Towards a public health approach to parenting

MATTHEW R. SANDERS *and* **ALINA MORAWSKA** *on the importance of parenting, and properly assessing interventions.*

AS Sutton and colleagues described in the previous article, there are various parenting, school and community, and personal factors at play in determining a child's risk of developing serious conduct problems. The temptation is therefore to conclude that when it comes to interventions, 'more is better than less'; but we think that this has not been convincingly demonstrated.

Some large-scale multi-risk-factor-reduction approaches that include parenting, school and child-specific interventions with older school-aged children have shown promise but are complex to administer, costly to implement and have yet to show strong long-term outcomes. But in young children (toddler and preschool-aged children) there is strong evidence that social-learning-based parenting programmes are effective with a wide range of families from quite diverse socio-economic and ethnic backgrounds. We choose to focus on such programmes.

Parenting is the key

There are two keys to diverting children from the pathway towards externalising problems and crime: parenting and early intervention. Even factors that don't immediately appear to be related to parenting in fact are: for example, the impact of financial difficulties and high-crime neighbourhoods on the child is mediated primarily through the effect on the family and the parent–child relationship (Conger *et al*., 1992). And early intervention is vital because it has been shown to be more effective (e.g. Tremblay

ASSESSING EVIDENCE ON PARENTING PROGRAMMES

The following criteria can be used to assess the strength of evidence, by whether a programme clearly meets them, only partially, does not meet them, or there is insufficient information available.

- Strength of supporting evidence (e.g. randomised control trials; independent replication across sites and investigators; no known negative side-effects of intervention; robustness demonstrated through evaluation of derivative programmes with other high-risk populations; follow-up data to demonstrate durability; main outcomes both statistically and clinically meaningful)
- Programme reach (e.g. applied to a range of presenting problems and ages; flexible delivery modalities; multiple levels of parent intervention available of differing intensity depending on specific risk and protective factors)
- Theoretical basis (e.g. process uses scientifically derived principles of behaviour, affective and cognitive change; collaborative and empowering model to promote self-sufficiency and self-regulation; range of active skills and training strategies used, such as coaching, feedback and homework assignments; times of delivery of interventions developmentally to maximise impact, such as at the transition to school)
- Promotional strategies (e.g. has materials available to service providers; has a specific component focused on working effectively with the media)
- Cultural appropriateness (e.g. has been shown to be culturally acceptable and effective in diverse cultural contexts)
- Dissemination strategy (e.g. wide availability of parent and practitioner resources; delivered by accredited trainers via properly evaluated training procedures)
- Organisational support (e.g. has a post-training peer support supervision network available to trained providers; practitioner and parent websites available and regularly maintained)
- Evaluation (e.g. programme advocates routine evaluation of child and parent outcomes achieved)
- Cost-effectiveness (e.g. cost information readily available; has had an independent cost-effectiveness analysis conducted)
- Consumer acceptability (e.g. has been shown to have high consumer acceptability)

WEBLINKS

Parenting and Family Support Centre:

www.pfsc.uq.edu.au

Prevention Research: *www.preventionresearch.org*

et al., 1995), easier (e.g. Kazdin, 1987), and more cost-effective in both the short and long terms (Schweinhart & Weikart, 1992). Indeed, the public cost from childhood for individuals with persistent, poorly controlled antisocial behaviour is up to 19 times higher than for control children, involving many agencies (Scott *et al*., 2001).

Quality of parenting is the strongest potentially modifiable risk factor contributing to early-onset conduct problems. Evidence from behaviour genetics research and epidemiological, correlational, and experimental studies shows that parenting practices have a major influence on many different domains of children's development (Collins *et al*., 2000). Specifically, the lack of a warm, positive relationship with parents, insecure attachment and inadequate supervision of and involvement with children are strongly associated with children's increased risk for behavioural and emotional problems (e.g. Frick *et al*., 1992; Patterson *et al*., 1992; Shaw *et al*., 1996).

Children who experience a pattern of harsh discipline in which limits are intermittently enforced learn to achieve desired ends through coercive means (Patterson *et al*., 1989, 1992). This coercive pattern contributes to the development of problem behaviour, and the child fails to learn self-control and positive social skills. These young children are at significant risk for subsequent difficulties with school adaptation and relationships with peers and teachers, further compounding their risk for eventual problems such as substance use, antisocial behaviour, and participation in delinquent activities (e.g. Loeber & Farrington, 1998). On the other hand, when a parent interacts with a young child in ways that involve many warm, responsive, reinforcing, and stimulating exchanges, clear, calm instructions and non-harsh, consistent discipline, a positive and caring relationship between parent and child is more likely to be established, as well as socially skilled repertoires in the child (Ainsworth, 1979; Rutter, 1979).

What works?

Parenting interventions, derived from social-learning, and cognitive-behavioural principles, are considered the interventions of choice for conduct problems in young children (Prinz & Jones, 2003). Parent management training (PMT) programmes have also proven efficacious in prevention studies (e.g. Sanders *et al*., 2000). In these programmes, parents are typically taught to increase positive interactions with children and to reduce coercive and inconsistent parenting practices.

Studies evaluating PMT interventions often show large effect sizes (Serketich & Dumas, 1996) and have been replicated many times across different studies, investigators and countries (Sanders, 1999). The effects often generalise to a variety of home and community settings (McNeil *et al*., 1991; Sanders & Dadds, 1982), with two-biological-parent families, step-parents, and single parents. The results are maintained over time (Long *et al*., 1994), and are associated with high levels of consumer satisfaction (McMahon, 1999).

Media Training Courses 2006

The British Psychological Society

Working with the media? Want to gain some valuable tips and experience?

Whether you are a complete beginner or looking to update your skills, you will find our training sessions stimulating and enjoyable.

An Introduction to Working with the Media

A one-day immersion in the media – newspapers, magazines, radio and television – with lots of hands-on experience. This course is designed to give a general introduction to how the media operates, as well as introducing some of the skills necessary in media liaison. e.g. press release writing and interview techniques.

Members' Cost: £120 (inc. VAT) **Dates available:** 18 September 2006; 4 December 2006.

Broadcast Interview Skills

A one-day course that covers everything required for speakers to feel confident about taking on broadcast interviews. It will focus on radio interviews, but will also cover TV interview techniques.

Delegates will be provided with plenty of practical opportunity to get in front of the microphone and to gain experience of actually being interviewed.

Members' Cost: £170 (inc. VAT) **Dates available:** 21 August 2006; 11 December 2006.

All courses take place in London and include lunch and course materials.

Registration form and further details from:
Dawn Schubert
Administrator, Publications & Communications Directorate
Tel: 0116 252 9581; E-mail: mediatraining@bps.org.uk

Studies on PMT show improvements in parental perceptions and parenting skills, improvements in children's social skills and school adjustment, and reductions in behaviour and attention problems (Barlow & Stewart-Brown, 2000). What's more, evidence is mounting that a variety of delivery modalities can produce positive outcomes for children (Sanders, 1999), including individually administered face-to-face, group, telephone-assisted, and self-directed programmes. In addition, a number of effectiveness trials of PMT interventions have demonstrated meaningful effects for children who already have conduct problems (e.g. Dishion *et al.*, 2002; Scott *et al.*, 2001; Taylor *et al.*, 1998).

The benefits of PMT interventions are not restricted to children; several studies have shown beneficial effects in other aspects of family functioning, including reduced maternal depression and stress, increases in parental satisfaction and efficacy, and reduced couple conflict over parenting issues (Sanders *et al.*, 2000; Sanders & McFarland, 2000; Schuhmann *et al.*, 1998; Webster-Stratton, 1990).

How do we judge?

There is increasing evidence that brief self-directed interventions can be effective in reducing early conduct problems (e.g. Morawska & Sanders, in press; Sanders *et al.*, 2000). The assumption that programmes that address more parenting and family risk factors work better is not supported by several studies. So how do we judge the relative merits of very different programmes, and the evidence for them? The box on p.476 lists some operational criteria that can be applied in evaluating the strength of evidence of various parenting programmes in reducing risk of antisocial behaviour.

Using such criteria we can assess the pros and cons of programmes such as Fast Track – a comprehensive, multicentre, multicomponent programme providing long-term services to children exhibiting aggressive behaviours. The intervention includes classroom management, child directed interventions such as socio-cognitive skills training, parent training, and home visiting. In a prevention trial, over 800 high-risk children were randomly assigned to the Fast Track intervention or to a control group. By the end of the third year of the intervention 37 per cent of the intervention group were considered free of serious conduct problems, compared with 27 per cent of the control group. Teacher ratings of conduct problems provided some evidence that the intervention was preventing conduct problems at school (Conduct Problems Prevention Research Group, 2002). While the effects of Fast Track as a preventive intervention are promising, it is an expensive, resource-intensive intervention, and the cost-effectiveness of the programme will need to be examined once long-term outcome

References

Ainsworth, M.S. (1979). Infant–mother attachment. *American Psychologist, 34*, 932–937.

Barlow, J. & Stewart-Brown, S. (2000). Behavior problems and group-based parent education programs. *Journal of Developmental and Behavioral Pediatrics, 21*, 356–370.

Biglan, A. (1995). Translating what we know about the context of antisocial behavior into a lower prevalence of such behavior. *Journal of Applied Behavior Analysis, 28*, 479–492.

Collins, W.A., Maccoby, E.E., Steinberg, L., Hetherington, E.M. & Bornstein, M.H. (2000). Contemporary research on parenting: The case for nature and nurture. *American Psychologist, 55*, 218–232.

Conduct Problems Prevention Research Group (2002). Evaluation of the first 3 years of the Fast Track prevention trial with children at high risk for adolescent conduct problems. *Journal of Abnormal Child Psychology, 30*, 19–35.

Conger, R.D., Conger, K.J., Elder Jr, G.H. *et al.* (1992). A family process model of hardship and adjustment of early adolescent boys. *Child Development, 63*, 526–541.

Dishion, T.J., Kavanagh, K., Schneiger, A., Nelson, S. & Kaufman, N. K. (2002). Preventing early adolescent substance use: A family-centered strategy for the public middle school. *Prevention Science, 3*, 191–202.

Frick, P.J., Lahey, B.B., Loeber, R. & Stouthamer-Loeber, M. (1992). Familial risk factors to oppositional defiant disorder and conduct disorder. *Journal of Consulting and Clinical Psychology, 60*, 49–55.

Kazdin, A.E. (1987). Treatment of antisocial behaviour in children. *Psychological Bulletin, 102*, 187–203.

Loeber, R. & Farrington, D.P. (1998). Never too early, never too late: Risk factors and successful interventions for serious and violent juvenile offenders. *Studies on Crime and Crime Prevention, 7*, 7–30.

Long, P., Forehand, R., Wierson, M. & Morgan, A. (1994). Does parent training with young noncompliant children have long-term effects? *Behaviour Research and Therapy, 32*, 101–107.

McMahon, R.J. (1999). Parent training. In S.W. Russ & T.H. Ollendick (Eds.) *Handbook of psychotherapies with children and families* (pp.153–180). New York: Plenum Press.

McNeil, C.B., Eyberg, S., Eisenstadt, T.H. & Newcomb, K. (1991). Parent–child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. *Journal of Clinical Child Psychology, 20*, 140–151.

Morawska, A. & Sanders, M.R. (2006). Self-administered behavioural family intervention for parents of toddlers: Part I – Efficacy. *Journal of Consulting and Clinical Psychology, 74,* 10–19.

Patterson, G.R., DeBaryske, B.D. & Ransey, E. (1989). A developmental perceptive on antisocial behavior. *American Psychologist, 44*, 329–335.

Patterson, G.R., Reid, J.B. & Dishion, T.J. (1992). *Antisocial boys*. Eugene, OR: Castalia.

Prinz, R.J. & Jones, T.L. (2003). Family-based interventions. In C. A. Essau (Ed.) *Conduct and oppositional defiant disorders: Epidemiology, risk factors, and treatment* (pp.279–298). Mahwah, NJ: Lawrence Erlbaum.

Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. In M.W. Kent & J. E. Roif (Eds.) *Primary prevention of psychopathology. Volume III: Social competence in children* (pp.49–74). Hanover, NH: University of New England Press.

Sanders, M.R. (1999). Triple P–Positive Parenting Program: Towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clinical Child and Family Psychology Review, 2*, 71–90.

Sanders, M.R. & Dadds, M.R. (1982). The effects of planned activities and child management procedures in parent training: An analysis of setting generality. *Behavior Therapy, 13*, 452–461.

Sanders, M.R., Markie-Dadds, C., Tully, L.A. & Bor, W. (2000). The Triple P–Positive Parenting Program: A comparison of enhanced, standard and self-directed behavioural family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68*, 624–640.

Sanders, M.R. & McFarland, M. (2000). Treatment of depressed mothers with disruptive children: A controlled evaluation of cognitive behavioural family intervention. *Behavior Therapy, 31*, 89–112.

Schuhmann, E.M., Foote, R.C., Eyberg, S.M., Boggs, S.R. & Algina, J. (1998). Efficacy of parent–child interaction therapy: Interim report of a randomized trial with short-term maintenance. *Journal of Clinical Child Psychology, 27*, 34–45.

Schweinhart, L.J. & Weikart, D.P. (1992). High/Scope Perry Preschool Program outcomes. In J. McCord & R.E. Tremblay (Eds.) *Preventing antisocial behavior: Interventions from birth through adolescence* (pp.67–86). New York: Guilford Press.

Scott, S., Spender, Q., Doolan, M., Jacobs, B. & Aspland, H. (2001). Multicenter controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. *British Medical Journal, 323*, 194–198.

Serketich, W.J. & Dumas, J.E. (1996). The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. *Behavior Therapy, 27*, 171–186.

Shaw, D.S., Owens, E.B., Vondra, J.I., Keenan, K. & Winslow, E.B. (1996). Early risk factors and pathway in the development of early disruptive behaviour problems. *Development and Psychopathology, 8*, 679–699.

Taylor, T.K., Schmidt, F., Pepler, D. & Hodgins, C. (1998). A comparison of eclectic treatment with Webster-Stratton's parents and children series in a children's mental health center: A randomized controlled trial. *Behavior Therapy, 29*, 221–240.

Tremblay, R.E., Pagani-Kurtz, L., Masse, L.C., Vitaro, F. & Pihl, R.O. (1995). A bimodal preventive intervention for disruptive kindergarten boys: Its impact through mid-adolescence. *Journal of Consulting and Clinical Psychology, 63*, 560–568.

Webster-Stratton, C. (1990). Enhancing the effectiveness of self-administered videotape parent training for families with conduct-problem children. *Journal of Abnormal Child Psychology, 18*, 479–492.

data become available. However, few prevention programmes are able to meet all the criteria outlined above.

Fast Track, and approaches discussed by Sutton and colleagues in the previous article such as the Nurse-Family Partnership and the Perry Preschool Program, tend to be very resource intensive, but there is evidence that such approaches are also cost-effective in the long term. Nevertheless these approaches tend to target very high-risk children, from highly disadvantaged backgrounds. While children from such backgrounds need assistance and intervention, focusing solely on the very disadvantaged end of the spectrum misses a large proportion of children and families who are also at risk for antisocial and conduct problems.

Toward a public health model

To address the difficulties of poor population reach of evidence-based parenting programmes, a public health approach to improving parenting is required. Reducing the prevalence of children's behaviour problems will require that a large proportion of the population be reached with effective parenting strategies (Biglan, 1995). Thus, a key assumption of a public health or population-based approach is that parenting intervention strategies should be widely accessible in the community. In addition, a public health approach to behaviour change assumes that the mass media play an important role in reaching individuals to affect their knowledge, attitudes and behaviours, in changing public norms, and in affecting institutional policies.

One example of a public health approach to parenting is the Triple P system developed by Sanders and colleagues (Sanders, 1999). The Triple P Positive Parenting Program was designed as a comprehensive population-level system of parenting and family support. It aims to enhance parental competence, prevent dysfunctional parenting practices, and promote better teamwork between partners, thereby reducing an important set of family risk factors associated with behavioural and emotional problems in children and adolescents. The multilevel system includes five levels of intervention of increasing intensity and narrowing population reach:

- Universal Triple P (Level 1) is a media and communication strategy designed to target all parents in a population;

SHOUT /REPORTDIGITAL.CO.UK

Home visits are resource-intensive

- Selected Triple P (Level 2) is a brief one- or two-session intervention;
- Primary care Triple P (Level 3) is a more intensive but brief four-session primary care intervention;
- Standard Triple P (Level 4) is a more intensive eight- to ten-session active skills training programme;
- Enhanced Triple P (Level 5) is the most intensive parenting intervention that targets parenting, partner skills, emotion coping skills, and attribution retraining for the highest-risk families.

Various components of the Triple P system have been subjected to a series of controlled evaluations, and have consistently shown positive effects on observed and parent-reported child behaviour problems, parenting practices, and parents' adjustment. In the Triple P system, the mass media are utilised extensively in a strategic manner to normalise and acknowledge the difficulties of parenting experiences, to break down parents' sense of social isolation regarding parenting, to destigmatise getting help, to impart parenting information directly to parents, and to alter the community context for parenting (Sanders, 1999).

Conclusion

There are currently two diverging lines of research on how best to prevent conduct problems using differing levels of intensity of intervention. One line focuses on targeting disadvantaged, high risk children, with high-intensity, multicomponent interventions. These interventions typically reach only a small percentage of children who develop conduct problems. The other line of research centres on children with moderate to high levels of risk, and emphasises simplifying the complexity and duration and increasing the population reach of interventions. These two approaches are not mutually exclusive.

It is becoming increasingly evident from the parent training literature that more is not necessarily better than less, when it comes to prevention and intervention with children at risk for behavioural and emotional disorders. While some children and families require intensive interventions, brief targeted methods can be effective even for high-risk children, especially with young children. For moderate-severity problems it may be more efficient to provide a moderate-intensity intervention, and should this prove to be inadequate additional intervention modules could be delivered.

The alternative is to provide all at-risk children with high-intensity interventions, regardless of need and potential response to lower levels of intervention intensity. Such an approach is not cost-effective and is unsustainable for public health systems. A public health approach needs to focus on efficiency and cost-effectiveness in delivering interventions at a population level. A multilevel intervention approach targeting various problem intensities and levels of risk, provides a model for the reduction of population rates of antisocial behaviour.

■ *Matthew R. Sanders is Professor of Clinical Psychology at the University of Queensland, Brisbane, Australia. E-mail: matts@psy.uq.edu.au.*

■ *Alina Morawska is at the University of Queensland. Email: alina@psy.uq.edu.au.*

DISCUSS AND DEBATE

What are the disadvantages of offering high-intensity interventions?

Is there a trade-off between the intensity of a parenting intervention and the level of population reach achieved?

Can we accurately predict from the pre-intervention characteristics of parents who will respond to different levels of parenting interventions?

How important is the cost-effectiveness of interventions delivered to families?

Have your say on these or other issues this article raises. E-mail 'Letters' on psychologist@bps.org.uk or contribute to our forum via www.thepsychologist.org.uk.