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Consumer engagement and the development, evaluation and dissemination of evidence-based parenting programs

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Abstract

A consumer perspective can contribute much to enhancing the "ecological fit" of population level parenting interventions so they meet the needs of parents. This approach involves building relationships with consumer groups and soliciting consumer input into the relevance and acceptability of interventions, clarifying the enablers and barriers to engagement and involvement of parents, and clarifying variables that influence a parent's program completion. The adoption of a more collaborative approach to working with consumers is important if meaningful population level change in the prevalence of serious social, emotional and behavioral problems in children and young people is to be achieved. Parents seeking assistance for their children's behavior come from a diverse range of socioeconomic backgrounds, educational levels, cultures and languages. This paper examines consumer engagement strategies that can be employed throughout the process of program development, evaluation, training and dissemination and in "scaling up" the intervention. We argue that a multi-level public health approach to parenting intervention requires a strong consumer perspective to enable interventions to be more responsive to the preferences and needs of families and to ensure improved population reach of interventions. Examples from large scale dissemination trials are used to illustrate how consumer input can result in an increasingly differentiated suite of evidence-based parenting programs.

As evidence demonstrating the efficacy of behaviorally based parenting programs increases (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009), so does professional obligation to ensure that effective programs are made more widely available. Policy led initiatives have resulted in unprecedented parental access to evidence-based parenting programs in several countries including the United Kingdom (Scott, 2010), Canada, US, various European countries, and in Australia and New Zealand. Increased access has also occurred in Asian countries such as Hong Kong (Leung, Sanders, Leung, Mak, & Lau, 2003). Efforts to disseminate parenting programs more widely have been in part a response to the continuing high level of psychosocial problems experienced by children and young people (e.g. Sanders, Markie-Dadds, Rinaldis, Firman, & Baig, 2007; Sawyer et al., 2000; Beyer & Furniss, 2007), as well as the demonstrated value of parenting programs in both the prevention and treatment of conduct problems (Dretzke et al., 2009; Prinz et al., 2009; United Nations Office on Drugs and Crime [UNDOC], 2009; World Health Organisation, 2009) and the prevention of child maltreatment (Mercy & Saul, 2009; Prinz et al., 2009). In this paper we argue that the success of translational research efforts to "scale up"

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empirically supported parenting interventions are likely to be more successful when program developers, researchers, service providers and funders adopt a strong consumer focus to their work with families.

Interest in capturing the consumer perspective in behavior therapy is not new. In the 1970's a range of studies were undertaken to "socially validate" various behavioral procedures used with children and young people (Wolf, 1978). Studies seeking the views of parents and teachers regarding the acceptability of behavior change procedures (e.g., praise, timeout) established that consumers of behavioral programs were generally supportive of these interventions (e.g., Kazdin, 1980). Although alternative views have been expressed regarding appropriate methodologies to conduct social validation studies (e.g., Fawcett, 1991; Witt, 1986), the role of consumers in the development of a scientific approach to parenting intervention is broader than determining the acceptability of interventions. Recent debate about the involvement of consumers in psychological interventions has raised the potential value of direct-to-consumer marketing of interventions (DTCM). Direct-to-consumer marketing of drugs has caused considerable controversy in the pharmaceutical industry and calls to ban the practice (Hollon, 2005; Strange, 2007). Although the DTCM debate has yet to be played out in the field of evidence-based parenting programs there is a need for greater clarity around the role of consumers in parenting programs. We argue that better engagement with consumers has the potential to improve the quality and ecological fit of interventions and their evaluation.

Consumer engagement refers to a process whereby parents' knowledge and experience about raising children and their family situation is shared in a collaborative dialogue with program developers, practitioners, and researchers. This information sharing is fundamentally for the benefit of consumers (although knowledge about consumer views clearly has benefits to professionals, developers and researchers). As a collaborative, bidirectional process of exchange consumer knowledge and experience can be combined synergistically with professional expertise to produce better interventions and enhanced outcomes for the consumer group. For example, Stepping Stones Triple P which had previously been developed for parents of children with an intellectual disability was adapted effectively for use with parents of children with Autism Spectrum Disorder through engaging with the consumer group (Whittingham, Sofronoff, Sheffield, & Sanders, 2009). In this context it is important to note that the ultimate recipients of parenting interventions are children and young people, who along with parents, are the major beneficiaries of improved family relationships that often result from good parenting programs. The issue of how to engage children as consumers is clearly an important and relatively neglected issue in parenting research. Although beyond the scope of the present paper, children are being increasingly targeted by commercial interests and marketers in recognition of their influence over family purchases. Moreover, one could argue that the perceived consumer group varies as a function of the child's problem or age. For example the consumer group may include both parent and youth in the case of a 15 year old with depression, however include only the parents with a 3-year old with conduct problems.

The rationale for strengthening relationships with consumer groups is that many parents who are looking for assistance with their children find it difficult to access suitable services, particularly evidence-based parenting programs. Evidence-based parenting programs are programs that have been rigorously evaluated through randomised control trials and show increased positive parenting practices and reduced ineffective disciplinary practices. They produce better mental health and developmental outcomes in children than do comparison conditions, such as care as usual, no treatment, or wait list control conditions (e.g., Sanders, 1999; Taylor & Biglan, 1998). Typically only a small percentage of parents participate in evidence-based parenting programs (Sanders et al., 2007). Low participation rates by parents

mean programs have inadequate population reach resulting in weak effects at a population level. Concerns about low participation, high dropout rates and the social stigma associated with participating in parenting programs, has led to increasing calls for the adoption of a public health approach to the delivery of parenting services. This is particularly evident with the most disadvantaged and marginalized groups who are at risk of maltreating their children, or those who are mandated to undertake parenting programs.

We and others have argued that a public health approach to the delivery of prevention services including parenting programs (Biglan, 1995; Jackson & Dickinson, 2009; Prinz & Sanders, 2007; Sanders, Cann, & Markie-Dadds, 2007) is needed to reach families who most need parenting support (Sanders, 1999; 2010). Adoption of a population approach and the need to engage a wider range of parents in programs has provided an impetus for research seeking to improve our understanding of the experiences of parents as consumers of parenting programs (Sanders, 2008). It is through building stronger collaborative partnerships with consumers that the next generation of consumer informed evidence-based parenting programs will evolve.

Consumerism, self-regulation and the principle of sufficiency

The term consumer in a health context has been defined as a receiver or a potential receiver of health care products, programs, or services (Boote, Telforf, & Cooper, 2002). Much of the debate about whether clients should be viewed as consumers centers on the context within which parents are accessing parenting programs or services. When a parent assumes the client or patient role the underlying premise is that the clinician's professional expertise will inform the assessment of the client's problems and the most efficacious treatment will be provided to alleviate the client's difficulty. In this instance the parent is assuming the role of a '*client*' or '*patient*' and is either paying for services personally, through some form of insurance company, or through its taxation revenue. The role of the parent in parenting programs is to be cooperative, share their concerns, participate in the program, implement the parenting advice at home with their children, and generally follow the advice provided by the professional. The practitioner's role is to assess the parent's problem, maintain a good professional relationship with the parent, and provide professionally responsible and effective therapy. Therapy components may include explaining, modeling skills, observing parents implement skills and providing feedback to parents, and designing homework tasks to assist the parent to apply the skills they have learned with their children. In this approach the practitioner largely determines what intervention will be provided, the dosage level to be used (intensity), and the length of the required intervention. Although this traditional clinical model of service delivery works reasonably well for individually administered programs when delivered in a mental health treatment context, it is inadequate as a model for the delivery of the full range of parenting services needed to reduce the prevalence rates of serious problems. For example, a multilevel population based approach could employ flexible delivery of parenting programs to increase the population reach of programs through the use of large group seminars, brief primary care interventions, web applications, and telephone based interventions (Sanders, 2010).

An alternative framework involves viewing the role of parents as both a client and consumer. Encouraging parents to see themselves as consumers of parenting services empowers parents to be more proactively involved in the development, implementation, evaluation and dissemination of parenting programs. A self-regulation approach (e.g., Karoly, 1993; Sanders, 2008) is particularly useful in supporting parents in the client and consumer roles. Self-regulation theory postulates that learning is a process whereby individuals are taught skills to change their own behavior and become independent problem solvers in a broader social environment (Karoly, 1993). A self-regulatory model when

applied to parenting support seeks to build parenting expertise, through empowering the parent with the relevant knowledge and skills in order to solve the specific problems experienced by the parent. For a parent to become a skilled self-regulator they may require support from others (including but not necessarily clinicians) to learn to manage or resolve their day to day parenting challenges. The adoption of a self-regulation approach is facilitated when consumers are well informed and know what programs work for which kinds of children and problems, and where they can find them. The ultimate goal of intervention should be to assist parents to become independent problem solvers where they acquire the skills and knowledge they require to tackle current problems or prevent future ones. Too great a reliance on practitioners for successful resolution of pre-existing problems may inadvertently create a level of dependency on others that undermines the goals of self-directedness and autonomy. A self-regulation perspective and consumer advocacy approach complement each other well.

Relationships between consumers and evidence-based programs

The value professionals place in adopting a consumer perspective to their work (including direct marketing of services or programs to consumers) depends on the importance attached to the role of consumers generally in developing, implementing and evaluating not only parenting services, but services in general. Many evidence-based parenting programs were developed in the 1960's and 1970's as individual or group administered programs to address an unmet need for effective treatments for aggressive and non-compliant children (e.g., Patterson, Reid, Jones, & Conger, 1975; Forehand & McMahon, 1981). However, these programs were primarily theory driven and built on evidence from systemic observations of parent-child interactions showing the relationship between parenting variables (e.g., harsh, inconsistent, coercive parenting practices) and adverse child outcomes (e.g., antisocial behavior, delinquency). This approach to intervention development supported by observational evidence has been the hallmark of behaviorally oriented programs and remains important so that the targets of intervention are variables that are causally implicated in the development or maintenance of child and youth problems. Contemporary parenting programs draw not only on this foundational work based in learning theory, applied behavior analysis, and cognitive-behavioral principles, but also developmental concepts (e.g., attachment), family-systems theory and principles and concepts derived from public health approaches to intervention. In this investigator-led process of program development, parents have always been important informants as recipients of parenting intervention; however, they have had a limited role in the design, refinement, implementation, evaluation, and subsequent "scaling up" of programs. The parents primarily provide feedback to researchers via consumer surveys (Turner & Sanders, 2006; Webster-Stratton, 1989) regarding their experience of the intervention and whether the program met their personal or child's needs. Although such consumer feedback is relevant, it is limiting and is provided mostly after the fact to gauge whether parents considered the program was worthwhile.

An alternative is to adopt a more collaborative approach to program development. This involves forming a partnership with consumers from the beginning. Such an approach can be operationalized in different ways; however, it involves actively harnessing the consumer's voice to strengthen the quality, relevance and effectiveness of an intervention. The participatory action research paradigm (PAR; Whyte, Greenwood, & Lazes, 1989) is one such model that advocates the direct involvement of consumers in determining the research questions, designs, methods, analyses, and products (Torre & Fine, 2006). The PAR model is increasingly being encouraged to be adopted within social sciences research (Whyte et al., 1989). Goodare and Smith (1995) argue that consumers should be a primary focus of attention when designing, conducting, and reporting on the outcomes of research. A collaborative approach based on a mutuality of respect between program developers,

researchers and the parent as consumer is required. Moreover, the relationship between consumers and developers should be viewed as dynamic, reciprocal and constantly evolving so that a meaningful role is created for consumers to provide input into the decision making process relevant to different stages of the development, implementation, evaluation and dissemination process.

The principles argued within the PAR model are also echoed within Diffusion of Innovations theory (Rogers, 1995). Diffusion of Innovations theory focuses on three key characteristics in order to facilitate the dissemination of new ideas, products, or programs, and they include, (a) perceptions people/government/organisations have of the innovation; (b) characteristics of the people who adopt or fail to adopt the innovation, and (c) contextual factors, particularly marketing and organisational factors (Berwick, 2003). In a systematic review of Diffusion of Innovations theory, Greenhalgh et al (2004) noted that in order for a program to have success there needs to be a participatory process where consumers and developers are involved in reciprocal interactions during the research process in order to produce more valid and meaningful products, programs, or services.The advantages of such an approach are that program developers can more readily identify enablers and barriers to parental participation (e.g., time commitment required, the cost, location, timing of programs, program format and mode of delivery) and steps can be taken to ensure that programs are tailored or customized to the needs and preferences of parents (Parloff, 1983). The same model of program development can also act as a blueprint for other psychological interventions. Through garnering the consumers' perspectives regarding how they are coping with the specific problems, combined with the clinicians' and researchers' knowledge, a synergistic relationship can develop and new insights (e.g., preferred modes of delivery of a program such as web, TV, radio, groups, or preferred methods of recruiting and engaging parents) can be gained to improve the condition of the consumer group (Boote et al., 2002). Moreover, engagement with consumers at the program design stage has the added benefit of promoting client interest in the success of the program, cooperation, and fidelity (Goodare & Smith, 1995). How the program is delivered, by whom, and program content may influence whether potential consumers will be attracted to a particular program or service. The consumers' perspective helps to ensure that programs are better tailored to meet the specific needs of the target population (Boyd, Diamond, & Bourjolly, 2006).

Consumer oriented research in parenting has included: (a) research seeking to describe parents' views on the type of parenting support parents are seeking in raising their children. These have included use of focus groups and web surveys of defined populations of parents (Sanders & Kirby, 2010); (b) research which surveys parents' opinions about the appropriateness and effectiveness of program content (including specific parenting procedures used to change children's behavior) and the methods used to deliver programs (including modes of program delivery such as group vs individual vs telephone-assisted vs web delivered); (c) research on the cultural relevance and appropriateness of parenting programs in meeting the needs of parents and their children (Morawska, Sanders, Goadby, Headley, & Hodge, in press); d) research into the aids and obstacles to participation in parenting programs (Cunningham et al., 2000; Morawska & Sanders, 2006); and e) research examining the efficacy of self-help or technology assisted interventions that are delivered directly to parents with no professional involvement.

Direct to Consumer Marketing of Parenting Interventions

Marketing of a product or practice directly to consumers has a long history in the drug industry and in health promotion efforts targeting diet, exercise, smoking, and safe sex. As with the medical profession (Reast, Palihawadana, & Shabbir, 2008) many mental health practitioners have a somewhat cynical view of the motivation of businesses that seek to

influence consumers with mental health or other health related issues through direct advertising. They view many of the types of communications broadcast on television such as TV advertisements extolling the virtues of particular health products (e.g., drugs, health services) as marketing hype or public relations spin. The messages are seen to be biased, manipulative and self-serving. In the context of marketing of drugs to consumers, Strange (2007) argues that "Direct to consumer marketing (DTCM) ads manipulate the patient's agenda and steal precious time away from an evidence-based primary care clinician agenda that is attempting to promote health behavior, screen for early stage treatable disease, and address mental health" (p101). Products are often advertised making unsubstantiated claims of benefits often through use of "client" or "expert" testimonials. Although in health professions misleading advertising by developers or disseminators is discouraged and considered unethical, consumers themselves or paid professionals can also make exaggerated or inaccurate claims of benefit. Despite these DTCM caveats, a respectful collaborative relationship with consumers has great potential to improve the quality of communication between program developers and consumers and thereby improve the accessibility and utilization of evidence-based programs by parents. A series of recommendations are provided at the end of this paper in order to avoid some of the pitfalls that can result from DTCM.

The issue is not so much how to market programs to consumers but how to lay the foundations for successful collaborative relationships with consumers for the mutual benefit of all concerned (parents, program developers, service providers, evaluators, disseminators and funders). Consumers can be empowered to take control of their lives when they are more knowledgeable about what works to solve a problem, and when their experience is harnessed and taken into account when designing or evaluating programs (Turner & Sanders, 2006). The aim should be to increase consumer knowledge and positive sentiment with the end goal being to increase the desirability of using a program or practice. When consumers are excluded from the decision making process they have little investment in supporting or advocating for better access to programs and many vulnerable parents and families continue to be alienated and marginalized. When parents become aware that a valued benefit may result from participating in a parenting program, consumer demand is likely to increase. When consumer demand increases service providers and agencies are more likely to consider referring a parent to or adopting an evidence-based program to respond to the identified demand. Research can help identify what parents are seeking with respect to parenting support on how they deal with children's problems including what services they are looking for, how they would prefer to receive services, how much of a particular service they want, and what parents are prepared to invest to access a service (e.g., their time and family resources). An accurate and socially responsible marketing campaign can help counteract messages that target parents or their children to buy other goods (e.g. fast food, automobiles, toys) and potentially non-evidenced based parenting services.

Towards better engagement with consumers

Increasing parental awareness of parenting programs to improve participation rates

Parenting programs need to inform parents of the existence of evidence-based programs. There are several examples of successful communication strategies targeting consumers directly that are designed to destigmatize and normalize parents' participation in parenting programs. An example of one such sophisticated social marketing strategy is the "*Stay Positive*" campaign (see www.triplep-staypositive.org) first developed for the Amsterdam City Council as part of a community wide positive parenting strategy. This program aimed to increase parental awareness of available parenting programs and was first used to increase public awareness of the commencement of the Triple P-Positive Parenting Program in Amsterdam, The Netherlands (Goossens, 2009). It has subsequently been adapted in English

and used in other sites implementing population level parenting strategies. Campaign elements included key positive parenting messages on billboards, bus shelters, a positive parenting newspaper (tippaper), brochures, TV commercials and post cards. In addition, memorabilia such as shopping bags, pens, and fridge magnets were used. The Stay Positive website also provides downloadable tip sheets, brief positive parenting messages, and a navigation pathway for parents to identify a local accredited Triple P practitioner. In a city where very few parents would have known about Triple P, the campaign over a 10 month period increased the awareness of Triple P in Amsterdam to 72% of parents having heard of the program by the end of the promotion.

In another population level intervention *Every Family* (Sanders et al., 2008), a multi-component media strategy spanning 24 months, was used to increase parental awareness of available evidence-based parenting interventions. The media and communication strategy included television current affairs stories, radio spots, newspaper columns, school newsletters, posters, brochures, and a website. Compared to communities that did not have the communication strategy, parental awareness of Triple P as assessed through random household telephone surveys was 82% vs. 46%. In the Amsterdam and *Every Family* examples the media and communication strategy targeting consumers was supported by multiple levels of intervention. In addition, both marketing campaigns not only included a number of media outlets in order to enhance parental awareness, but also included a long-term approach to marketing. The duration of the Amsterdam campaign lasted 10 months and the *Every Family* media campaign 24 months. The duration of these respective campaigns coupled with the multiple media outlets targeted were likely contributors to the success of increasing parental awareness in these communities.

Increasing acceptability of intervention methods

The acceptability of a parenting intervention refers to the extent to which parents consider that a parenting program or specific parenting advice provided is useful (e.g., sleep management routine, routine for managing temper tantrums), relevant, and culturally appropriate. Parents can make judgments of acceptability concerning the content, format and modes of delivery used to implement a program or advice. Several studies have successfully tailored existing evidence-based parenting programs following either qualitative methods (e.g., focus groups), quantitative methods (e.g., questionnaires) and relevant theory. For example, the 17 core strategies advocated in Triple P (e.g., praise, incidental teaching, quiet time, time out) have been assessed and evaluated with different cultures, such as Japanese parents (Matsumoto, Sofronoff, & Sanders, 2008) and Chinese parents (Leung et al, 2003), with each study establishing that the advocated parenting strategies were acceptable. Whittingham, Sofronoff, Sheffield, and Sanders (2009) surveyed parents with a child who has an Autistic Spectrum Disorder to determine whether the specific parenting strategies used in the Stepping Stones Triple P were acceptable or needed to be modified. The process adopted by Whittingham et al. (2009) conveys the dual message that consumers' views are important, and that their views can influence program design.

Consumers' use of evidence-based lists

Service providers are gate keepers to programs in many communities. Practitioner's lack of familiarity or training in the use of evidence-based programs is a significant obstacle to parents seeking assistance for their children. Negative attitudes can be communicated through practitioners' silence or active discouragement serving as a barrier to parents participating (Morawska, Sanders, M.R., O'Brien, McAulliffe, & Anderson, in press). One way of reducing the potential negative influence of professionals is through the development of independent evidence-based lists. The UK has adopted such a framework with the National Institute of Clinical Excellence and Social Care (NICE), and the National Academy

of Parenting Research (NAPR) having independent evidence-based lists. The USA has also adopted a similar pathway with many independent evidence-based lists being developed (e.g., Blueprints for Violence Prevention; Substance Abuse and Mental Health Services Administration (SAMHSA); California Evidence-Based Clearinghouse for Social Work; Coalition for Evidence-Based Policy). In Australia and New Zealand there has been an increased emphasis on funding evidence-based parenting interventions for the treatment of conduct disorders in children (e.g., Interagency Plan for Conduct Disorder, 2007). Through initiatives such as these, practitioners are increasingly being funded to employ evidence-based programs when delivering services to parents. Additionally, this approach emphasizes that the quality of evidence supporting an intervention is important. Clinical folklore, professional wisdom or theoretical allegiances are an insufficient basis for determining what interventions are funded. Despite such initiatives, it can then be very difficult for parents to locate trained practitioners who can deliver evidence-based parenting programs. As consumers become better informed about available evidence regarding what works pressure is created on the program disseminators. As program disseminators need to develop appropriate programs to train a sufficient number of practitioners to provide adequate access to evidence-based programs for parents. In a survey of working parents in the UK the demonstrated effectiveness of a program was a strong predictor of parents' decision to participate in a parenting program delivered through the workplace (Sanders et al., in press). Providing information to parents about whether a program is effective is one way of facilitating the engagement of key target groups, in this case parents in the workplace. However, this strategy in isolation is not robust enough to facilitate engagement of different target groups. Consequently, further efforts need to be made to help assist with engaging different populations (e.g., custodial/informal grandparents, culturally diverse families).

Facilitating engagement of key target groups

Vulnerable families can be difficult to engage in parenting programs. Minority parents, immigrant and refugee parents from culturally diverse backgrounds are less likely than Caucasian families to access parenting programs and mental health services (Cheung & Snowden, 1990; Harachi, Catalano, & Hawkins, 1997; Snowden & Yamada, 2005; Cunningham et al., 2000; Katz, La Placa, & Hunter, 2007; Sawrikar & Katz, 2008). Several strategies can potentially increase the involvement of these minority groups within the research process, including : (a) creating trust between the consumer and researchers; (b) having rewards available for the consumer's time spent on research activity; and (c) sharing the research findings at the early stage with the consumer group (Boote et al., 2002; Davis, 1990). Qualitative research methods (e.g., focus groups, key stakeholder feedback, web surveys) can provide useful insights and are especially applicable to the exploration of new topics (e.g., program content) and complex issues (e.g., custodial/informal grandparent care). Focus groups provide a useful framework for accessing the viewpoints of consumers, as they are cost-effective, provide observational and interview data, permit discussion of ideas, activities and group exercises, and allow for draft or pilot program materials to be reviewed (Bernal, 2006; Colucci, 2007). Focus groups also facilitate a trust exchange between consumers and researchers, particularly if researchers make explicit to the consumer group that their views and experiences have the potential to influence program design. Although there are limitations to a focus group approach such as participants being potentially influenced by strong opinion leaders within the group, this can be counteracted to a degree by an experienced facilitator (Morgan, Krueger, & King, 1998). Content and thematic analysis of the focus group data can be then used to inform the program design in terms of content area to be covered and preferred delivery methods (for different approaches to analysis of qualitative data see Braun & Clarke, 2006).

It is important that consumers are reimbursed for their time through information access or other compensatory means (Davis, 1990). To continue the established trust with the consumer group of interest, results should be shared with them. This can be achieved through multiple mediums, such as the media (e.g., press release, radio, and television), sharing the results of the first study with participants by sending emails/letters or directing them to a website publishing the findings (for an example see www.exp.psy.uq.edu.au/grandparents), or conducting pilot groups with consumers discussing the developed program materials. Running of pilot groups also provides additional opportunities for further program refinement, and emphasis can be placed on other aspects of program development, such as design of materials, images, and formatting to facilitate readability.

Enhancing consumer commitment

Once consumers are engaged in a program or service they need to be sufficiently motivated to complete the program. There are many possible ways to increase consumer motivation and commitment. One such avenue is to include the consumer as part of the program development team. The consumer's perspective is important data in its own right (Garfield, 1983). In contributing data a sense of "ownership" is being promoted so that consumers feel that programs are more responsive to their needs. For example, through elicitation of consumer preference information, relevant and meaningful examples can be included as part of the program activities such as exercises (e.g., using grandparents dropping off or picking up grandchildren from parents as an example of a high risk situation in a grandparenting program). In a parenting program for indigenous parents the use of video footage depicting an indigenous parent demonstrating a specific strategy with their children may increase the perceive relevance of the example (Jackson & Dickinson, 2009). If parents feel the examples and material being presented is meaningful parents are more likely to be motivated to participate.

Directly changing parenting practices via parental modeling

Another approach to direct engagement with consumers is to deliver media messages via television programming. A small number of studies have examined the effects of broadcast television programs on parenting practices. Sanders, Montgomery, and Brechman-Toussaint (2000) is an example of one such study that examined the feasibility of a television series in promoting positive parenting practices. The television series, *Families*, shown during primetime on commercial television in New Zealand comprised of 12, 30-minute episodes. An infotainment-style program was used to ensure the widest reach of the program. It adopted an entertaining format to provide practical information and advice to parents on a variety of common behavioural and developmental problems in children, as well as other parenting issues. The main segments covered were: (a) a feature story presenting brief discussions on a number of family issues (e.g., school involvement, role of fathers); (b) a celebrity family discussing issues about their family; (c) family health care tips; (d) animal care and integrating pets into family life; (e) interesting facts about the current state of families in society; and (f) a weekly Triple P segment.

The five–seven minute Triple P segment each week enabled parents to complete a 12-session Triple P intervention while at home. The Triple P segments provided brief examples of the causes of child behaviour problems from a social learning perspective, provided guidance on how to monitor child behaviour, and presented clear guidelines and modelled a range of parenting strategies to encourage desirable behaviour in children, prevent problems from occurring, and manage difficult child behaviour problems. These strategies were integrated into plans for dealing with common problems (e.g., whining, disobedience, aggression, temper tantrums), for promoting children's development (e.g., encouraging creativity and involvement in physical activities, helping with homework), and for managing

developmental issues (e.g., cooperative play; sleeping and eating difficulties). A cross-promotion strategy using newspapers, posters, and magazines was used to encourage parents to watch the program and to contact Triple P for more information. The *Families* tip sheets (i.e., engaging written materials that provide a back-up self-help strategy based on the information in the Triple P segment) were also available by writing to a Triple P centre, calling the Triple P information line, or through a retail chain store.

The purpose of the Sanders et al. (2000) study was to determine whether the delivery of parenting information via television programming would be effective in reducing disruptive child behavior and increasing family adjustment. The study randomly assigned 56 mothers with 2- to 8-year-old children either to the media intervention or waitlist control group. Intervention mothers were given the television series in the form of videos and tip sheets. Mothers in the media condition reported significant reductions in the number of child behavior problems post-treatment in comparison to the control group (Cohen's d=.68). Mothers in the media condition also reported an increased sense of competence and satisfaction in their parenting abilities relative to mothers in the control group (d=.59). Collectively, these results demonstrated the effectiveness that high reaching broadcast television programs can have in improving child behaviour and parenting confidence.

"Driving Mum and Dad Mad" Reality Parenting Series

A second study examined the effects of an observational documentary series on parenting broadcast on British television (Sanders, Calam, Durand, Liversidge, & Carmont, 2008). Triple P was the subject of a six-episode, 30-minute television series *Driving Mum and Dad Mad* on ITV1 (the largest commercial network in the UK). The series attracted an average of 4.6 million viewers and 25% market share of the viewing audience in the UK. This series depicted the experiences and emotional journey of five families with severe conduct-problem children as they participated in Group Triple P (an eight-session intensive group program). The effects of the series on viewers were evaluated in a randomized trial involving 454 families via a web-based assessment prior to and following the broadcast of the series. The study compared the effects of two viewing conditions (standard vs. enhanced). Families in the standard condition watched the six-episode series and had access to written informational tip sheets on the ITV website (www.itv.com/mumanddad). Families in the enhanced condition also received individually tailored support through a 10-session self-paced workbook and access to a specially designed website (www.greatparentingexperiment.net.uk). The website included downloadable tip sheets, email reminders to watch the show, key message prompts to implement program tips, audio-streamed positive parenting messages, and video-streamed segments from the Triple P video *Every Parent's Survival Guide* providing more detailed demonstrations and explanations of the parenting techniques. Finally, parents were also provided with email support from trained Triple P providers.

The study showed that although parents in both the standard and the enhanced media viewing conditions reported significant improvement in child behaviour, the enhanced program provided additional benefits on measures of dysfunctional parenting, parental anger about child behaviour, and parental disagreements about discipline (Sanders, Calam, Durand, Liversidge, & Carmont, 2008). This study demonstrated the audience potential of a parenting series based on the actual experiences of real families undergoing an evidence-based group parenting intervention.

Learnings from large scale dissemination efforts

Several large scale projects seeking to produce population level change in parenting practices have employed a range of direct-to-consumer strategies that encompass Level 1

Universal Triple P (e.g., Prinz et al., 2009; Sanders et al., 2008). These strategies included many of the media and communications strategies described in the two previous television studies (Sanders et al., 2000; Sanders, Calam, Durand, Liversidge, & Carmont, 2008), and some have also included the use of television commercials. Two such initiatives are described below.

Every Family

In an effort to forestall the development of mental health problems in children, an initiative known as *Every Family* was implemented as a population level intervention targeting the transition to school in Australia (Sanders et al., 2008). The target population of *Every Family* was all parents of 4- to 7-year old children residing in ten geographical catchment areas in Brisbane (intervention communities) and ten care as usual (CAU) comparison communities from sociodemographically matched catchment areas in Sydney (5) and Melbourne (5). All five levels of the Triple P system were employed (see Table 1); including a local mass media strategy (Levels 1 and 2), a primary care strategy (Level 3) , and two more intensive levels of parenting interventions (Levels 4 and 5) delivered by a range of service providers (e.g., health, education, and welfare sectors). Program outcomes were assessed through a computer-assisted telephone interview of a random sample of households (N = 3000) in each community at pre-intervention and again at two years post-intervention. At post-intervention there were significantly greater reductions in the intervention communities in the number of children with clinically elevated and borderline behavioral and emotional problems compared to the CAU communities. Similarly parents reported a greater reduction in the prevalence of depression, stress and coercive parenting.

Core Universal Triple P techniques were employed as part of the *Every Family initiative*. This included adopting a coordinated media and community education campaign involving social marketing and health promotion strategies. The aim of these techniques was to promote the use of positive parenting practices in the community; increase the receptivity of parents towards participating in Triple P and other family/child interventions; de-stigmatize and normalize the process of seeking help for children with behavioral and emotional problems; increase the visibility and reach of the various interventions; and counter the often alarmist, sensational or parent-blaming messages in the media. The target communities were provided with information about common behavioral, developmental and mental health problems in children and their families, the value of positive parenting in preventing and reducing these problems, and ways to obtain further information, advice and support. They received access to low-cost, high quality written resources through a range of venues in the community (e.g., preschools, schools, childcare centers and public libraries) and access to a telephone support service with Triple P trained counselors through Parentline, a statewide telephone counseling service for parents. Existing partnerships with local media outlets (e.g., media and television stations) and new partnerships with community-based media outlets were used to support the media campaign. A cross promotional media strategy comprising both print and electronic media was employed. Media activities included a positive parenting newspaper column in local newspapers, a positive parenting segment on national and local radio, positive parenting messages for broadcast on radio, and a series of positive parenting community service announcements on a major local television channel.

US Triple P System Population Trial

This study examined the value of a public health approach to the prevention of child maltreatment (Prinz et al., 2009). Eighteen (18) counties in the US state of South Carolina were randomly assigned to either dissemination of the Triple P system or to the services-as-usual control condition. Professional training in the intervention condition was provided for an existing workforce (over 600 service providers), as well as universal media and

communication strategies. Large effect sizes were found for three independently derived population indicators: substantiated child maltreatment, child out-of home placements, and child maltreatment injuries. This study is the first to randomize geographical areas and show preventive impact on child maltreatment at a population level using evidence-based parenting interventions. The Universal facet of the Triple P intervention involved the implementation of media and informational strategies pertaining to positive parenting. These strategies are intended to destigmatize parenting and family support, make effective parenting strategies readily accessible to all parents, and facilitate help-seeking and self-regulation by parents who need higher intensity intervention. Universal Triple P includes the use of radio, local newspapers, newsletters at schools, mass mailings to family households, presence at community events, and website information. Use of local newspapers takes three forms: (a) positive parenting articles on specific topics of interest to parents; (b) local press releases on human interest stories that link with Triple P activities; and (c) stories generated by reporters with whom the publicity team has developed working relationships. The intervention avoided any media outlets (e.g., television) or communication strategies that overlapped with the control counties. At the conclusion of the intervention there was an observed significant increase in public awareness of Triple P in the intervention communities compared to the control condition. These results suggest that the strategies included as part of the Universal facet of Triple P were successful.

Building relationships with the media to inform consumers

Working with journalists

Many professionals have ambivalent feelings towards journalists and the media in general. While recognizing the value of good “press” about their program, some researchers can relate to stories about bad experiences with the media. These complaints often focus on concerns about being misquoted or quoted out of context, or if clients are used in a story there can be concerns about their problems being sensationalized. The sensationalizing of cases is quite common with television stories on children with discipline behavior problems. Parents may be portrayed as incompetent. These types of concerns have led many professionals and organizations to avoid the media altogether rather than to work out better ways of getting positive, optimistic messages about children and parenting out to the public at large. We have found building strong relationships with journalists, producers, and the media in general takes time and persistence (For more information about strategies for working with the media please see Sanders & Prinz, 2008).

Working with Radio

Professionals are often invited by the media to make informed “expert” comments on topical issues relating to children and families. Our centre (The Parenting and Family Support Centre) has worked with media organizations for many years to provide informed commentary about a variety of parenting or family issues. The first author has been a regular guest commentator on a weekly 10 minute parenting segment for a number of years on ABC Morning programs (ABC is the National broadcaster in Australia). The aim has been to destigmatize parenting issues, to promote public awareness of the importance of the parenting role, and the value of being prepared to undertake the tasks of parenthood. The segment deals with listener generated questions and topics that cover a wide variety of parenting issues. This segment is podcasted and is accessible throughout the world via the web (http://www.abc.net.au/brisbane). Although the radio remains a popular medium it has less penetration and is considered a less important source for acquiring news and information than television (Hofstetter, Schultze & Mulvihill, 1992; Zimmerman, 1996). There is some evidence that it is also a less preferred source for acquiring information than

television and newspapers (Federation of Australian Commercial Television Stations, 1995). Nevertheless, radio reaches a segment of the parenting population.

Social marketing

When considering the idea of increasing the exposure of psychological services to the public it is important that the needs of the consumer are kept at the forefront and whether exposure will lead to benefits or conversely possible risk of harm. Social marketing material can include, but is not limited to, components such as posters, websites, newspaper advertisements, radio advertisements, books, DVD's, and celebrity endorsement. Another possibility for social marketing material is to directly inform the consumer of services, particularly, empirically supported treatments. This could be done through multiple pathways, however a website or digital web station offers a particularly useful and cost-effective way to permit this knowledge base to be shared with consumers

Marketing to parents

Direct-to-consumer marketing (DTCM) of any health resource can be considered controversial (Reast, Palihawandana, & Shabbir, 2008). In the USA DTCM of prescription drugs began in the early 1980s (Hoek & Gendall, 2002), however this act has not been replicated in other developed countries. According to Reast et al. (2008) this is partly due to pharmaceutical companies overstating the impact particular products can have, and de-emphasising possible negative side-effects. When entertaining the concept of directly marketing behavioural interventions, particularly parenting programs to consumers, the concept of duty of care is critical.There are clear dangers in overstating the case for the effectiveness of parenting programs, as parents may be mislead into expecting outcomes the programs cannot deliver. Advertising a program's benefits can amount to public relations spin and take claimed program benefits well beyond what can reasonably be concluded from the available evidence.

When children and families are involved in marketing and promotional materials (testimonial advocacy) there are duty of care issues related to the potential adverse effects that can occur for children and parents, particularly when appearing in television programs depicting children with emotional and behavioral problems. One approach to minimize this adverse effect is to ensure professional support is available to the parents and families around the time the program is broadcast, not just when it was made. After working with various media outlets on many such programs, to our knowledge there have been very few adverse events stemming from a family's involvement with media stories.

Some professionals object to what they see as unsolicited and unwarranted intrusions into established professional relationships with clients that result from direct marketing to parents of opportunities to be involved in parenting studies. Such views, although at one level appear to protect parents, may be patronizing and designed to effectively maintain the power base of certain professionals as gate keepers to services. Parents have a legitimate right to access evidenced-based parenting programs and to make a decision for themselves as to whether they wish to be involved.

We can learn a great deal from the problems experienced by drug companies and the weight loss industry, such as avoiding false guarantees and alarmist messages that can bring companies and organizations into disrepute. There is a need for ethical guidelines for professionals involved in direct to consumer activity particularly involving the media to ensure that children and parents are not exploited in a way that potentially harms either in the long term.

Limitations of consumer involvement

Although adopting a consumer perspective offers a useful complement to theory driven program development initiatives, particularly with new populations, it still is not a panacea. When adopting a consumer focused research agenda it is important to document who has been consulted as part of the consumer involvement process, as what may work with one subgroup of the population may not work with another. Consumer involvement is more usefully viewed as an ongoing feature of good program development. A program should not be considered 'completed' after it has been developed and tailored to the population of interest. Rather, the program should continue to evolve through ongoing consumer feedback, new findings from other evaluation studies, and theoretical insights that are provided via research into the mechanisms of change that help explain intervention effects.

As part of program delivery it is also important to recognize that each client, consumer, patient, or participant that is involved brings their own unique background to the program. Consequently, program developers need to be flexible enough to allow for the consumer's voice to be heard and responded to appropriately thereby ensuring tailored program delivery. This tailoring may include adapting examples used in workbooks, discussion or demonstration DVDs to make them more culturally relevant, spending more or less time on specific activities, providing assistance completing written exercises when literacy problems are encountered, or allowing other extended family members to take part in the program (e.g., grandparents). If the program does not allow for such modifications, facilitators can be met with consumer resistance.

Recommendations for consumer involvement in research

Consumer involvement throughout the research and development process is a necessary element in effective program development. This is a view shared by many researchers and community organizations (Boote et al., 2002; Centre for Health Promotion, 2010). Public health researchers have advocated a number of useful guidelines to promote better involvement with consumers (Oliver et al., 2004; Sanders & Prinz, 2008): (a) Establish consumer reference groups to provide advice and input into how to engage with the consumer group of interest, and gather ideas from consumers about program content; (b) Establish an end user consumer advisory group to provide feedback regarding the design of program content, materials, and modes of delivery; (c) Allocate time and funds to permit consultations with the consumer group and consider paying consumers for their time; (d) Conduct face-to-face or web-based focus groups with parents to solicit opinions from consumers; (e) Routinely assess consumer satisfaction with program delivery through structured interviews or questionnaires; (f) Routinely assess and document strategies used to engage consumers; (g) Conduct research on consumer views on the cultural relevance of parenting strategies and methods of delivering programs to parents; (h) Ensure results of research are communicated to consumers in a form that is appropriate, unbiased, and understandable (e.g., through websites, newsletters, radio, or television); (i) Conduct pilot studies with consumer groups and modify the program as appropriate; (j) Document clearly the level of consumer involvement throughout the research and dissemination process; and (k) Consider the use of internet or online parenting programs as an avenue to further increase consumer engagement and reach difficult target populations (e.g., rural, single parent families, dual working households).

Conclusion

In conclusion, there are substantial potential benefits of direct collaborative engagement with consumers throughout the development, evaluation, dissemination and "scaling up" of evidence-based parenting programs. There is no single way in which parents as consumers should be involved in program development or delivery and different opportunities will arise

with different consumer groups. The main potential advantage to parents is that more effective parenting programs will be developed to benefit children, young people, and families as a whole. However, there are many different consumer views on how children should be raised. Some of these views may lead to new insights into how to tackle a difficult problem; others will not. Attempts to sample consumer opinion will of necessity raise the question of whose voice the identified parent consumer is speaking on behalf of. Potential sampling bias and the non-representativeness of consumer advocacy groups or self-appointed members of focus groups of parents targeted by an intervention does not obviate the value of directly soliciting the involvement of a range of consumers with the view to better tailoring of interventions. It is the synergistic interaction between the knowledge and experience of consumers combined with the theories, scientific evidence and professional experience of the practitioner that will ultimately result in improved quality of parenting interventions.

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Table 1

The Triple P Model of Parenting and Family Support

Level of Intervention	Target Population	Intervention Methods	Practitioners
Level 1 Media-based parent information campaign Universal Triple P	All parents interested in information about parenting and promoting their child's development.	Coordinated media and health promotion campaign raising awareness of parent issues and encouraging participation in parenting programs. May involve electronic and print media (e.g., community service announcements, talk-back radio, newspaper and magazine editorials).	Typically coordinated by area media liaison officers or mental health or welfare staff.
Level 2 Health promotion strategy / brief selective intervention Selected Triple P Selected Teen Triple P	Parents interested in parenting education or with specific concerns about their child's development or behavior.	Health promotion information or specific advice for a discrete developmental issue or minor child behavior problem. May involve a group seminar process or brief (up to 20 minutes) telephone or face-to-face clinician contact.	Parent support during routine well-child health care (e.g., child and community health, education, allied health, and childcare staff).
Level 3 Narrow focus parent training Primary Care Triple P Primary Care Teen Triple P	Parents with specific concerns as above who require consultations or active skills training.	Brief program (about 80 minutes over four sessions) combining advice, rehearsal, and self-evaluation to teach parents to manage a discrete child problem behavior. May involve telephone or face-to-face clinician contact or group sessions.	Same as for Level 2.
Level 4 Broad focus parent training Standard Triple P Group Triple P; Group Teen Triple P; Self-Directed Triple P; Self-Directed Teen Triple P	Parents wanting intensive training in positive parenting skills. Typically parents of children with behavior problems such as aggressive or oppositional behavior.	Broad focus program (about 10 hours over 8–10 sessions) focusing on parent-child interaction and the application of parenting skills to a broad range of target behaviors. Includes generalization enhancement strategies. May be self-directed or involve telephone or face-to-face clinician contact or group sessions.	Intensive parenting interventions (e.g., mental health and welfare staff, and other allied health and education professionals who regularly consult with parents about child behavior).
Stepping Stones Triple P	Families of preschool children with disabilities who have or are at risk of developing behavioral or emotional disorders.	A parallel 10-session individually tailored program with a focus on disabilities. Sessions typically last 60–90 minutes (with the exception of three practice sessions which last 40 minutes).	Same as above.
Level 5 Behavioral family intervention modules Enhanced Triple P	Parents of children with behavior problems and concurrent family dysfunction such as parental depression or stress, or conflict between partners.	Intensive individually tailored program with modules (60–90 minute sessions) including practice sessions to enhance parenting skills, mood management and stress coping skills, and partner support skills.	Intensive family intervention work (e.g., mental health and welfare staff).
Pathways Triple P	Parents at risk of maltreating their children. Targets anger management problems and other factors associated with abuse.	Modules include attribution retraining and anger management.	Same as above.