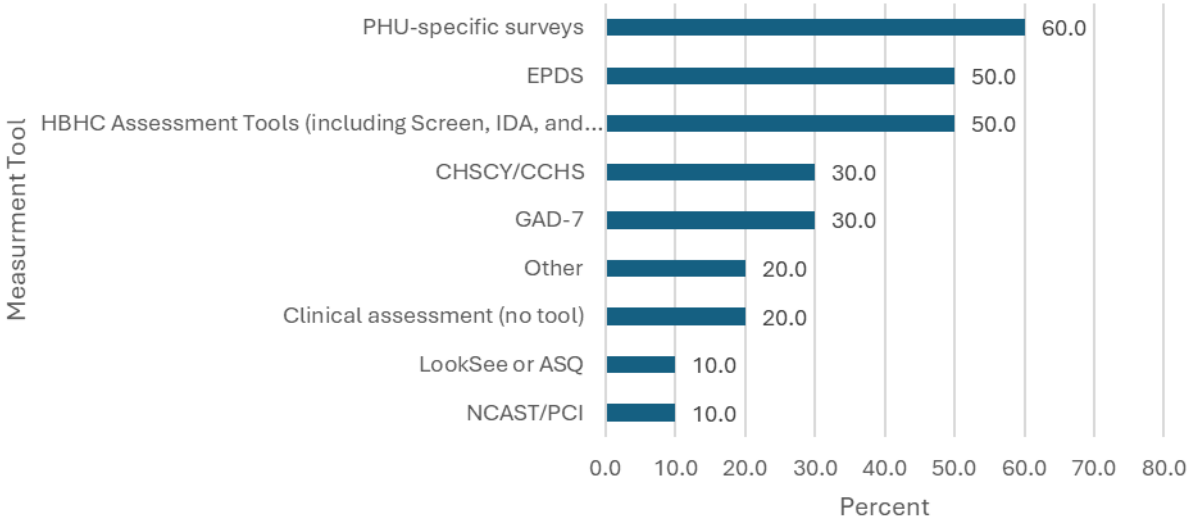
Figure 6: Types of measurement tools/data used to measure parenting skills and behaviours



Parent/Parenting Stress (N=10)

Although parent and parenting stress may also be captured in the domain on parent mental health and well-being, it was highlighted by the health units as an important and complex component in parenting that would benefit from its own domain. However, most of the measurement tools were like those reported in the parent mental health domain. Only three PHUs reported using the self-rated life stress question from CHSCY for parents/caregivers which is representative (Figure 7).

Figure 7: Types of measurement tools/data used to measure parent or parenting stress



Co-parenting or Family Functioning (N=9)

Only nine PHUs reported on the use of co-parenting or family functioning measurement tools or indicators; 77.8% reported using HBHC assessment tools, 55.6% reported using various other tools, 44.4% reported capturing this data using PHU-specific surveys and 33.3% used the CHSCY which has a dedicated family functioning module in the 2023 survey.

Parenting Satisfaction (N=5)

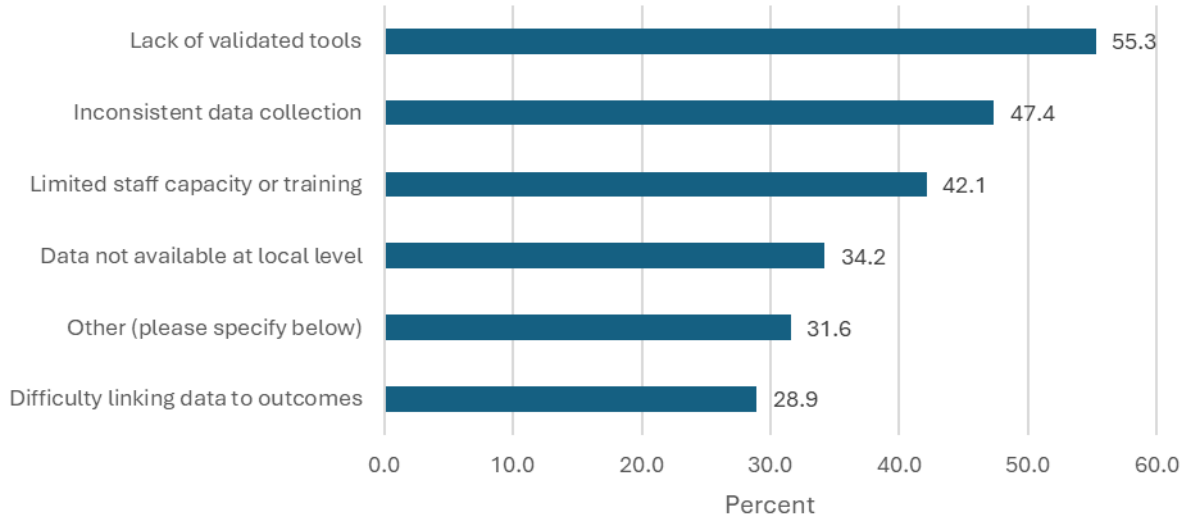
Parent satisfaction was reported by five PHUs; two reported using the HBHC IDA, and 3 reported using PHU-specific client surveys after specific programs or workshops. Understanding the concept of parenting satisfaction and how it relates to parenting confidence and self-efficacy is needed to clarify how to appropriately measure it for population assessment and surveillance.

Challenges and Needs

PHUs were asked to report on the adequacy of their currently available parenting indicators. While 36.8% reported they were “somewhat” adequate and 10.5% reported they were “mostly” adequate, 34.2% said “a little” and 18.4% said they were “not at all” adequate. No PHUs reported that the current parenting indicators were “completely” adequate. When asked to identify explicit challenges, PHUs identified data availability, infrastructure, and methodological challenges to the use of consistent and actionable parenting indicators in Ontario. Availability challenges centred around inconsistent data collection, lack of validated tools for public health, and available at the local level. Data accessibility challenges were described due to old and outdated infrastructure housing the HBHC data through the

HCD-ISCIS data system. Methodological challenges centred around a lack of sociodemographic and timely data and linking data to outcomes (Figure 8).

Figure 8: Percent of PHUs reporting on reasons for parenting indicator challenges



Lack of Standardized Tools and Data Availability

Many PHUs (55%) reported the absence of standardized provincial indicators and measurement tools across health units. There was broad agreement that establishing provincial indicators would enable alignment in data collection practices and improve comparability across the province. Current population-level surveys and routinely collected data, such as the HBHC universal screen, do not adequately report on concepts related to parenting and early relational health. Measuring parenting supports such as access to informal networks or low-barrier services remain poorly developed. As well, 42% of PHUs described limitations in staff awareness of validated measurement tools and gaps in capacity to implement them consistently.

Data Infrastructure and System Limitations

There was also a clearly reported need for accessible data. Although many tools, including NCAST, EPDS, and ASQ, are used consistently across programs, their data are not fully integrated into centralized systems such as HCD-ISCIS, limiting PHUs' ability to access aggregate scores. As a result, even when standardized tools are administered, the corresponding data may not be retrievable for reporting. Several participants also highlighted the lack of longitudinal data and the challenge of generating follow-up information and the ability to track outcomes over time when interactions with families are brief or one-time sessions.

Methodological Challenges

A few methodological challenges to the current indicators and data sources were identified by respondents including inconsistent methods for data collection, representativeness, timeliness, and reportability at the local level. Current data collection methods were perceived to result in systematic underrepresentation of some groups, while many surveys and administrative systems lacked detailed sociodemographic variables at all; data required for equity-informed stratified analyses for program planning. Concerns were raised regarding the representativeness of existing datasets as was the timeliness of population-level data, which often become accessible only after several years, restricting

their usefulness for real-time program planning or responsiveness to emerging needs. Finally, national survey sample sizes were noted to be too small for meaningful local-level reporting, limiting their utility for PHUs.

Phase 2: Public Health Expert Consultation

The Parenting CoP met in January 2026 to review the environmental scan results, with participation from 34 PHU staff across 23 PHUs. The CoP made several decisions regarding specific indicators and tools that were reported in the survey but subsequently determined to be not appropriate for inclusion (Table 1). Tools requiring specialized training or subjective interpretation, such as the NCAST-PCI Feeding and Teaching scales, PIPE, and item-level HBHC IDA data, were deemed inappropriate for population-level measurement and excluded from the main indicator list. It was discussed that some data sources may be retained in a category of HBHC-specific evaluation indicators, provided they are clearly delineated from the broader population indicator set.

Given the prominence of HBHC tools reported by the PHUs, there was a targeted discussion to determine whether these tools could support population-level indicators. Parenting CoP members described their access and use of HBHC data through the Health Child Development (HCD) ISCIS/IRSS system. Staff experiences using this data were compared across PHUs to assess ability to extract aggregate data, consistency of HBHC screen and IDA administration and scoring, usability for routine reporting, and potential for provincial comparability. Due to the overall inconsistency in HBHC screen administration and population coverage, as well as the inconsistent use of assessment tools, like NCAST-PCI, described in Table 1, consensus was reached to exclude all HBHC data, including the universal screen.

Table 1: Consensus on inclusion and exclusion of reported parenting indicators

Indicator / Tool	Decision	Rationale
Edinburgh Perinatal/Postnatal Depression Scale (EPDS)	Exclude; may be retained for evaluation purposes	• Data cannot be aggregated provincially • Limited usability outside program-specific contexts
HBHC Screen (Universal)	Exclude	• Screen coverage rates vary across PHUs therefore it is not generalizable for population surveillance (provincially coverage is <80% of live births) • Concerns about the validity of the parenting questions • Inconsistent screen quality across health units
HBHC In-Depth Assessment (IDA)	Exclude; may be retained for evaluation purposes	• Only overall risk score extractable from HCD-ISCIS/IRSS, item-level data inaccessible • Inconsistent IDA quality across health units • Not generalizable for population surveillance

Indicator / Tool	Decision	Rationale
NCAST / PCI Scales	Exclude; may be retained for evaluation purposes	• Requires specialized training • Complex scoring • Data unavailable in aggregate • Inconsistent use
PIPE Tool	Exclude	• No numerical score • Qualitative tool not suitable for indicators
Population Health Surveys (CHSCY, CCHS, etc.)	Retain	• Accessible, standardized, and comparable across Ontario and Canada
BORN Indicators	Retain	• Registry status provides standardized provincial perinatal data for all live births

Compiled List of Indicators for Prioritization

After discussion and consensus with the Parenting CoP, 33 indicators across six domains were determined to be included in the prioritization exercise (Table 2). The new data source provided from the APHEO ACER WG was from the Canadian Community Health Survey (CCHS)[22] module on Social Provisions which provided data for the domain "Parenting Supports."

Table 2: List for Prioritization

Domain	Age of child	Indicator	Data Source
Parent Mental Health and Well-being	Prenatal	Percent of mothers experiencing anxiety in pregnancy	BORN
Parent Mental Health and Well-being	Prenatal	Percent of mothers experiencing depression in pregnancy	BORN
Parent Mental Health and Well-being	Prenatal	Percent of mothers experiencing any mental health concern in pregnancy	BORN
Parent Mental Health and Well-being	Prenatal	Percent of mothers with a history of postpartum depression	BORN

Domain	Age of child	Indicator	Data Source
Parent Mental Health and Well-being	1-17 years	Percent of parents reporting their self-perceived mental health as negative (fair/poor)	CHSCY
Parent Mental Health and Well-being	1-17 years	Percent of parents reporting severe distress (≥13)	CHSCY
Parent Mental Health and Well-being	1-17 years	Percent of parents who were diagnosed by a health care provider with a mental health condition expected to last 6 months or longer	CHSCY
Parent Mental Health and Well-being	0-17 years	Percent of parents with a substance use problem – drugs or heavy drinking	CCHS
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who praise child a few times a week or less	CHSCY
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who focuses attention on child a few times a week or less	CHSCY
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who laughs with child a few times a week or less	CHSCY
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who does something special with child a few times a week or less	CHSCY
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who play sport/hobbies/games with child a few times a week or less	CHSCY
Parent-child Relationship	1-11 years	Percentage of parents who spend at least 3 hours per week reading to/with their child	CHSCY
Parent stress	1-17 years	Percent of parents who report their life being quite a bit or extremely stressful	CHSCY
Parenting skills/ behaviours	0-17 years	Rate of emergency department visits due to abuse, neglect, maltreatment	IntelliHealth
Parenting skills/ behaviours	0-16 years	Incidence rate of substantiated maltreatment investigation of children under 16 years old, by case	Local Children

Domain	Age of child	Indicator	Data Source
		category, and whether investigation or required ongoing support, or out of home placement.	Services Data
Parenting skills/ behaviours	1-14 years	Percent of parents reporting children spanked with hand by parental figure (“harsh parenting”)	CHSCY
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree they can turn to each other for support in times of trouble	CHSCY
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree indiviudals in the family are accepted for what they are	CHSCY
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree they can express feeling to each other	CHSCY
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree they feel accepted for what they are	CHSCY
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree they are able to make decisions about how to solve problems	CHSCY
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree they confide in each other	CHSCY
Co-parenting or family functioning	0-17 years	Adults with children at home who perceive a high level of social support	CCHS
Co-parenting or family functioning	1-17 years	Percent of children with a lone parent	CHSCY
Co-parenting or family functioning	1-17 years	Percent of youth (15-17) reporting emotional IPV (ever vs. never)	CHSCY
Co-parenting or family functioning	1-17 years	Percent of youth (15-17) reporting physical IPV (ever vs. never)	CHSCY

Domain	Age of child	Indicator	Data Source
Parenting supports	0-17 years	Emotional security and well-being – % of parents who report having close relationships that provide emotional security and well-being	CCHS
Parenting supports	0-17 years	Social support – % of parents who have someone to talk to about important decisions in their life	CCHS
Parenting supports	0-17 years	Competence and skills are recognized – % of parents who report having relationships where their competence and skills are recognized	CCHS
Parenting supports	0-17 years	Shared beliefs – % of parents who are part of a group who share their attitudes and beliefs	CCHS
Parenting supports	0-17 years	People to count on - % of parents who report having people they can count on in an emergency	CCHS

Phase 3: Prioritization

In March 2026, the Parenting CoP held a prioritization exercise for the identified parenting indicators. Participation included 31 individuals, representing 18 public health units, one academic partner, and the Applied Public Health Science Specialist in Healthy Growth and Development at Public Health Ontario. Members unable to attend the session were provided the prioritization results and invited to submit narrative feedback. Participants logged into Mentimeter™ using a QR code and were able to rate each indicator on the five criteria (communication power, importance/proxy power, data power, actionability, and cultural inclusivity) on a scale of 1 to 5 (strongly disagree to strongly agree).

Across 33 indicators, the average scores of all five criteria ranged from 2.9 to 4.0 out of 5. The top ten prioritized indicators are presented in Appendix Table 2. Percent of mothers experiencing any mental health concern in pregnancy from BORN data was the top ranked indicator with a score of 4.0. This indicator had the highest score on data power, importance, and communication. The lowest average scored indicator was “percent of parents with a substance use problem – drugs or heavy drinking” from CCHS, scoring the lowest on data power, cultural inclusivity, and actionability.

No indicator scored above a 3.2 on cultural inclusivity demonstrating that understanding parenting and early relational health needs for diverse communities will likely require independent PHU surveys of their local regions. Participants noted that most indicators scored lower on cultural inclusivity because the data sources, such as Statistics Canada questionnaires, are not culturally appropriate and may not reflect diverse parenting norms or experiences. Data power was viewed as highest for BORN, which is a birth registry providing data on all live births across Ontario. CHSCY indicators were rated as moderate, with many falling marginally below threshold of usefulness at the PHU level due to sample size limitations.[23] The CCHS parent module was consistently seen as the weakest source of data, with low sample sizes limiting local PHU reportability. Indicators related to parent stress, parent–child relationship behaviours, spanking, and social support were considered the most actionable because they are modifiable and lend themselves to clear intervention strategies. Conversely, indicators tied to severe mental illness and structural issues such as lone parenting were viewed as having low actionability, given their complexity and limited potential for direct public health intervention.

Parent Mental Health and Wellbeing

Parent mental health indicators generally had the highest prioritization scores despite cultural inclusivity scores being consistently lower. Participants discussed this as likely due to stigma and cultural differences in recognition and reporting. Data power was ranked as highest for BORN indicators, which receives data for all live births across the province, including from midwives, and has its own data quality protocols for ensuring high-quality data. Indicators representing mental health severity or clinical mental health diagnoses tended to have lower actionability scores. Participants noted that the composite "any mental health concern" measure was clearer and more communicative than each individual mental health conditions, despite anxiety and depression in pregnancy ranking in the top 10 overall. Although the parent substance use indicator was identified as important, the data power was very low due to challenges in measurement, differing definitions of types of substances (e.g., alcohol and drugs), and differing definitions in intensity of substance use (e.g., ever use vs. daily use), and the weakness of the data source (CCHS).

Parent-child relationship

The highest scoring indicator for parent-child relationship was "Percent of parents who spend less than 3 hours per week reading to/with their child" from CHSCY. Discussion among participants about parent–child relationship indicators highlighted concerns about cultural variability, clarity, and socioeconomic bias across several measures. Participants noted that indicators such as *praising* or *focusing attention* are highly subjective and interpreted differently across cultures, making them harder to interpret and communicate. The indicator *doing something special with child* was criticized for socioeconomic bias, as "special" activities often correlate with financial resources rather than relational quality. In contrast, *laughing with child* emerged as the second strongest parent-child relationship indicator because it is universally understood, culturally inclusive, and supported by evidence.[24] Indicators involving shared activities (e.g., playing games or reading together) were viewed more favorably for their clarity and relevance to bonding and development.

Parent Stress

There was only one identified parent stress indicator which was ranked 8th overall with a score of 3.72. Participants acknowledged parent and parenting stress as both highly relevant and very complex. They agreed that stress is a universal and recognizable concept, which contributed to its strong communication and importance scores. Additionally, several participants noted that public health nurses routinely encounter and support families experiencing stress, making the indicator feel highly actionable in day-to-day practice. However, it also emphasized that "stress" is not a single, uniform construct and its sources can vary widely, including financial strain, interpersonal challenges, mental health concerns, caregiving load, or substance use. This diversity makes it difficult to design population-level interventions that effectively address all underlying causes, leading some participants to temper their actionability ratings. The group also reflected on how parenting stress aligns with the broader OEAR Framework,[8] where reducing sources of stress is considered foundational,[25] yet often challenging in practice because many contributing factors fall outside the purview of public health. Overall, the indicator was seen as meaningful and practical, but also multifaceted, requiring nuanced interpretation and cross-sector collaboration to address effectively.

Parenting Skills and Behaviours

There were only three identified indicators in the Parenting Skills and Behaviours domain. All three indicators received consistently high scores for importance (>4), however, scored lower for cultural inclusivity, data power and actionability. The highest ranked indicator in this domain was only ranked 20th overall. Spanking/harsh parenting was viewed as the most actionable. Concerns about data power

were noted across all indicators, including underreporting of emergency department visits, inconsistent access to child welfare data across PHUs, and the likelihood that parent and caregiver self-reported spanking/harsh parenting underestimates true prevalence.

Co-parenting and Family Functioning

The youth-reported physical IPV indicator scored exceptionally high (4th ranked overall) likely due to the well-established association with trauma and acute and long-term mental health outcomes. Emotional IPV was ranked lower due to the current coding scheme of ever vs. never. However, when ranking by actionability emotional IPV was 6th with a score of 3.5 and physical IPV was 7th with a score of 3.4. The McMaster Family Functioning Scale questions from CHSCY scored high for importance and strong communication value, however only one of the questions was ranked in the top ten. Across all 10 family functioning indicators, participants highlighted ongoing challenges related to cultural inclusivity.

Parent Supports

Participants emphasized strong importance scores across the social support indicators, particularly for *people to count on* and *emotional security and wellbeing*, which were viewed as central to family and child well-being. However, data power for these measures remained consistently low due to very small sample sizes and limited reportability at the PHU-level. In addition, some indicators, such as *competence and skills recognized,* were noted as more difficult to communicate clearly, reducing their practical utility despite their conceptual relevance. Nonetheless, three parent support indicators were ranked in the top 10 with only the "percent who have someone to talk to about important decisions in their life" not being included in the final priority list (Table 3).

Headliner Indicators

To reduce the number of indicators and maximize the number of domains represented, the top two ranked indicators for each domain were included in the final list (Table 4). Three indicators were included for parent mental health and well-being because of measurement at two different time points (pregnancy and during childhood) and difference in mental health severity (general mental health status and intensity of distress).

Table 3: Priority parenting indicators for Ontario PHUs

Domain	Age of child	Indicator	Data Source
Parent Mental Health and Well-being	Prenatal	Percent of mothers experiencing any mental health concern in pregnancy	BORN
Parent Mental Health and Well-being	1-17 years	Percent of parents reporting severe distress	CHSCY
Parent Mental Health and Well-being	1-17 years	Percent of parents reporting their self-perceived mental health as negative (fair/poor)	CHSCY
Parent stress	1-17 years	Percent of parents who report their life being quite a bit or extremely stressful	CHSCY

Domain	Age of child	Indicator	Data Source
Parent-child Relationship	1-11 years	Percentage of parents who spend less than 3 hours per week reading to/with their child	CHSCY
Parent-child Relationship	1-11 years	Percentage of parents who laugh with child a few times a week or less	CHSCY
Co-parenting or family functioning	15-17 years	Percent of youth (15-17) reporting physical IPV (ever vs. never)	CHSCY
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17 years) who agree/strongly agree they can turn to each other for support in times of trouble	CHSCY
Parent Supports	0-17 years	Percent of parents who report having close relationships that provide emotional security and well-being	CCHS
Parent Supports	0-17 years	Percent of parents who report having people they can count on in an emergency	CCHS
Parenting skills/ behaviours	0-16 years	Incidence rate of substantiated maltreatment investigation of children under 16 years old, by case category, and whether investigation or required ongoing support, or out of home placement.	Children Services
Parenting skills/ behaviours	1-14 years	Percent of parents reporting children spanked with hand by parental figure ("harsh parenting")	CHSCY

Discussion

This environmental scan and prioritization process sought to identify feasible, accessible, and provincially comparable parenting and early relational health indicators for public health planning and surveillance. All parts of this process were overseen by the Ontario Parenting Community of Practice. Based on the previous PHO scoping review, no other provinces or territories in Canada have a core set of parenting indicators that are routinely measured or reported outside of population health surveys such as CCHS/CHSCY. The group provided critical review of the draft indicators and highlighted substantial limitations in the usability of many of the reported indicators at a population level. Collectively, the results underscored the urgent need for more robust, accessible data sources, and indicators for public health and across Ontario's early years settings. Despite several limitations of the currently available data, 12 indicators were proposed to address key parenting domains in public health practice.

Across PHUs, there has been a shift from a focus on *parenting* toward the broader and more inclusive concept of *early relational health*.[3] This change reflects a expanded understanding of how children's development is shaped not only by the behaviours of individual parents but by the quality of the relationships and environments surrounding them.[5] Emerging evidence highlights that safe, stable, and nurturing relationships, whether within families, early childhood settings, or the broader community,

are foundational to buffering adversity and supporting resilience in early childhood.[26] However, there is uncertainty in how to measure these concepts at a population level.[3]

A key finding was the need to refine the conceptual structure of the indicator set. Although initial domains, such as parent mental health, parent–child attachment and bonding, and parenting skills and behaviours, were derived from a scoping review and environmental scan the group observed opportunities to further clarify domain definitions and develop subdomains. Such refinement would support clearer alignment between indicators and early relational health constructs and improve conceptual coherence in a future ERH framework.

Participants emphasized significant gaps in routine measurement of parenting knowledge, parenting skills and behaviours, parenting confidence or self-efficacy, and parent supports, particularly in the early years. This aligns with experiences from other PHU indicator development initiatives, which identified major data gaps between the BORN prenatal and postpartum data and senior kindergarten Early Development Instrument data collection at age 5-6 years. Participants agreed that the current landscape lacks comprehensive indicators for children aged 0-6 years, reinforcing the need for indicator development efforts and strengthened provincial data infrastructure. These findings are in line with the most recent report from PHO, the Knowledge Institute and Sick Kids.[27]

Although there was a perceived lack of standardized indicators across the province, many PHUs reported using the same tools. However, what was really identified was a lack of data accessibility. The best example to illustrate data inaccessibility across Ontario is in the use of perinatal mental health tools. Across Ontario 28 out of 29 PHUs reported using the EPDS to measure perinatal mental health through HBHC, perinatal adjustment programs, or other public health delivered postpartum mental health services. However, due to data infrastructure limitations, an aggregate score of EPDS data is neither available at the PHU-level nor at the provincial-level. This was also consistent with other validated mental health tools such as the GAD-7 and the PHQ-9. These shortcomings of infrastructure highlight the need for data system modernization in public health, a responsibility that extends beyond local public health agencies.

The most substantive discussion centred on the feasibility of using HBHC program data, particularly tools such as the EPDS, NCAST/PCI scales, PIPE, and the In-Depth Assessment (IDA), for population-level or program evaluation indicators. There was consensus that these tools, despite their clinical and programmatic value, are not accessible in a form that allows extraction, or aggregation. Further, the utility of these indicators, beyond HBHC program evaluation, is uncertain as these data are only collected on a targeted population. There was also debate about use of the HBHC Universal Screening Questionnaire. Some PHUs with small population sizes and geographies, reported screening coverage rates well over 80%, however the majority of PHUs were below this threshold. Moreover, the validity of the questions addressing parenting were called into question when discussing the hospital nurses' ability to assess nuanced differences between support for parenting and supports for caring for the baby. Overall, it was deemed the HBHC screen was not a valid and reliable source of data.

The final list of prioritized indicators demonstrated the significant value of having valid and reliable data that is reportable at the local level, such as BORN data. As well, public health staff perceived parent mental health and well-being as fundamental to early relational health and parenting capacity. The lowest ranked indicators were those in the parenting skills and behaviours domain including harsh parenting practices and incidences of abuse and neglect. This was due to low scores on both cultural inclusivity and actionability. However, traditionally PHUs have invested in delivering programs aimed at improving parenting skills and confidence through parent training programs like Triple P[28] and Nobody's Perfect.[29]

Indicators in the parent-child relationship and co-parenting/family functioning domains had high scores. This is likely the result of the CoP expertise in understanding concepts of early relational health and its

importance in brain development and resilience building. To identify the early relational health needs of their community, it is crucial for PHUs to have data to support their decision-making. At present, available indicators do not provide a complete picture of early relational health at a population level. Although two indicators were prioritized for parent supports, which are measured in CCHS, there are limitations including small sample sizes of parents in the CCHS data and low variability across the indicators (over 95% of parents describe having people to count on and emotional security and well-being). There are likely better indicators that can be developed to measure early relational health and parenting supports. Overall, the group favored indicators that reflected universally meaningful interactions while expressing caution about those shaped heavily by cultural norms or socioeconomic context.

Limitations and Strengths

This rigorous process to identify and prioritize parenting indicators had multiple strengths. Firstly, a comprehensive literature review was conducted[7] as well as this environmental scan to identify indicators. Secondly, public health parenting experts, engaged through the CoP, provided important context to survey results. Finally, prioritization was undertaken using criteria informed by the public health literature and agreed upon through consensus by CoP members. As well, Mentimeter proved to be an efficient and well-liked tool among the CoP, particularly for its ability to support real-time discussion of ranking results.

Despite these strengths, this process also had several limitations. Initially, both evaluation and population indicators were included during the identification process, which made the approach too complex. Therefore, the environmental scan survey asked participants to include indicators and data that was too broad and many PHUs reported data sources that were inaccessible. As well, even though the prenatal period and all childhood was in scope, these indicators are not comprehensive of assessing parenting of adolescents and prenatal behaviours/risk factors. During the prioritization process, input from epidemiologists was needed to assess the strength of the data sources and the ability to report estimates by PHU. Although the prioritization criteria were finalized by the CoP, there were still five, which is more than in other published literature. Having fewer prioritization criteria may have simplified the process and improved clarity.

Next Steps

This project provided foundational insight into how parenting and ERH are currently measured across public health practice in Ontario. However, several system-level considerations to support future effective parenting indicator development and use were highlighted. PHU's identified key next steps including updating the HBHC universal screen to ensure continued relevance, investing in dedicated liaison roles to support consistent completion and follow-up, and strengthening collaboration with the Ministry of Health and Ministry of Community Children and Social Services to align expectations. In addition to these system-level considerations, future indicator development should prioritize the gaps identified in this work such as parenting supports, knowledge, and self-efficacy. Further, future indicators should emphasize clarity, feasibility, sensitivity to change over time, and relevance across diverse local contexts and cultures. Collectively, these considerations highlight the importance of pairing indicator development with enabling infrastructure and cross-sector collaboration to support meaningful, sustainable, and actionable population-level assessment and surveillance.

Conclusion

This project underscored the limited availability of provincial-level parenting and ERH data and emphasized the need for investment in valid, reliable, and accessible data. The decisions emerging from the Parenting CoP, particularly the removal of HBHC program-level data and exclusion of tools that lack accessibility, will help ensure that the resulting indicator set is practical, evidence-informed, and aligned with broader provincial initiatives. Ultimately, this work highlights both the challenges and opportunities in strengthening Ontario's capacity to measure and monitor early relational health and provides a foundational step toward developing interventions to address the parenting and early relational health needs of communities.

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Appendix

Table 1: Examples of indicators for each domain and common tools/measures

Parenting Domain	Example Indicators	Common Tools/Measures
Parental Stress	• Frequency of feeling overwhelmed by parenting responsibilities • Perceived stress levels	**Parenting Stress Index (PSI), PSI-Short Form**, Parental Stress Scale (PSS)
Parenting Confidence / Self-efficacy	• Parent's belief in their ability to handle parenting challenges • Confidence managing routines	**Parenting Sense of Competence Scale (PSOC)**, Tool to Measure Parenting Self-Efficacy (TOPSE)
Parent-Child Attachment	• Parent reports feeling emotionally close to their child Parent responds promptly to distress • Parent engages in positive serve and return interactions • Parent reports and demonstrates safe, stable and nurturing relationship with child	**Maternal Postnatal Attachment Scale (MPAS)**, **Ages & Stages Questionnaire Social-Emotional (ASQ-SE)**, observational tools
Parenting Knowledge	• Knowledge of child developmental milestones • Knowledge of importance of healthy brain development, attachment/early relational health, core life skills, positive parenting strategies • Awareness of safety practices	**Knowledge of Infant Development Inventory (KIDI)**, custom quizzes/surveys
Parenting Behaviors / Skills	• Consistency in setting limits • Use of positive discipline strategies • Use of positive serve and return interactions	**Alabama Parenting Questionnaire (APQ)**, **Parenting Practices Questionnaire (PPQ)**
Parent Mental Health	• Symptoms of depression, anxiety, or emotional distress • Parental strengths/resilience factors (e.g. engagement with community supports)	**Edinburgh Postnatal Depression Scale (EPDS)**, PHQ-9, GAD-7
Family Functioning / Co-parenting	• Communication and cooperation between caregivers Conflict resolution in parenting roles	**Family Assessment Device (FAD)**, **Co-parenting Relationship Scale (CRS)**

Parenting Domain	Example Indicators	Common Tools/Measures
	• Family and parenting supports (e.g. other caring adults in child's life)	
Parenting Satisfaction	• Overall satisfaction with the parenting role • Feeling fulfilled as a parent	**PSOC Satisfaction Subscale**, **Parental Satisfaction Questionnaire (PSQ)**

Table 2: Prioritization scoring of parenting indicators by criteria

Domain	Age of child	Indicator	Communication	Importance	Data	Actionability	Cultural inclusivity	Average score
Parent Mental Health and Well-being	Prenatal	Percent of mothers experiencing any mental health concern in pregnancy	4.4	4.6	4.6	3.8	2.8	4.04
Parent Mental Health and Well-being	Prenatal	Percent of mothers experiencing depression in pregnancy	4.2	4.4	4.6	4	2.7	3.98
Parent-child Relationship	1-11 years	Percentage of parents who spend less than 3 hours per week reading to/with their child	4.3	4.4	3.6	3.9	3.2	3.88
Co-parenting or family functioning	15-17 years	Percent of youth (15-17) reporting physical IPV (ever vs. never)	4.3	4.6	3.8	3.4	3.1	3.84
Parent Supports	0-17 years	Emotional security and well-being – % who report having close relationships that provide emotional security and well-being	4.1	4.7	3.5	3.7	3.1	3.82
Parent Mental Health and Well-being	Prenatal	Percent of mothers experiencing anxiety in pregnancy	3.8	4.2	4.2	4	2.8	3.80
Parent Supports	0-17 years	People to count on - % of parents who report having people they can count on in an emergency	4.4	4.6	3.6	3.1	3.2	3.78
Parent stress	1-17 years	Percent of parents who report their life being quite a bit or extremely stressful	4.3	4.4	3.6	3.3	3	3.72

Domain	Age of child	Indicator	Communication	Importance	Data	Actionability	Cultural inclusivity	Average score
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17 years) who agree/strongly agree they can turn to each other for support in times of trouble	4	4.4	3.6	3.4	3.1	3.70
Parent Supports	0-17 years	Social support – % who have someone to talk to about important decisions in their life	4.1	4.3	3.6	3.4	3	3.68
Parent Mental Health and Well-being	Prenatal	Percent of mothers with a history of postpartum depression	3.7	3.8	4.6	3.5	2.7	3.66
Parent Mental Health and Well-being	1-17 years	Percent of parents reporting severe distress (≥13) (Prochaska et al., 2012)	3.6	4.3	4	3.4	3	3.66
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who laughs with child a few times a week or less	4	4.1	3.3	3.5	3.1	3.60
Parent Mental Health and Well-being	1-17 years	Percent of parents reporting their self-percevied mental health as negative (fair/poor)	4.1	4	3.8	3.4	2.7	3.60
Co-parenting or family functioning	15-17 years	Percent of youth (15-17) reporting emotional IPV (ever vs. never)	3.9	4.4	3.4	3.5	2.7	3.58
Co-parenting or family functioning	0-17 years	Adults with children at home who perceive a high level of social support	3.8	4.2	3.3	3.4	3.2	3.58

Domain	Age of child	Indicator	Communication	Importance	Data	Actionability	Cultural inclusivity	Average score
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree they can express feeling to each other	4	4.3	3.4	3.4	2.6	3.54
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree they confide in each other	3.9	4.1	3.5	3.2	2.9	3.52
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree they feel accepted for what they are	3.7	4.2	3.5	3.2	2.9	3.50
Parenting skills/ behaviours	0-16 years	Incidence rate of substantiated maltreatment investigation of children under 16 years old, by case category, and whether investigation or required ongoing support, or out of home placement.	3.7	4.5	3.2	3.2	2.9	3.50
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17years) who agree/strongly agree individuals in the family are accepted for what they are	3.6	4.2	3.5	3.3	2.8	3.48
Parenting skills/ behaviours	0-17 years	Rate of emergency department visits due to abuse, neglect, maltreatment	3.5	4.3	3.3	3.2	2.9	3.44
Parenting skills/ behaviours	1-14 years	Percent of parents reporting children spanked with hand by parental figure (“harsh parenting”)	3.6	4.2	3.1	3.5	2.5	3.38

Domain	Age of child	Indicator	Communication	Importance	Data	Actionability	Cultural inclusivity	Average score
Parent Mental Health and Well-being	1-17 years	Percent of parents who were diagnosed by a health care provider with a mental health condition expected to last 6 months or longer	3.4	4	3.8	3	2.6	3.36
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who praise child a few times a week or less	3.6	3.7	3.3	3.4	2.7	3.34
Co-parenting or family functioning	1-17 years	Percent of parents (1-11 years) or youth (12-17 years) who agree/strongly agree they are able to make decisions about how to solve problems	3.5	3.9	3.4	3.1	2.7	3.32
Co-parenting or family functioning	1-17 years	Lone-parent family	3.6	3.8	3.7	2.7	2.4	3.24
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who does something special with child a few times a week or less	3.1	3.6	3.2	3.1	2.6	3.12
Parent Supports	0-17 years	Shared beliefs – % who are part of a group who share their attitudes and beliefs	3.4	3.2	3.1	2.8	2.9	3.08
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who focuses attention on child a few times a week or less	2.9	3.5	3.3	2.9	2.6	3.04
Parent-child Relationship	1-11 years	Parent-child interaction (PCI): Percentage of parents who play sport/hobbies/games with child a few times a week or less	3.3	3.4	3	2.9	2.6	3.04

Domain	Age of child	Indicator	Communication	Importance	Data	Actionability	Cultural inclusivity	Average score
Parent Supports	0-17 years	Competence and skills are recognized – % who report having relationships where their competence and skills are recognized	3.1	3.4	3.1	2.5	2.5	2.92
Parent Mental Health and Well-being	0-18 years	Percent of parents with a substance use problem - drugs or heavy drinking	3	3.9	2.3	2.8	2.5	2.90

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