Challenges in Implementing Preventive Interventions

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Many preventive interventions seeking to reduce children's exposure to violence have been developed including parenting programs, school based interventions, social skills training programs and media interventions. However, of the potentially modifiable factors related to children's exposure to violence none is more important than the quality of parenting children receive. This section discusses some of the practical implementation challenges in implementing and sustaining preventive interventions. Our focus will be on learning derived from research on parenting but many of the principles are also relevant to other types of preventive intervention.

Growing consensus among developmental, family and clinical psychologists, criminologists, public health researchers, policy advocates for evidence-based practices, and prevention scientists highlights that safe, nurturing and positive parent-child interactions lay the foundations for healthy child development (Dretzke et al., 2009, Gutman & Feinstein, 2010, Kirp, 2011, Stack et al. 2010).

How children are raised influences their risk of exposure to violence and affects many different aspects of their lives including brain development, language, social skills, emotional regulation, mental and physical health, health risk behavior and their capacity to cope with a spectrum of major life events (Belsky & de Haan, 2011). These life events and transitions include parental separation and divorce (e.g., Stallman & Sanders, 2007), loss (e.g., Bradley, 2007), chronic illness (e.g., Gustafsson at al. 2002), recovery following natural disasters (e.g., Jones et al. 2009) and parental mental illness (e.g., McFarland & Sanders, 2003).

Adverse family experiences such as interrupted maternal care, living with one biological parent, exposure to criticism and harsh, punitive disciplinary practices, family dysfunction and lower marital adjustment, parental distress and parental psychopathology are all associated with an increased risk of exposure to violence and other mental health

problems in children and adolescents (Baker et al. 2005). Conversely, exposure to competent parenting (defined here as warm, responsive, consistent parenting that provides boundaries and contingent limits for children in a low conflict family environment) affords children many developmental and life advantages including secure attachment, accelerated language development, greater readiness for school, higher academic achievement, reduced risk of antisocial behavior, substance abuse problems, an increased likelihood of involvement in higher education, improved physical health, and greater capacity for later intimate relationships (Moffitt et al. 2011, Gutman & Feinstein, 2010, Stack et al. 2010). There is no more important potentially modifiable target of preventive intervention that parenting.

WHY PARENTING PROGRAMS ARE SO IMPORTANT TO PREVENTION

Four decades of experimental clinical research have demonstrated that structured parenting programs based on social learning models are among the most efficacious and cost-effective interventions available to promote the mental health and well-being of children, particularly children at risk of developing social and emotional problems and child maltreatment (Mihalopoulos et al. 2011, Taylor & Biglan, 1998; National Research Council and Institute of Medicine, 2009).

Positive parenting programs based on social learning and cognitive-behavioral principles are the most effective in reducing problem behaviors in children and adolescents (Dretzke et al. 2009, Kazdin & Blase, 2011). Different delivery formats have been successfully trialed including individual programs, small group programs, large group seminar programs, self-directed programs, telephone-assisted programs and more recently online parenting programs (see Dretzke et al. 2009; Sanders, 2012). The cumulative evidence clearly supports the efficacy and robustness of social learning based parenting interventions however, the limited reach of most evidence-based parent programs ensures that these

programs make little impact on prevalence rates of social and emotional problems of children and child maltreatment at a population level.

Self-Regulation and the Adoption of a Public Health Framework

The realisation that most parents experiencing significant problems or who are at risk of harming their children receive no assistance, combined with the recognition that many more parents needed to complete parenting programs in order to make any significant impact on social and emotional problems of children, has led to the development of a public health approach to parenting support. Traditional clinical models primarily focus on the treatment of high risk or vulnerable children and their parents with already well-established problems, typically leave untreated the majority of children who are at risk of violence exposure and the majority of parents who have concerns about everyday parenting issues. Various epidemiological surveys show that most parents concerned about their children's behavior or adjustment do not receive professional assistance for these problems and when they do, they typically consult family doctors or teachers who rarely have specialized training in parent consultation skills (see Dittman et al. 2011). A public health approach to increasing parenting support offers an alternative framework to ensure that large numbers of parents who might benefit actually do participate to produce meaningful change at a whole of population level rather than exclusive focus on individual improvement at an individual case level (Prinz & Sanders, 2007).

For a public health approach to be accepted by the community at large, an approach is needed that protects and promotes parents' fundamental rights to make decisions about how they raise their children; rather than the approach that is judgmental, critical, or prescriptive. By offering parents information and strategies that have been shown to work, parents can make more informed choices about how to tackle their concerns about parenting. The principle of self-regulation is a central construct in parenting programs. Self-regulation is a

process whereby individuals are taught skills to change their own behavior and become independent problem solvers in a broader social environment that supports parenting and family relationships (Karoly, 1993, Sanders & Mazzucchelli, 2011). According to Bandura, the development of self-regulation is related to personal, environmental and behavioural factors; these factors operate separately but are interdependent (Bandura, 1986).

BUILDING A FAMILY FOCUSED POPULATION APPROACH TO VIOLENCE PREVENTION

Collins' et al. (2009) recently advocated a model of building the components of an intervention prior to implementing a complex multicomponent system of intervention. This approach to building a system of intervention involves developing and testing in isolation the different levels and variants of the program rather than to integrate multiple levels at the outset. The Triple P system of parenting interventions used this approach to develop a spectrum of integrated, theoretically consistent, preventive and treatment interventions that included a range of programs from very "light touch" low intensity programs to more intensive programs for complex and difficult to treat behavioral and emotional problems (Sanders, 2012).

Implementation of a system of parenting support involves targeting defined geographical catchment areas and tracking the population level impact on indices of child wellbeing, maltreatment and parenting. The simultaneous implementation of multiple levels allows for synergies to develop and helped to create momentum for a parenting program in a community. To date, two large scale population level evaluations have been published that have shown the feasibility and cost effectiveness of this approach (Sanders et al, 2008; Prinz et al, 2009) with several others in progress in the UK, Canada, Sweden, Ireland, Australia, New Zealand, and Belgium.

Prinz et al (2009) used a cluster design to randomise eighteen counties in South Carolina (USA) to either the Triple P system or to care-as-usual control. Following intervention the Triple P counties observed lower rates of founded cases of child maltreatment, hospitalizations and injuries due to maltreatment, and out of home placements due to maltreatment. This was the first time a public health parenting intervention has shown positive population level effects on child maltreatment in a randomized design with county as the unit of random assignment.

MAKING PREVENTION WORK AT THE COAL FACE

The implementation on a large scale of prevention programs has contributed significantly to our understanding about some of the logistical and other challenges that must be addressed to make prevention programs work. The following factors need to be considered.

Having programs available that work

Parents prefer programs that are supported by evidence that they actually work. However, parents vary greatly in the level and type of support they require or are prepared to participate in. Some parents are seeking basic advice on dealing with common parenting problems and issues (e.g., establishing bedtime routines), and yet others have more serious problems that require more intensive intervention over a longer period of time. This variation means a range of delivery formats, variants and different levels of intensity of intervention. To ensure that the diverse needs of parents are addressed, a population-level parenting strategy requires different evidence-based interventions to be available. It is important that programs included in a comprehensive model build in strategies that successfully engage vulnerable populations including families living in poverty, ethnic minority groups, parents with mental health difficulties, and parents with histories of family violence and so on.

Having evidence of cost-effectiveness

Programs are more likely to be supported and sustained over time if they are cost effective. Public health approaches that include universal components are attacked because they are considered too expensive. However, a public health approach to parenting support can be a very cost effective approach to prevention. Foster et al. (2008) estimated that the infrastructure costs associated with the implementation of the Triple P system in the US was $12 per participant, a cost that could be recovered in a single year by as little as a 10% reduction in the rate of abuse and neglect. Aos et al (2011) conducted a careful economic analysis of the costs and benefits of implementing the Triple P system only using indices of improvement on rates of child maltreatment (out of home placements and rates of abuse and neglect). Their findings showed that for an estimated total intervention cost of $137 per family if only 10% of parents received Triple P, there would be a positive benefit of $1237 per participant, with a benefit to cost ratio of $9.22. The benefit to cost ratio would be even higher when higher rates of participation are modeled.

Ensuring Cultural Relevance and Acceptability

Preventive interventions need to be acceptable to ethnically and socioeconomically diverse parents. RCT's, focus groups and survey methods have been increasingly used to establish the acceptability and effectiveness of positive parenting strategies (e.g. praise, positive attention, quiet time, timeout) with a diverse range of parents, including parents from Australia, New Zealand, Japan, Singapore, Hong Kong, Iran, Scotland, England, Ireland, Sweden, Belgium, the Netherlands, Germany, Turkey, Switzerland, South Africa and Panama (e.g., Bodenmann et al. 2008, Matsumoto et al. 2010). It is important to access parents as "end users" directly rather than to rely exclusively on the views of professionals serving minority populations who can seek to be "cultural gatekeepers" holding views on cultural acceptability that differ from parents they serve (Morawska et al. 2012).

Reducing Stigma associated with Participation

Most parents raise their children without any professional help. It is still not socially normative to undertake formal training preparation as a parent and as a result many parents begin their parenting careers ill prepared for the task. What makes this situation puzzling is that surveys of parents show that most support the idea of completing a parenting programme and those that do overwhelmingly perceive them as helpful. Despite this many practitioners struggle to fill free parenting groups or classes. Laudable calls to make parenting programmes more readily available to a wider range of parents will not work without a carefully planned strategy to enhance parenting involvement. This will require a blending of mass communication strategies and techniques (social marketing), and a renewed focus on engaging "parents as consumers" or "end users" so that programmes offered as seen as responsive to need. Social marketing should aim to de-stigmatize and normalize seeking help for parenting and to increase the visibility of programmes on offer in a local community. A social marketing strategy is also needed to counter alarmist, sensationalised and parent-blaming messages in the media.

A social marketing strategy needs to emphasise the benefits of positive parenting including helping children learn vital social and emotional skills that enable children to succeed at school and in life. The key messages need to empower parents rather than make them feel guilty or incompetent.

Engaging Consumers in the Development of Evidence-based Programs

The content of prevention programs and the processes of delivery benefits greatly from consumer input (Sanders & Kirby, 2011). For example, Metzler et al. (2011) showed parents a prototypical episode of a television series on positive parenting being used in a clinical trial to ensure the footage was considered culturally acceptable and engaging to a mixed race sample of US parents (including samples of Caucasian, Spanish speaking and

African American parents). Parents overwhelmingly confirmed that that multicultural footage was acceptable to them.

Kirby and Sanders (2011) used focus groups with grandparents to identify parenting situations grandparents found challenging to deal with (e.g. communicating about grandchild discipline with their own adult children). Resulting from these focus groups, Group Triple P was modified to include a greater focus on conflict management and team work with birth parents. Consumer preference surveys can be used to solicit parents' and practitioners' views on the cultural appropriateness and relevance of parenting procedures, materials (written and DVD), program features and delivery methods (Morawska et al. 2010).

Even with better social marketing and consumer engagement a parent who is initially receptive to undertaking a parenting programme may not complete a programme. This can result for many different reasons including competing demands and priorities such as work commitments, health crises, housing problems or financial worries. Some parents also lead such chaotic lives that any regular commitment is challenging. Other parents lack support from partners or extended family. Parents with drug, alcohol or serious mental health problems, the task of completing a parenting programme competes with other major life events and crises. However, not all parents want or are able to complete group programmes and there is a clear need for more flexibility in delivering parenting programs. This was the rationale for the development of different formats of parenting advice (e.g., large group, small group, individual, over the phone, guided self-help and web-based delivery of programmes). When parents are empowered with the tools for personal change they require to parent their children positively, the resulting benefits for children and the community at large are immense.

Establishing Achievable Participation Targets

Careful attention needs to be given to ensuring that participation targets are set at the outset so that the necessary numbers of practitioners are trained who have the capacity and organizational support to implement the program with fidelity. The resources required to implement the program vary as a function of the costs of delivering the intervention (number of sessions required), the type of provider who delivers the program (e.g., nurses, psychologists, social workers, teachers, family support workers, doctors) and how active practitioners are after initial training. Very active practitioners may see hundreds of families a year and achieve far greater population reach than a large number of practitioners who use the intervention very infrequently (Shapiro et al. in press).

Having an Evaluation Plan and Tracking Population Level Indicators

Reliable ways of assessing the prevalence and incidence rates of rates of maltreatment and dysfunctional and positive parenting practices targeted by an intervention is a major challenge for all prevention interventions. The approaches used to assess population level effects include accessing aggregate archival data at a county or local government level to track rates over time of child abuse and neglect cases, hospitalizations and emergency room visits due to maltreatment and out of home placements (Prinz & Sanders, 2007). Household telephone surveys using random digit dialing have also been used (Sanders et al. 2007). Population level indices can also be complemented by service based data concerning outcomes achieved by participating parents using standardized parent or child report instruments. Data linkage at the individual case level across different administrative systems in health, education and welfare sectors is particularly valuable and can enable a broader range of outcomes to be assessed at an individual case level over time. There is a need for a range of brief, reliable, valid, and change sensitive measures of parenting for use in public health interventions. Such measures need to be low cost, easy to use, score and interpret, have

low literacy demands, be easy to translate into different languages and have consistent response formats across different areas assessed.

CREATING SUSTAINABLE SYSTEMS OF TRAINING AND DISSEMINATION

The emerging field of implementation science is devoted to studying the implementation process associated with the successful translation of research findings into practice. Several world bodies have recognized that positive parenting programs are essential to increase safe, stable, and nurturing relationships between children and their parents/carer if global violence is to be reduced. These groups include the World Health Organization's Violence Prevention Alliance (www.who.int/violenceprevention). Various models of sustainable program implementation have also emerged and are being evaluated (Aarons et al. 2011, Fixsen et al. 2005, Sanders & Murphy-Brennan, 2010a, b). Unfortunately, most of the discussion about implementation has focussed on high income countries (mostly English speaking countries) where the majority of efficacy trials have been conducted. However, there is a great need to introduce culturally appropriate and effective parenting support to low and middle income countries in Sub Saharan Africa, Central and South America, Central and South East Asia, the Middle East and Eastern Europe where high rates of child maltreatment, family violence and substance abuse are common (UNODC, 2009, WHO, 2009). In order to achieve successful implementation , parenting interventions must possess several important characteristics.

Capacity to go to Scale

The capacity of an evidence-based program to be scaled up is crucial. "Going to scale" means that program developers and disseminators (purveyors) have the relevant knowledge, experience and the resources to roll out programs on a large scale and the ability to respond to workforce training demands. This requires a dedicated dissemination organization with fiscal resources and organizational expertise to manage the process.

Developing a System of Professional Training

Parents accessing parenting services expect programs to be delivered competently by professionals. Evidence-based programs achieve the best results when delivered with fidelity (Beidas & Kendall, 2010) and practitioners with higher levels of competence produce better child outcomes while incompetently delivered evidence-based programs may even be harmful (Henggeler, 2011). Despite this, in many countries the workforce delivering advice and guidance to parents is a diverse multidisciplinary group of often undertrained, poorly supervised and relatively poorly qualified practitioners. This is even more pronounced in poorer rural and remote communities in high income countries, and low and middle income countries.

A dissemination organization needs the infrastructure, financial capacity or the necessary business acumen to disseminate the program on a global scale in a sustainable manner. Such a task requires collaborators and partners outside psychology to provide expertise in business, marketing, publishing, management of intellectually property matters and international business.

Flexible Tailoring and Responsive Program Delivery

Many manualized evidence-based prevention programs have been criticized as being rigid and inflexible. Mazzucchelli and Sanders (2010) argued that delivering a program with fidelity should not mean inflexible delivery, and that there are high and low risk variations in content and process that can influence clinical outcomes. The training process should encourage practitioners to work collaboratively with parents and to be responsive to client need and situational context while preserving the key or essential elements of the program. Adapting examples used to illustrate key teaching points and customized homework tasks can respond to the needs of specific client populations. Through this type of tailoring core

concepts and procedures are preserved but the idiosyncratic needs of particular parent group are also attended to (e.g., parents of twins or triplets, parents of children with special needs).

Tailoring Training Methods to Target Groups

As prevention programs are delivered to a broad range of service providers the delivery of professional training courses has to be customized to a certain extent to cater for the special characteristics of the service providers undergoing training. This can be accomplished by ensuring trainers are familiar with the local context including where different providers work, their role in providing parenting support, their professional backgrounds and level of experience. This tailoring can involve selection of relevant (to the audience) case examples and illustrations, drawing upon the knowledge, experience and expertise of the group, and by drawing to the attention of the group the variant and invariant features of the program.

Maintaining Training Quality

Maintaining the quality of the training process itself needs to be carefully managed by the training organization to minimize program drift at source. To prevent program drift, all trainers use standardized materials (including participant notes, training exercises, and training DVD's demonstrating core consultation skills) and adhere to a quality assurance process. Trainers become part of a trainer network and have to adhere to a quality assurance process as part of the maintenance of their accreditation.

Providing Technical and Consultation Support

Program disseminators can provide ongoing back-up consultative advice post-training to organizations (e.g. e-mail contact, teleconferences, staff meetings and arranged update days to address administrative issues (e.g., data management, performance indicators), logistical issues (e.g., avoidance of accreditation workshops due to anxiety; referral strategies) and clinical issues (e.g., dealing with specific populations, clinical process

problems) identified by practitioners. These contacts actively engage agency staff in troubleshooting.

An online practitioner network can be established to provide ongoing technical support to practitioners using the program. Such a network can provide practitioners with downloadable clinical tools and resources (e.g., monitoring forms, public domain questionnaires, session checklists), updates of new research findings, and practice tips and suggestions. For Triple P practitioners, there is an international practitioner network for accredited providers that enables them to keep up to date with latest developments in the world of Triple P including research findings and new programs being released.

Encouraging Reflective Practice through Supervision

Practitioners who access supervision and workplace support post training are more likely to implement Triple P. A self-regulatory peer-assisted approach is the preferred method of supervision in the dissemination of Triple P (see Sanders & Murphy-Brennan, 2010a, Turner et al. 2011). The self-regulation approach to supervision is as an alternative to more traditional, hierarchically-based group or individual clinical supervision with an experienced expert supervisor who provides mentoring, feedback and advice to a supervisee. The self-regulation model utilizes the power and influence of the peer group to promote reciprocal learning outcomes for all participants in supervision groups which means that peers become attuned to not only assessing the clinical skills of fellow practitioners, but they also provide a motivational context to enable peer colleagues to change their own behaviors, cognitions and emotions so they become proficient in delivering interventions.

Importance of Organizational Leadership

The successful implementation of evidence based interventions requires strong local leadership and the creation of an organizational climate that embraces evidence-based ways of working with clients (Aarons et al, 2009, Fixsen et al. 2005). Many organizations pay lip

service to installing evidence-based practices while failing to create an organizational climate or workforce development strategy that sustains effective program use.

The quality of organizational leadership influences innovation within practice settings. Line managers seeking to improve service quality through the use of EBP's can encounter significant resistance from staff particularly if adoption of the practice has been a top-down process with little consultation with staff. When line managers prepare staff adequately to undertake training they are typically looking forward to the experience, are motivated to learn and ready to participate. Additionally, the implementation of evidence-based practice within a workforce has been shown to affect staff emotional exhaustion and retention, with research indicating EBPs that have ongoing fidelity monitoring are likely to produce higher levels of staff retention and lower levels of emotional exhaustion (Aarons et al 2009a).

Better organizational support can be ensured by providing manager briefings prior to the commencement of staff training. These briefings include an overview of the system of intervention, its evidence-base and the process of training to be undertaken by staff, how staff can be supported by managers through the training and accreditation process, how to set implementation targets, and how to support their staff with ongoing delivery of the program. Managers attending these sessions report greater clarity in knowledge of program requirements, are more motivated to adopt the program, feel supported by the program disseminator (i.e., training organization) in getting started, and are in a better position to support staff through the training, accreditation and implementation phases.

Ensuring Adequate Infrastructure Support

Organizations providing services to parents and families are typically funded to deliver treatment services to defined high need client groups. The adoption of a public health approach to the provision of parenting services represents a significant shift in policy for

many organizations. They do not see themselves as delivering prevention programs to parents and to become involved requires a significant reorientation of a workforce to prevention, early intervention and mental health promotion. Organizations need to ensure that adequate funding is available to support the delivery of an intervention.

In large scale roll outs of it is critical to ensure adequate funding and infrastructure is in place. Many government departments or organizations fund the initial training of their own staff and other agencies serving a population, but then expect the local agencies to allocate funding from their own budgets to fund the implementation costs (e.g., to purchase necessary parent resources).

IMPLICATIONS

Public Policy Advocacy

Children's risk of exposure to violence can be affected by the broader social ecology that affects families including economic downturn, war, natural disaster, and the law. Prevention scientists should advocate for child and family-friendly public policies and practices that promote the well being of children and families. Such policies can include supporting bans on the use of corporal punishment in schools and homes, increasing access to high quality and affordable child care, provision of universal health care, access to quality early child development programs, limiting exposure of children to violent television and computer games, and restricting access to unhealthy school meals. Prevention programs are likely to work best when they occur in a socio-political climate that values children, recognizes the importance of the parenting role and is prepared to invest in providing parenting support for a better future for children. Achieving this outcome requires a multilevel parenting support strategy that targets all parents.

Despite the considerable evidence showing that parenting programs are among the most efficacious and cost-effective interventions available to reduce violence exposure and to

promote the mental health and well being of children and adolescents, the majority of families who might benefit do not participate in parenting programs.

A whole-of-population approach to the prevention of violence that blends universal and targeted interventions should aim to increase parental self-efficacy, knowledge and competence in the use of skills that promote positive development in children and adolescents. This change in focus will enable millions more children around the world to experience the benefits of positive family environments that promote healthy development and as a consequence fewer children will be exposed to maltreatment and other forms of violence. When families are empowered with the tools for personal change they require to parent their children positively, the resulting benefits for children, adolescents, parents, and the community at large are immense.

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