

community education and social marketing

Literature Review



To inform a
campaign to improve
the safety and wellbeing
of children in the
Northern Territory

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On behalf of the Caring for Kids Consortium

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Definitions

A number of terms are often used interchangeably which, in fact, reflect different methods (or refer to different components of methods) to promote the safety and wellbeing of children.

In this review we refer to terms such as “social marketing”, “community education”, “campaigns” and “programs”. These are defined for the purposes of this review.

“Community Education” refers to a “process whereby learning is used for individual, community and global improvement. It is characterised by the integrated involvement of people of all ages, use of community learning resources and research to bring about community change and recognition that people can learn through, with and from each other to create a better world” (Akande 2007). Community education aims to facilitate collective problem solving by community members by equipping them with the knowledge to facilitate action, and through promoting citizen participation and shared decision making (Akande 2007). In the NT, the term “community” may be used to denote people who reside in a particular locality or geographic region, as well as people who are connected through common characteristics or interests, or through cultural and/or historical heritage.

“Social marketing” is the “application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary or involuntary behaviour of target audiences in order to improve the welfare of individuals and society” (Donovan and Henley 2010). Drawing on the fields of psychology, sociology, marketing and communication theory, social marketing aims to address the wellbeing of the community to accomplish social good and a community wide behavioural change that is specific, healthy and sustainable (Donovan and Henley 2010). Effective social marketing includes strategies that target change in social environments, communities, social policy, and legislation, rather than solely relying on individuals to change their behaviour (Donovan and Henley 2010; Horsfall, Bromfield et al. 2010).

“Campaigns” are a strategic set of activities which have been designed to achieve a particular purpose (Dorfman, Ervice et al. 2002). In this review, we examine campaigns which have the purpose of changing knowledge, creating awareness, challenging attitudes and promoting positive behaviours and reducing negative behaviours towards children.

“Programs” are defined as “collections of practices that are done within known parameters (philosophy, values, service delivery structure, and treatment components)” (Mildon 2011). Practices are the skills, techniques, and strategies a practitioner may use in the course of their work with children, families and communities (Mildon 2011).

In addition to the key concepts defined above, the terms “safety” and “wellbeing” are frequently used, but rarely defined. For the purposes of this review we have used the definitions used by the NT Office of Children and Families, Community Child Safety and Wellbeing Teams:

“Child wellbeing” is the good physical, emotional and psychological health of a child.

A child can be considered “safe” when there is no serious threat of danger to a child’s wellbeing within the family environment or when the protective capacities within the family can manage such threats of danger to a child’s wellbeing.

1. background

Purpose of literature review

The aim of this review is to inform a community education and social marketing strategy to improve the safety and wellbeing of children in the Northern Territory (NT).

Examining national and international literature provides an overview of the current research on i) what helps communities and families to keep their children safe; ii) the use and effectiveness of social marketing and community education approaches for the prevention of child abuse and neglect and/or approaches in remote and/or Aboriginal contexts and iii) their applicability to the NT context.

In doing so the review seeks to answer the following questions:

- **Why is there a need for a community education and social marketing campaign in the NT?**
- **Why do strategies need to reach Aboriginal families?**
- **What helps communities and families to keep their children safe?**
- **What methods of delivery (what strategies) are best for achieving change?**
- **Who should key messages be targeted at?**

Why is there a need for a community education and social marketing campaign in the Northern Territory?

Child maltreatment is a preventable phenomenon which is one of the most potent predictors of poor mental health and wellbeing in children and adults (O'Connell, Boat et al. 2009). Children who grow up in unsafe home and community environments, and who experience trauma, violence and neglect demonstrate difficulties in emotion regulation, behaviour, responses to stress, and interactions with others (Barth, Scarborough et al. 2008; Jordan and Sketchley 2009). Effective strategies to prevent and respond to child abuse and neglect have the potential to help children reach their full cognitive, social and physical potential (Beckett, Maughan et al. 2006). Parental substance misuse, mental health problems and domestic violence are described as "key risk factors" for child abuse and neglect that often co-occur as part of a complex set of social and family issues (Bromfield and Lamont, 2010).

A number of public inquiries, and subsequent reports, highlight the need for more information to be provided to families, communities and practitioners about what constitutes child abuse and neglect, its impacts, and the actions that can be taken to promote children's safety in their homes, schools and communities. These inquiries highlight the specific needs of a range of target groups including the general population (NAPCAN 2010), Aboriginal families (SNAICC 2004; Northern Territory Government 2010) (Wild and Anderson 2007) (Mullighan 2008), families from migrant and refugee backgrounds (Lewig, Arney et al. 2010), and practitioners from family support, health, education, and social work disciplines (Arnold, Maio-Taddeo et al. 2008) (Arnold and Maio-Taddeo 2008; Parry, Maio-Taddeo et al. 2009) (Crettenden, Zerk et al. 2010).

The Board of Inquiry into Child Protection in the NT identified the need for community education campaigns which focus on content areas such as "acceptable parenting practices, child abuse and neglect, the role of child protection, other services and communities in child abuse prevention and response, and mandatory reporting requirements" (Northern Territory Government 2010).

Noting the number of disparate community education activities occurring in the NT, Recommendation 146 of the *Growing them strong, together* report suggests that the NT Government develops and delivers a comprehensive community education strategy to highlight key messages about child protection and child wellbeing. This recognises the importance of making contemporary knowledge and understandings around child development accessible to the broader NT community, as well as the critical impact of the early years for child health, learning and behaviour in order to prevent child abuse and neglect.

Why do strategies need to reach Aboriginal families?

The Northern Territory has a unique geographic, cultural, socio-demographic, historical, linguistic and economic profile when compared with other Australian jurisdictions (Silburn, Robinson et al. 2010). This poses challenges both to the delivery of services and to the development of universal strategies to promote children's safety. Current rates of notification for child neglect in the NT highlight the growing concern about the health and wellbeing of young children and the conditions of their families and home environment (Guthridge, Ryan et al. 2012). They signal the pressing need for significant improvement to systems of early intervention and preventive family support (Silburn, Robinson et al. 2010).

Over one quarter (28.6%) of the 211,295 people living in the NT identify as Aboriginal or Torres Strait Islander, compared to 2.5% of the Australian population as a whole (Census, 2011). The 2011 Census found that 23.2% of the NT population is aged 0–14 years (increasing to 38% for the Aboriginal and Torres Strait Islander population in the NT), which is higher than the national average of 19.3%.

In 2010–2011, 83% of NT children aged 0–17 who were the subjects of substantiations of child abuse and neglect were Aboriginal (AIHW 2012). The most common substantiation type for Aboriginal children was neglect (54%). From 1999–2010, the overall annual rates of notification for maltreatment of Aboriginal children showed an increase of 21%, with the greatest increases in notifications for neglect and emotional abuse. There were parallel increases in rates of substantiated cases of maltreatment (Guthridge et al, 2012). While both the NT Government and the Australian Government's 'Closing the Gap' strategies prioritise child safety in the NT as a key goal, this data highlights the particular need to improve outcomes for Aboriginal children living in the NT.

Compared with their non-Indigenous counterparts, Indigenous NT children are more likely to be born to younger parents, have lower birth weights, live in socioeconomically disadvantaged households, have had involvement with the child protection system, and live in remote communities where basic needs such as housing and nutrition are not always adequately met. (Silburn, Robinson et al. 2010)

It is imperative that any community education campaign in the NT resonates with Aboriginal families, recognising the strengths and diversity within, and between families, and uses messages and strategies which are culturally sensitive to Aboriginal people and communities. For Aboriginal communities it is important that new knowledge builds upon Aboriginal child rearing practices (Kruske, Belton et al. 2012). Consequently, this review incorporates the literature exploring the strengths and needs of Aboriginal families in the NT, and explores specific community change strategies which have been successful in Indigenous contexts.

Key Learnings

- **Effective strategies to prevent and respond to child abuse and neglect have the potential to help children reach their full cognitive, social and physical potential.**
- **Families, communities and practitioners require more information about what constitutes child abuse and neglect, its impact and how it can be prevented.**
- **Due to the over-representation of Aboriginal children in the NT statutory child protection system it is imperative that community education strategies resonate with Aboriginal families, communities and practitioners.**

2. what helps families and communities keep their children safe?

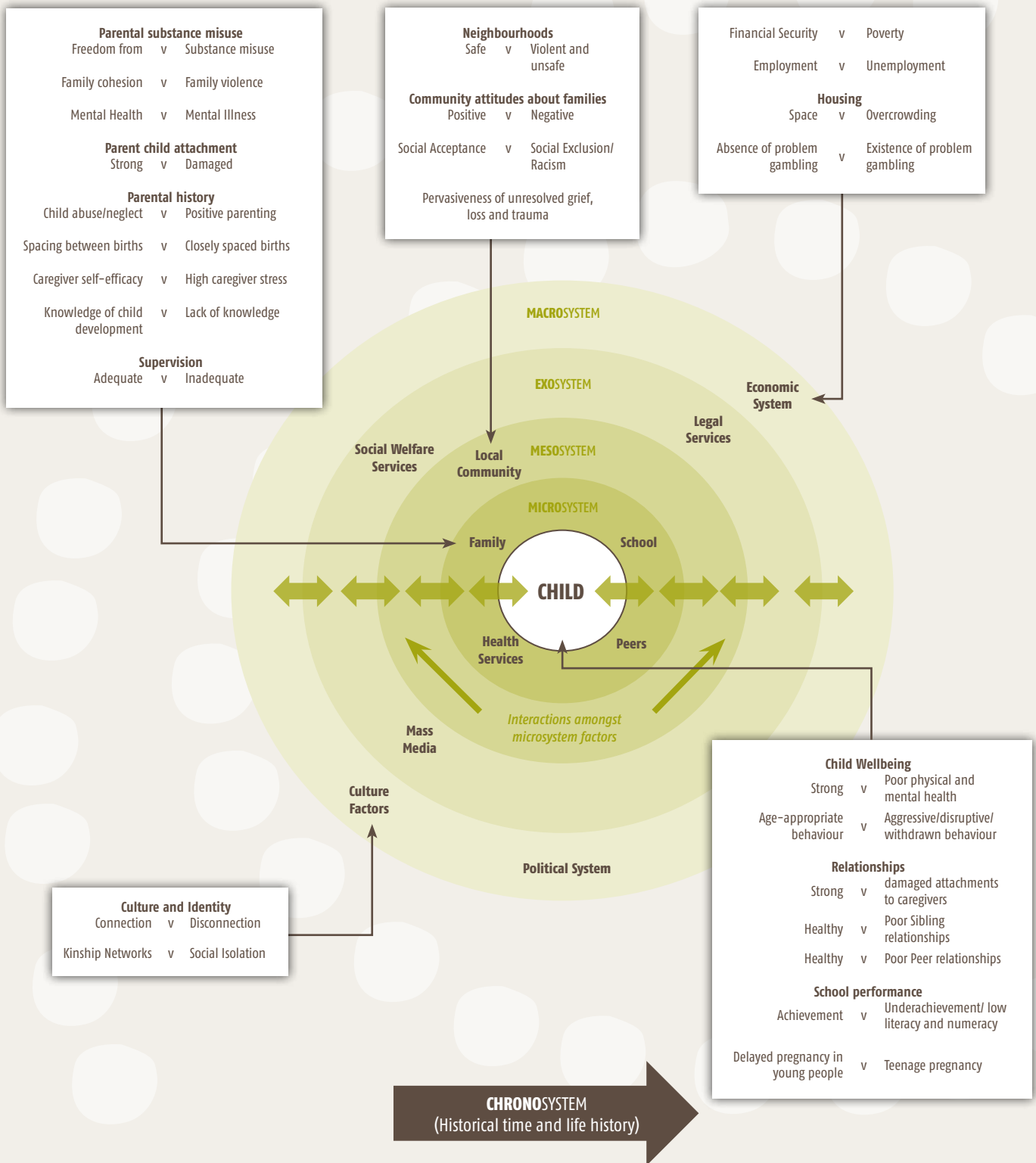
The concept of child safety incorporates a number of dimensions. Child safety involves the preservation and protection of children's physical, psychological, developmental and cultural wellbeing. To understand what helps keep children safe, it is important to recognise the characteristics of family and community environments that pose risks to children and the impact of these risks. Ecological theory (Bronfenbrenner, 1986) is a commonly used framework to explain the systems of support which can help or hinder a child as they grow. This framework illustrates how a child's development is affected by complex interactions of factors at multiple levels: the level of the child, their family and immediate environments (such as peers and schools), the broader social system (such as their local communities and the media), and other political, cultural and economic systems (see Figure 1).

While children of different ages require a different intensity of caregiving, all children and young people require caregivers who are attentive and respond sensitively to their needs, who provide nurture and care, ensure they are in safe environments, stimulate their learning, establish boundaries and offer moral guidance (Centre for Community Child Health 2004). While all parents and caregivers, at certain times, find parenting difficult, it can become particularly challenging when they themselves may not have experienced adequate care as a child or are living in highly stressful and unsafe environments.

Understanding the effects of child maltreatment on children's development

Recently, there has been rapid development in our understanding of the impact of unsafe environments and negative childhood experiences on a child's development. It is now widely understood that adverse experiences in childhood can have a lifelong legacy by impacting on the developing brain, affecting the child's ability to regulate their own behaviour and to build trusting and trusted relationships with others (Shonkoff and Phillips 2000).

Children who experience predictable, safe, secure and warm relationships develop confidence to explore the world around them, meet new challenges and tolerate infrequent stress (National Scientific Council on the Developing Child 2005). They have positive expectations of those around them. However, children who experience highly traumatising and stressful situations may display hyperarousal responses (such as defiance, resistance, aggression, hypervigilance, anxiety or panic) or dissociative responses (withdrawal from the outer world, appearing detached and numb). While these responses may appear strange and difficult in environments that are not threatening, they serve an adaptive function helping children to cope in chaotic and unpredictable situations (Perry 2004).



Based on Santrock (2007) and adapted from (Sanson and Stanley 2010)

Figure 1. Representation of Bronfenbrenner's socio-ecological model of development and protective and risk factors

Early childhood experiences influence the developing brain. Maltreatment, exposure to toxic levels of stress, or to emotional and physical deprivation (child neglect), can impair the connection of brain circuits which, in some instances, can lead to the development of a smaller brain. This impairs cognition (learning and memory), emotional functioning, physical growth and attention (Middlebrooks and Audage 2007; O'Connell, Boat et al. 2009). These cognitive and psychosocial impairments can lead to learning and developmental problems (poor transition to school and early drop out); externalising behaviour problems including antisocial and risk taking behaviours (substance misuse and criminal activity); and significant mental health problems (post traumatic stress disorder, anxiety, depression, suicidal ideation and behaviour) (Haskett, Nears et al. 2006; Cutajar, Mullen et al. 2010; Lamont 2010).

The sustained production of excess stress hormones in response to highly chaotic and unpredictable experiences, can suppress the human immune system (Middlebrooks and Audage 2007; Fuller-Thomson and Brennenstuhl 2009). Abuse in childhood has been associated with chronic adult health conditions such as heart disease, diabetes, arthritis, bronchitis/emphysema and cancer (Middlebrooks and Audage 2007; Fuller-Thomson and Brennenstuhl 2009). Other physical effects of child maltreatment can include physical health problems as a result of malnourishment and medical neglect, brain damage and fractures from physical abuse sexually transmitted infections and pregnancy from sexual abuse (Lamont 2010).

Importance of intervening early in the life of the child and early in the life of the problem

Development during pregnancy and in infancy is incredibly rapid and is also a period of high vulnerability for the child. Research has repeatedly demonstrated that intervening early in the child's life through the provision of high quality antenatal care, cessation of smoking and drinking in pregnancy, good nutrition for mothers and infants, early breastfeeding and parenting which supports the developing brain (e.g. through frequent interactions with caregivers and opportunities for stimulation) will set a foundation for the child which can last a lifetime (Winter 2010).

Programs which support the development of empathy and strong relationships and secure attachments with caregivers will not only serve a protective function for the infants, children and young people involved but are also likely to have intergenerational impacts as these children become parents and caregivers themselves. Children with poor attachments to their caregivers may be more likely to have difficult social relationships as adults and as parents and caregivers may respond inappropriately to the care needs of children (Smallbone, Marshall et al. 2008) (Lyons-Ruth and Jacobvitz 1999).

The literature has been consistent with regards to the importance of intervening as early as possible in the lives of parents and families as an effective strategy in preventing child abuse and neglect (Barth 1991; Eckenrode, Ganzel et al. 2000; Donelan-McCall, Eckenrode et al. 2009; Howard and Brooks-Gunn 2009; Zielinski, Eckenrode et al. 2009). Not only are there better outcomes for the protection and safety of children but also most cost effective options for investing at this primary prevention level (O'Donnell, Scott et al. 2008). The research evidence reveals that long-term support is required for families with complex problems, therefore, it is important to have dedicated programs for those families with issues of poor mental health, substance abuse and domestic violence (Guterman 1997; O'Donnell, Nassar et al. 2010). Programs which are responsive to the needs of families and which prevent problems from developing into crises are beneficial for families and cost-effective.

'Toxic stress' refers to strong, frequent or prolonged activation of the body's stress management system. Stressful situations that are chronic, uncontrollable, and/or experienced without the child having access to support from caregiving adults tend to provoke these types of toxic stress responses National Scientific Council on the Developing Child (2005). Excessive Stress Disrupts the Architecture of the Developing Brain. Waltham, MA, Brandeis University.

Protective and risk factors

The protective and risk factors which influence caregivers' efforts and abilities to keep their children safe operate at all levels of the child's (and the family's) social system. Protective and risk factors are seen as being at opposite ends of a continuum, as depicted in Box 1. These factors are inter-related and all exert influences on the ability of caregivers to keep children safe. These factors are also dynamic, that is they will change over time and in different circumstances.

Protective factors can exert their influence throughout the lifespan. As an example, Figure 2 identifies the ways in which protective factors can provide enriched experiences for children and adolescents in relation to educational participation and attainment. Many of these protective factors also support childrearing environments which promote children's safety and wellbeing in other areas of development, as will be discussed throughout this chapter.



Adapted from Silburn (2009) and taken from (Sanson and Stanley 2010)

Figure 2. Key leverage points to improve educational outcomes

Child-related factors

Children of different developmental ages and stages have different safety needs as well as different levels and types of vulnerability. Infancy is a period of rapid brain and physical development, and a time of high dependency, with infants requiring caregivers to recognise and respond to their cues for nurture, interaction and attention. In the NT, the highest rate of substantiations of child abuse and neglect are for infants less than one year old – a rate of 48.3 per 1000 children compared with rates of 29.4 and lower for other age groups (Australian Institute of Health and Welfare 2012). This is also the highest substantiation rate for infants in any jurisdiction in Australia (the national rate is 12.0 per 1000 infants)(Australian Institute of Health and Welfare 2012).

Research from South Australia identifies that while infants may be particularly vulnerable, there is a need to monitor and ensure the safety and wellbeing of children throughout childhood, with new notifications being received about children and young people throughout this period (Hirte, Rogers et al. 2008). Each developmental stage presents new challenges with children increasingly becoming independent from their families, becoming exposed to riskier situations in which they must make judgements about their own safety, and the increasing influence of peers and others outside the family as children get older.

As young people are increasingly exploring their identities throughout childhood and adolescence, their access to cultural practices, beliefs and values and opportunities for active participation in their communities can have a strong protective effect on their safety and wellbeing and can facilitate a successful transition to adolescence (Schorr and Marchand 2007).

Children and young people with higher care needs and with a greater dependency on others for meeting those needs (for example, children with complex medical needs, children with disabilities, and children exposed to alcohol in pregnancy) may have a greater likelihood of experiencing maltreatment (Tomison 1996). This is because their behaviours may be more likely to elicit harsh parenting, carers may become stressed and fatigued with the additional care needs of their children, there may be common factors which are associated both with the child's care needs and the ability of the parent to meet those needs (e.g. substance misuse), and because children with special needs encounter more adults in their lives as they receive care (Tomison 1996). It is important that their caregivers are supported with effective parenting strategies, opportunities for respite and that they can have confidence in the skills, abilities and intentions of others who are working with their children.

Parental protective and risk factors

The ability of parents to adapt to their child's changing needs can be helped and hindered by a range of factors (Centre for Community Child Health 2004). Parenting is learned throughout the life course. Parenting which promotes children's development and safety includes being able to understand a child or young person's signals and having a broad range of parenting responses to choose from in response to these signals. The ability to tune in and respond flexibly to children is called "parenting adaptability" and is learned through direct experience (parenting in the moment or by caring for siblings, nieces and nephews), from watching others (also known as modelling) and from other information sources (e.g. family members, books, television, websites) (Centre for Community Child Health 2004). That is, parenting is learnt by doing, watching, listening and asking. All of these allow opportunities for parents to gain knowledge, skills and understanding of what will meet children's needs at different life stages and in different contexts.

Risk factors are thought to influence caregiving in five core domains. These are thought to be common across all child maltreatment types (physical abuse, neglect, emotional abuse and, in part, child sexual abuse):

- social cognitive processing, for example, attributing hostile intent to children's behaviour, unreasonable expectations of children given their developmental stage, expectations of comfort and care from children rather than parents, and having a low sense of parental efficacy and control;
- impulse control, for example, reacting to children's behaviour without adequate reflection on the purposes and potential consequences of the response; coupled with parental anger this may result in escalation of physical discipline to abuse;
- parenting skills, for example, limited repertoire in the day to day care, discipline and monitoring of children; may include harsh or coercive techniques or overly permissive responses to children;
- social skills, for example, limited and poor communication with others, inability to read social cues, insensitivity to the needs of others; and
- stress management, for example, elevated levels of emotional arousal in response to stressful situations and ineffective coping strategies (Johnson, Stone et al. 2006).

Supporting parenting involves providing emotional and practical supports which assist parents in their roles and provide role models and contexts for nurturing and responsive parenting. When parents are overly stressed, inexperienced, ill-informed, pre-occupied or isolated, their caregiving can be characterised by a lack of nurturing, unpredictability, fear and threat (Perry 2004).

Parents who themselves have not had exposure to warm and responsive caregiving (e.g. through their own history of child abuse, neglect or removal from their parents) may have difficulties providing care and affection for their children (Lyons-Ruth and Jacobvitz 1999). Parents in stressful situations (e.g. for parents with mental illness, in situations of poverty, in the context of family violence) not only have a harder job to do, but are likely to have fewer emotional and economic resources available in their caregiving roles (Lyons-Ruth and Jacobvitz 1999).

Risk factors such as family violence, gambling, substance misuse, mental illness, disability, learning difficulties and early pregnancy are frequently interrelated and in the NT these are commonly found within a broader context of disadvantage – for example, unemployment, poor educational opportunities, homelessness, crime, community violence, victimisation and lack of social capital. (Northern Territory Government 2010)

The parents of Aboriginal children are far more likely than the parents of non-Aboriginal children to experience life stresses and, consequently, their children are more likely to be exposed to cumulative risk. The Western Australian Aboriginal Child Health Survey estimated that more than 20% of Aboriginal children live in families in which 7–14 life stress events have occurred in a 12 month period, and that their parents are exposed to more than three times the stressful life events than that experienced by carers of non-Aboriginal children (Silburn, Zubrick et al. 2006). The legacy of colonisation and the detrimental effect of past governmental policies on Aboriginal people are well-known. *The ongoing pervasiveness of loss and grief within the Aboriginal community, and its impact on the young, is often taken for granted and yet it creates an environment where a high degree of trauma is the norm (Northern Territory Government 2010).*

Young parenthood can be a risk factor as young parents may be inexperienced caregivers, may be in less stable relationships, and may need additional supports as they simultaneously navigate parenthood and adolescence. During this time, young parents may defer some or all of their parenting responsibilities to their own parents or grandparents, and may disengage from education and employment, which are also protective factors for children's safety and wellbeing. There are higher rates of teen pregnancy in the NT than in other parts of Australia: in 2008, the rate of babies per 1000 women aged 15–19 years was 52.2 in the NT compared with the national rate of 17.3 (Australian Bureau of Statistics 2009). Protective factors for child wellbeing include delaying pregnancy until after adolescence and spacing between births (Barnes, Ball et al. undated).

Community protective and risk factors

The community-level factors which strengthen the child safety and wellbeing include physical safety (such as adequate lighting, safe places to walk and play, road crossings), supportive relationships and positive attitudes towards children and young people, and positive social norms about childrearing. On the other hand children's safety and wellbeing is compromised by dangerous and stressful environments, relationships which involve conflict and violence, and community norms which support harsh or neglectful parenting (O'Connell, Boat et al. 2009).

In the NT, the high rates of neglect and exposure to physical violence are considered "*by-products of poverty and extreme disadvantage*" (Commission on Social Determinants of Health 2007; Northern Territory Government 2010). Poor housing standards, including limited facilities for food storage and cooking, and low housing availability across urban, regional and remote centres, pose risks to children's safety.

Neighbourhoods or communities which provide opportunities for healthy child development, through libraries and other settings for learning, social and recreational activities such as parks, child care, quality schools, health care services and employment opportunities serve a protective function for children's safety and wellbeing. Employment, income security, stable and secure housing in safe communities, access to affordable health care, food security, and opportunities for social care are a fundamental basis for a preventive approach to child protection in the NT (Jordan and Sketchley 2009).

As a result of high levels of disadvantage in the NT, there is limited access to services and supports which enhance parenting (Northern Territory Government 2010). In communities experiencing high levels of disadvantage, severe and pervasive risk factors at community level can lead to the normalisation of risk to children, for example, sexualised problem behaviours between children and chronic neglect (Northern Territory Government 2010).

The National Aboriginal and Torres Strait Islander Social Survey of 2008 estimated that, in the NT, approximately two-thirds of households with 0–14 year old Aboriginal children needed more rooms, approximately one-third lived in houses with major structural problems, one-third had facilities that were not available or working and almost one-third had run out of money for living expenses in previous year (Australian Bureau of Statistics 2009). Overcrowded conditions may mean that children are exposed to violence and sexual acts between adults. Such conditions where substance abuse and gambling are prevalent impacts on the availability of money for household necessities, may impact on parental vigilance and supervision of children and can involve many strangers in the home. In these households, child maltreatment becomes more likely as there are fewer economic and social resources to protect children's wellbeing.

Box 1 provides a summary of risk and protective factors which operate on child safety and wellbeing at the levels of child, family, local community and society

Box 1 . Protective and Risk Factors for children's safety and wellbeing

| | Protective Factor | Risk Factor |
|-------------------------|---|--|
| Child | <ul style="list-style-type: none"> Strong child wellbeing Age appropriate behaviour Strong relationships Healthy sibling relationships Healthy peer relationships Achieving well at school | <ul style="list-style-type: none"> Poor physical and mental health Aggressive/disruptive/withdrawn behaviour Damaged attachments to caregivers Poor sibling relationships Poor peer relationships Under achievement/ low literacy and numeracy |
| Family | <ul style="list-style-type: none"> Freedom from parental substance misuse Family cohesion Mental health Strong parent/child attachment Positive parenting Spacing between births Caregiver self-efficacy Knowledge of child development Adequate supervision | <ul style="list-style-type: none"> Parental substance misuse Family violence Mental illness Damaged attachment Child abuse/ neglect history Closely spaced births High care giver stress Lack of knowledge Inadequate supervision |
| Local Community | <ul style="list-style-type: none"> Safe neighbourhoods Positive community attitudes about families Social acceptance Resolution of grief, loss and trauma | <ul style="list-style-type: none"> Violent and unsafe Negative attitudes about families Social Exclusion/Racism Pervasiveness of unresolved grief, loss and trauma |
| Economic System | <ul style="list-style-type: none"> Financial security Employment Housing space Absence of problem gambling | <ul style="list-style-type: none"> Poverty Unemployment Overcrowding Existence of problem gambling |
| Cultural factors | <ul style="list-style-type: none"> Connection to cultural Identity | <ul style="list-style-type: none"> Disconnection to cultural identity |

Integrated children and families service system

As families have different levels and types of protective and risk factors, different strategies to promote children's safety will be required for diverse target groups. Increasingly, the field of child protection is embracing frameworks from the field of public health, which utilise the knowledge of the causes and consequences of child maltreatment and the levels of protective and risk factors to tailor approaches to specific target groups.

As multiple strategies are required in order to produce a population level impact on the safety of children, a public health model requires whole of government action and coordination, as well as a commitment from the community to the safety of children. The role of the government is to ensure families have access to the supports and services which will enhance their abilities to provide safe environments in which their children can flourish. In addition, the role of statutory child protection agencies is to work specifically with the adults responsible for children's care, when risks to children have been identified. Their role is to take specific steps to assess the safety of the child, to identify courses of action that could reduce risk and promote safety, and use statutory powers when caregivers may be unwilling or unable to make changes required to ensure their children's safety.

The NT Board of Inquiry into the Child Protection system proposed the following framework:

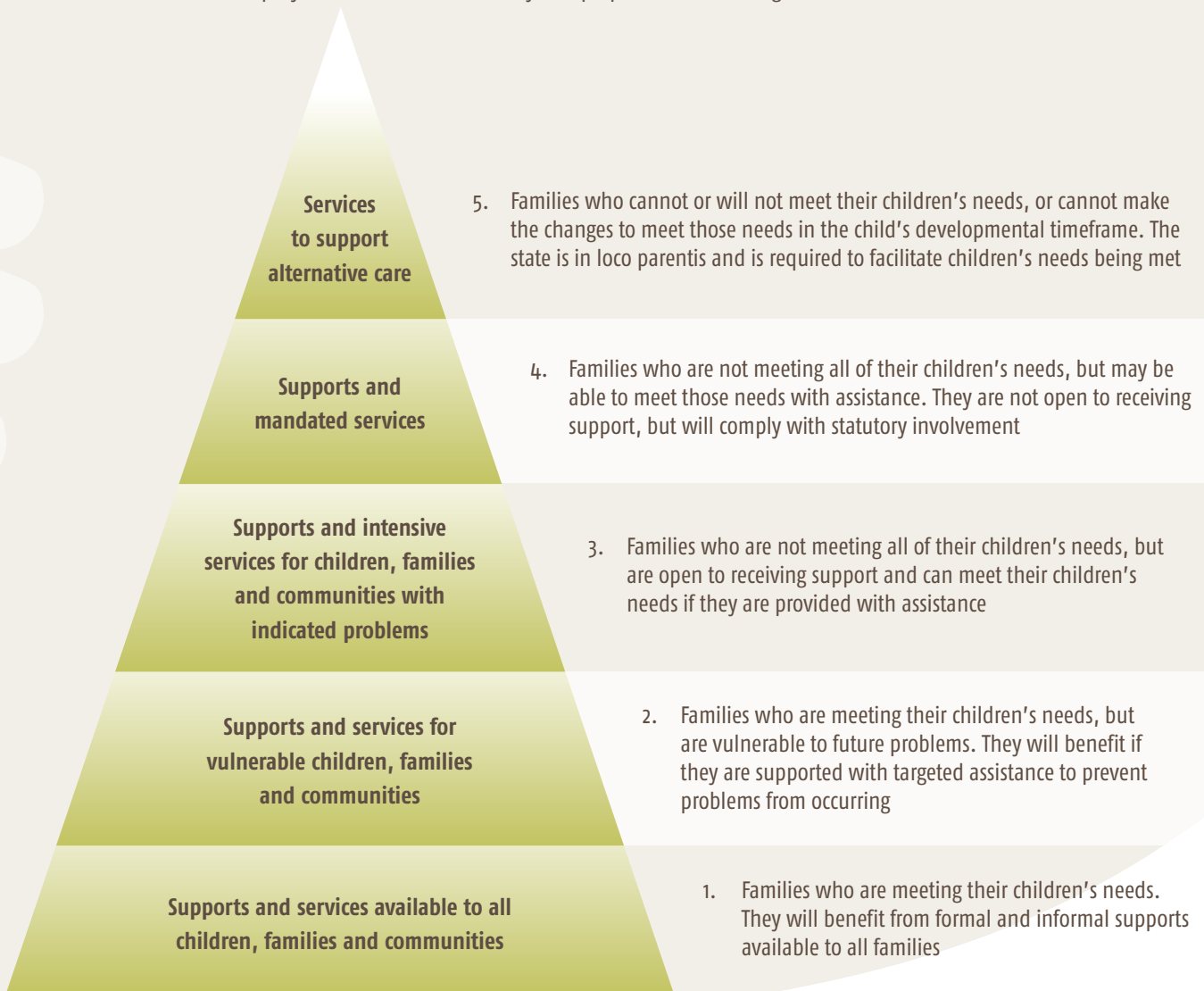


Figure 3. Integrated model for child protection services applied to the current service system

Primary Prevention: The first group identified in Figure 3 includes all families who can be supported by universal formal and informal supports and services to adequately care for their children. This includes specific support for fathers and mothers (and others involved in childrearing) in their caregiving roles. At this level it is assumed that all families are having their basic needs (interwoven emotional, mental, physical and spiritual) met. In the NT, this may not be the case for many families so primary prevention efforts should be focused at ensuring, as a baseline, these needs are met.

Prevention: The second group of families includes those who have no present concerns, but may be vulnerable to developing difficulties later which additional supports now will prevent. Risk groups are young mothers, caregivers with mental health problems, caregivers who had a history of out of home care placement when they were children, or communities in which alcohol or substance use is high.

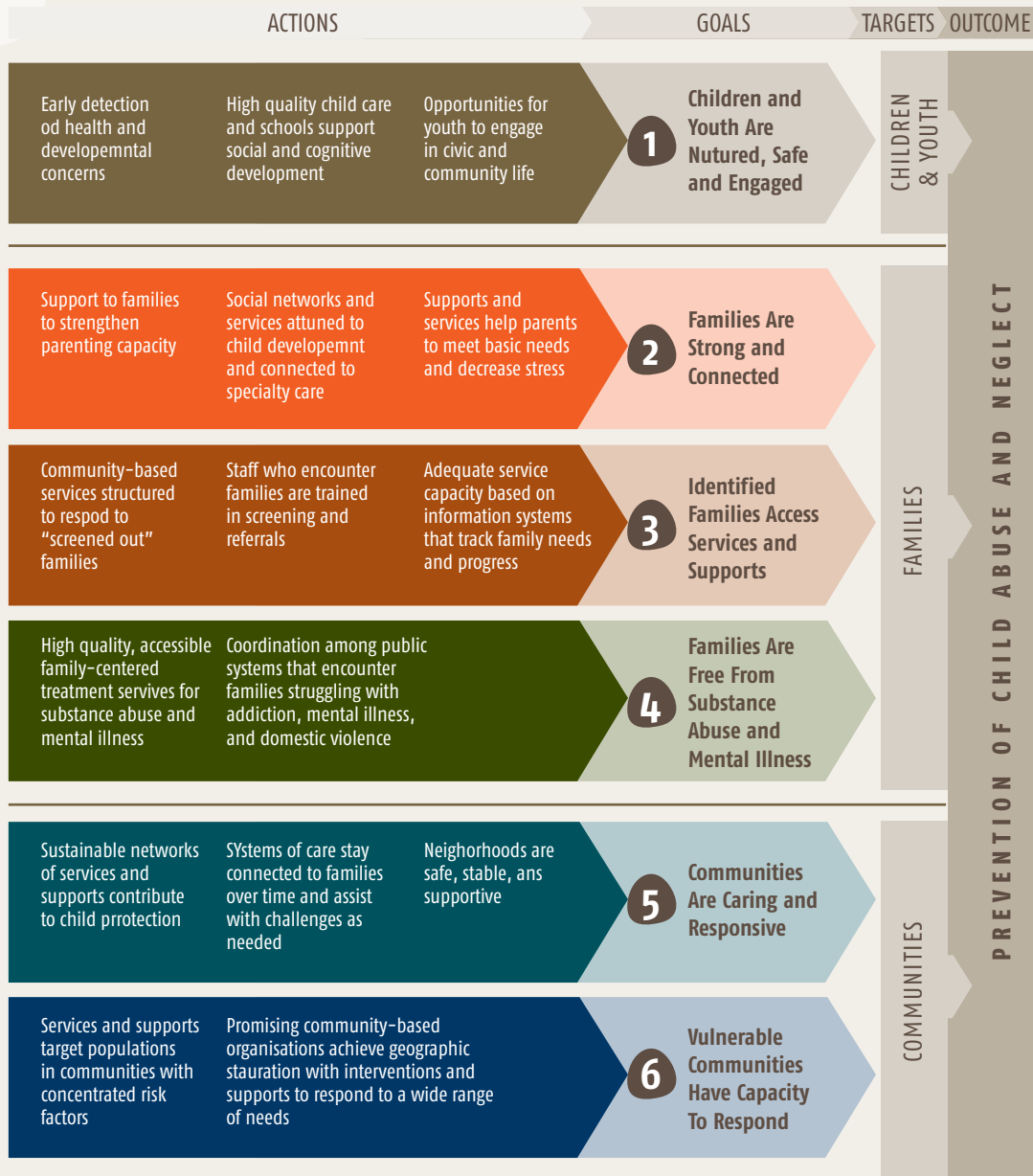
Early intervention: The third group of families includes those experiencing parenting difficulties or whose children's needs are currently beyond their capabilities. These families are proactive in seeking or are open to engaging with services to support them in their caregiving role. This may include caregivers who are struggling with the demands of their child's behaviour, caregivers who have ambivalent feelings towards their children, families who require practical support in order to meet their children's needs, and families in which children have emerging emotional and behavioural problems. Engaging Aboriginal families at this stage poses a challenge due to past welfare and child protection policies that led to the Stolen Generation, with many Aboriginal people continuing to view support services with suspicion.

Statutory Child Protection: The fourth group of families includes those where there are serious concerns about a child's wellbeing or safety. Initially they may not be open to receiving supports, nor present voluntarily for assistance, but will engage with relevant services if the statutory child protection agency intervenes. The child may need to be placed in alternative care arrangements in the short term until the parent can meet the child's needs with the ongoing supports provided.

Statutory out-of-home care: The fifth group of families includes those who do not have the capacity (often due to substance misuse, mental health issues, domestic violence) to meet their child's needs in the longer term, or cannot make necessary changes with supports within their child's developmental timeframe. Children in these families are likely to be placed in alternative care arrangements (including kinship care) for the long term. Ongoing supports are provided for the child, their alternative caregivers and their birth family.

An evidenced based model, Pathways to Prevention developed by Schorr and Marchand (2007) provides guidance to national, state and county governments in the US about actions they could support to prevent child abuse and neglect in their communities (see Figure 4).

Actions Overview, Prevention of Child Abuse and Neglect



Pathways Mapping Initiative, June 5, 2007

Figure 4. Pathway to the Prevention of Child Abuse and Neglect (Schorr and Marchand 2007)

The pathway recognises that prevention of child abuse and neglect is more likely if problems in child development can be picked up early, families and services can be engaged in providing enriched learning environments for children and to decrease parental stress, and high quality service provision with a trained workforce is provided for vulnerable families and families where mental illness, substance misuse and family violence are problems. The model also strongly emphasises coordinated service provision, with networks or “systems” of care providers providing consistent supports and messages for families in need, and that these networks remain connected to families to respond as needed over the lifetime of the family.

Both service system models described are based on an understanding of the protective and risk factors for children, and on recognition that the service needs, motivation and responsiveness of families may be different. These models also view families as dynamic systems with families at times having different levels of resilience and vulnerability. For example, parenting and children’s needs will change depending on the ages and stages for both children and their families. It is essential that systems are based on the identified critical periods for child development and key transition points for families in which support is most likely to be needed or welcomed (e.g. in expectation of the birth of a baby, preparing for the transition to school, after loss or bereavement), but also have the ability to be responsive to the needs of families as they arise (Schorr and Marchand 2007; O’Connell, Boat et al. 2009).

Key Learnings

- **To understand what helps keep children safe, it is important to identify risk and protective factors in family and community environments, and their impact.**
- **Early experiences of childhood abuse and neglect can adversely impact on brain development, impairing cognition, emotional functioning, physical growth and mental health throughout the life course of a child.**
- **Adaptive parenting which involves the ability to tune in and respond flexibly to children is learned through direct experience, from watching others and from other information sources.**
- **Young parents may need additional supports as they simultaneously navigate parenthood and adolescence.**
- **Other protective factors for child wellbeing include delaying pregnancy until after adolescence and spacing between births**
- **Children of different developmental ages and stages have different safety needs as well as different levels and types of vulnerability.**
- **Access to cultural practices, beliefs and values and opportunities for active participation in their communities can have a strong protective effect upon young people as they transition to adolescence.**
- **Children and young people with higher care needs may have a greater likelihood of experiencing maltreatment.**
- **Any community education strategy targeting child safety and wellbeing in the NT must be aligned with a coordinated service system which can predict and respond to the needs of caregivers and have a commitment from the community.**
- **Prevention of child abuse and neglect is more likely if problems in child development can be identified early. Intervening as early as possible in the lives of parents and families, to prevent crises developing is also identified as an effective strategy.**
- **Networks or “systems” of care providers need to be consistent in their support and messaging to individual families in need over the lifetime of that family.**
- **Strengthening families and communities is a long-term goal and multi-sector cooperation is needed.**

3. what strategies could be used to change behaviour to improve child safety and wellbeing?

Why community education and social marketing?

It is often assumed that knowledge acquisition will lead to behaviour change in adults who have responsibilities for keeping children safe. While gaining knowledge alone assists, it is often not sufficient to facilitate behaviour change. This is particularly relevant for entrenched or complex behaviours and for people who may feel that they have little or no control over their life circumstances (Saunders and Goddard 2002).

As such this review takes a particular focus on multimodal campaigns that integrate complementary community education and social marketing principles. We examine a range of strategies which have been used, or are potentially useful, in raising awareness and knowledge; shifting attitudes and beliefs; and changing behaviours about promoting the safety and wellbeing of children.

A range of health and social change practitioners now use communication and marketing concepts to develop campaigns that catalyse shifts in knowledge, attitudes and behaviour (Donovan and Henley 2010; Aboud and Singla 2012). Such campaigns are designed to inform, motivate or advocate (Donovan and Henley 2010) their target audiences. In this chapter we look at two such approaches: community education and social marketing and how they interrelate. We also examine the literature on the use of social marketing and community education for the prevention of child abuse and neglect and explore the potential application of these approaches to promote child safety and wellbeing in the NT.

Community Education

Community education refers to a “process whereby learning is used for individual, community and global betterment. It is characterized by the integrated involvement of people of all ages, use of community learning resources and research to bring about community change and recognition that people can learn through, with and from each other to create a better world” (Akande 2007). Community education aims to facilitate collective problem solving by community members by equipping them with the knowledge to facilitate action, and through promoting citizen participation and shared decision making (Akande 2007).

There have been wide array of community education efforts for the prevention of child maltreatment in Australia (Tomison 2000). These range from personalised or group programs to universal mass media awareness raising campaigns. These efforts can be viewed through a public health lens as primary, secondary or tertiary interventions. Alternatively they can be viewed through a socio-ecological framework that takes in to account interconnected systems that contribute to child safety and wellbeing. These efforts are designed to inform audiences and most often require voluntary involvement.

The mode of delivery of community education will vary according to the target audience and level of need. At the regional, state or national level mass media campaigns are often used to raise awareness. At the local community level information packages, resource centres and community development programs are common and, at the individual level, education is often delivered through training programs targeted at adults with particular professional or social roles, for example parents, teachers or mandated notifiers (Tomison 2000).

Some community education approaches have shown results in effective and sustained reduction of child maltreatment, behavioural parenting interventions in particular (Prinz, Sanders et al. 2009). To be effective, information needs to be broadcast with consideration of the audience, their attitude to the issue and their socio-cultural-economic circumstances.

Community education initiatives that employ social marketing principles can inform and persuade the audience to change or consider behaviour change. By taking a consumer perspective rather than a subject expert perspective such efforts can address the barriers and motivations for change rather than framing the behaviour as a lack of knowledge.

Social marketing

Social marketing uses the principles of marketing, such as identifying consumer needs and wants and segmenting target audiences according to demographic, psychographic, geographic and behavioural variables in order to change behaviour, usually with a societal goal in mind.

The objectives of social marketing are usually to change behaviour, by getting target audiences to accept, reject, modify or abandon behaviours. It achieves this by identifying and removing barriers (such as social and financial costs or structural factors inhibiting change) and conducting market research in order to understand existing knowledge, attitudes and beliefs and provide insights as to what communication strategies, message and tools are most likely to resonate with target segments to effect behaviour change.

Donovan and Henley (2010) describe social marketing as the, *“application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary or involuntary behaviour of target audiences in order to improve the welfare of individuals and society”* (Donovan and Henley 2010). The approach was first conceived in the 1970s by Kotler and Zahman who examined if marketing concepts and techniques could be effectively applied to the promotion of social objectives (Kotler and Zaltman 1971). Effective social marketing includes strategies that target change in social environments, communities, social policy, and legislation, rather than solely relying on individuals to change their behaviour (Donovan and Henley 2010; Horsfall, Bromfield et al. 2010).

Social marketing has been widely used in the public health and behaviour change field to influence practice related to smoking, diabetes, HIV/AIDS, mental health, the environment, road safety, teen pregnancy, nutrition, physical activity, substance misuse and heart disease. (Donovan, Henley et al. 2007; Horsfall, Bromfield et al. 2010) (McFadyen, Stead et al. 1999). Social marketing draws upon a wide range of theoretical bases, including psychology, anthropology, sociology, communications theory and political theory to provide frameworks to structure behaviour and attitudinal change initiatives (McFadyen, Stead et al. 1999).

Social marketing seeks to influence not only the individual, but through targeting the attitudes and behaviour of policy makers and influential interest groups, it can also have an impact on the structural factors (such as poverty and food security) which influence and constrain the behaviours and choices of individual (McFadyen, Stead et al. 1999). The potential for social marketing to influence all parts of a social system is of particular importance for the prevention of child abuse and neglect in the NT, where socio-political, historical, demographic, economic and geographic factors play a significant role in the prevalence of child neglect as does the behaviour of individuals. (Guthridge, Ryan et al. 2012).

Social marketing is still an emerging field for academic research so definitions are contested (Donovan and Henley 2010). It has been referred to in the literature synonymously with mass media campaigns, advertising, public awareness campaigns, community mobilisation, behaviour change communication, and community education (Tomison 2000; Horsfall, Bromfield et al. 2010; Aboud and Singla 2012; Saini and Mukul 2012). While social marketing usually involves these elements, such components of themselves do not constitute social marketing. What sets

social marketing strategies apart is a grounding in the fundamental marketing concepts of consumer orientation and exchange; "it emphasizes the perspective of the target audience as the basis for achieving mutually satisfying exchanges" (Donovan and Henley 2010). The basic principles of marketing are presented in the Table 1. below.

Table 1: Basic principles of marketing (adapted from Donovan and Henley 2010).

| | |
|---------------------------------|--|
| Two fundamental concepts | Consumer orientation (meeting wants and needs) Exchange |
| Three implementation principles | Customer value (product, price, place, promotion) Market segmentation (selectivity and concentration) Differential advantage (identifying the competition) |
| Three defining features | Use of market research An integrated approach to implementation Monitoring and influencing environmental factors |

Like traditional marketing, social marketing starts by identifying the needs, wants, values and perceptions of the target group and viewing the target audience as active participants in the process of behaviour or attitudinal change. As McFadyen and colleagues describe, the "consumer centred approach of social marketing asks not '*what is wrong with these people, why won't they understand?*', but, '*what is wrong with us? What don't we understand about our target audience?*'" (McFadyen, Stead et al. 1999).

Compared to commercial products or services, where the exchange is for payment by the consumer, the benefits of social marketing may be individual or societal wellbeing. This is especially the case with shifting attitudes for the prevention of problem behaviours (Donovan and Henley 2010; Aboud and Singla 2012). In a comparison of social marketing programs in South Asia with select successful public health programs in the USA, it was identified that American campaigns were more likely to involve intangible concepts, such as changes in ideas, attitudes and lifestyles (Saini and Mukul 2012). As such the 'price' or costs of change addressed were the perceived or psychological barriers.

In South Asia, programs that were most successful were associated with tangible products, such as soap or condoms, and the monetary price was the main barrier. As such, enabling changed behaviour involved subsidising that product or providing it free of charge (Saini and Mukul 2012). What this indicates is that collaboration with partners who can remove barriers can be a critical factor in achieving campaign objectives (Aboud and Singla 2012; Saini and Mukul 2012).

Models for developing an integrated social marketing campaign

The Precede-Proceed model developed by Green and colleagues (Horsfall, Bromfield et al. 2010) is a health promotion model that could be useful in developing an effective social marketing campaign. The Precede-Proceed model identifies core stages: formative research to assess the needs and contexts of the population, definition of the behaviour, selection of an appropriate theory of change, implementation and evaluation (Thomas, Leicht et al. 2003; Horsfall, Bromfield et al. 2010).

In a recent review of health behaviour change programs in developing country contexts, all of which use social marketing components, three fundamental requirements are identified: evidence, theory and an in-depth understanding of the audience (Aboud and Singla 2012). Research plays an essential role throughout the social marketing process (see Appendix A). It assists in identifying the needs and wants of the target audience(s) as well as the external influences on behaviour that could be the focus of the campaign. Potential key messages and strategies are pre-tested using market research techniques with representatives from the target audience, and finally the strategy is monitored and evaluated through a summative research process (McFadyen, Stead et al. 1999).

Just like any marketing campaign, a social marketing campaign works when it is based on good research, good planning, relevant attitudinal and behavioural models of change, when all elements in the marketing mix are integrated, and when the socio-cultural, legislative and structural environments facilitate (or at least don't inhibit) target audience members from responding to the campaign. A well-planned social marketing campaign stimulates people's motivations to respond, removes barriers to responding, provides them with the opportunity to respond, and where relevant, the skills and means to respond. (Donovan and Henley 2010)

The initial research for a social marketing campaign sets the directions for the subsequent strategy. For example, formative research in a campaign to promote mental health found that the term "mental health" itself had negative connotations with the general public, and was strongly associated with mental illness such as schizophrenia and depression. On the other hand, this research revealed that the term "mentally healthy person" was positively regarded and could be used as the basis of a campaign which focused on promoting mental, physical and social activity to encourage mental health (Donovan, Henley et al. 2007).

This discussion highlights the added complexity of developing a social marketing campaign for the prevention of child abuse and neglect, a phenomenon that is underpinned by interrelated, multi-faceted problems. There is no one 'product' that will prevent child abuse and neglect and that the factors underpinning it may vary depending upon the family, community or broader context. Understanding who the 'target audience' and how they conceptualise what 'child abuse' and 'neglect' is and what keeps children safe is imperative, particularly in a culturally diverse context such as the NT where these conceptualisations cannot be assumed.

Theories of behaviour change

It should be recognized that the behaviours may be difficult to change because they are habitual, normative and preventive. Habitual behaviours are difficult to change because they are performed automatically without much thought; normative behaviours bear the weight of tradition and approval; and preventive behaviours often lack a salient immediate outcome (Aboud and Singla 2012).

Campaigns that have a clear theory of change underpinning activities have been shown to be most effective (Donovan and Henley 2010; Aboud and Singla 2012). Horsfall and colleagues summarised theories of change that may be used in social marketing to prevent child abuse and neglect, and is presented in Table 2 (Horsfall, Bromfield et al. 2010).

Table 2: Theories of change associated with social marketing

| Theories of Change associated with social marketing | |
|---|---|
| Theory | Description |
| Individual change | |
| Health Belief Model | Individuals will change their behaviour when they perceive there is a threat to themselves, there is personal benefit to be gained and they have self efficacy to make the desired change. |
| Theory of Reasoned Action and Planned Behaviour | Behaviour can be predicted by people's intentions. An individual's attitudes, subjective norms (perceived approval/disapproval of others and motivation to comply) and perceived behaviour control can be influenced to change intentions and behaviour outcomes. |
| Social Cognitive/Social Learning Theory | Based on the premise that behaviour is a product of interactions between an individual (especially their self-efficacy) and their environment. Role modelling, observational learning and expectations of positive or negative reinforcement are key concepts for behaviour change. |
| Stages of Change Model/ Transtheoretical Model | There are five stages in the process of change: pre-contemplation, contemplation, preparation or determination, action, and maintenance. One or more stages can be targeted in social marketing interventions. Acknowledges that behaviour change is a process. |
| Community change | |
| Diffusion of Innovation | Introducing a new idea, practice or product into a community. These campaigns emphasise "newness" and benefits of adopting the innovation to appeal to community groups. |
| Community Organisation | Involving a segment of the community (community coalition) in problem solving and planning social marketing interventions for social issues. |
| Community Building | Also known as locality development and community capacity, this involves building capacity and empowerment across the whole of community. It emphasises enabling communities to help themselves. |

Taken from Horsfall et al. (Horsfall, Bromfield et al. 2010) – Note: The information in this table was adapted from the following sources: Baum (1998); DiClemente et al. (2009); Lin et al. (2007); Noar (2005–2006); Nutbeam & Harris (2004).

Since publication of this synopsis, another model has been developed by Cismaru and colleagues (Cismaru, Lavack et al. 2008), which integrates several of these theories. The Integrated Model for Social Marketers sees behaviour change occurring through six stages: pre-contemplation, contemplation, preparation, action, maintenance, relapse, and termination. The authors argue that a campaign should target each stage and focus on one or several variables that effect decision making: perceived vulnerability, perceived severity, response efficacy, self efficacy, and costs. To date there is no evidence of the model being applied to a campaign, thus the usability and effectiveness of the theory is unknown.

What do social marketing campaigns regarding children's safety and wellbeing look like?

Horsfall and colleagues (Horsfall, Bromfield et al. 2010) conducted a review of 21 distinct social marketing campaigns that targeted behaviours related to child maltreatment. All of these were implemented between 1995 and 2009 in Australia and overseas. A brief summary of that research is presented here combined with analysis of new related literature since 2010.

The goals of the campaigns reviewed by Horsfall et.al (2010) included: increasing knowledge; enhancing awareness; changing attitudes; and changing behaviour. The topics of the campaigns promoted various practices, including:

- help-seeking for parents;
- positive parenting strategies and positive adult role modelling for children;
- preventing shaken baby syndrome;
- the impact of domestic violence on children and young people and help-seeking for perpetrators and victims;
- promoting positive attitudes towards children;
- increasing awareness of and support for victims of child sexual abuse and incest, and promoting disclosures;
- identifying the responsibility of adults to protect children and actions adults can take to intervene and prevent abuse;
- asking family members and friends of parents with substance abuse problems to intervene to prevent and stop child abuse and neglect; and
- help-seeking on the part of young people perpetrating sexually abusive behaviours and their parents (Saunders and Goddard 2002; Thomas, Leicht et al. 2003; Horsfall, Bromfield et al. 2010).

The campaigns identified through the review predominantly targeted adults in the community, with a specific focus on parents as those with the primary responsibility for protecting children. In subsequent research the trend of targeting adults has continued, although this large audience has been further segmented in to parents, general public, offenders, mothers, and other at risk groups such as women who drink alcohol during pregnancy (Evans, Falconer et al. 2012; Hanson, Winberg et al. 2012; Schober, Fawcett et al. 2012; Stanley, Fell et al. 2012).

Social marketing campaigns have rarely targeted children. If they have it has related to child sexual abuse. A campaign in the Netherlands targeted children from 8 to 15 years to promote disclosure of abuse. The campaign focused on increasing awareness and identifying that supports are available for children and adults who disclose (Hoefnagels and Baartman 1997; Hoefnagels and Mudde 2000). Another campaign in the USA prompted young people who were displaying sexually abusive behaviours and their parents to seek help (the 1995-1997 Stop it Now campaign) (Horsfall, Bromfield et al. 2010). There are a number of sexual abuse prevention programs that also target children (Babatsikos 2010; Hunt and Walsh 2011; Walsh and Brandon 2012). Some authors have identified parents as underutilised "prevention partners" for this kind of abuse and recommend that interventions shift responsibility for prevention from children to adults (Wurtele 2009).

Less than half of the campaigns included other resources and supports within the community to reinforce the messages of the multimedia campaigns employed. Most referred members of the public to a phone helpline or a website for further information. Of those that did include this component, the support included information and resources and local projects reinforcing the message of the campaigns. (Horsfall, Bromfield et al. 2010). In the Horsfall et al. review the authors conclude that social marketing campaigns that combine mass media methods with a community-level strategy that target social determinants of behaviour are more likely to have an impact on long term social or behavioural change (Horsfall, Bromfield et al. 2010). In addition, alignment with support services was seen as critical, to make use of existing resources and to avoid overwhelming already stretched tertiary child protection systems.

The campaigns predominantly used television as a means of mass communication. Of the three campaigns that did not use this medium, one was because it was felt television broadcasting of the material would contaminate the control group of a randomised controlled trial. Other forms of community-based advertising (radio, posters, letter box drops, stickers) were used in a minority of the campaigns (but were more likely to be used in Australian campaigns compared with those from overseas) (Horsfall, Bromfield et al. 2010). In subsequent literature it is apparent that social marketing campaigns are employing more diverse communication channels and promotion methods, including creating movements (Schober, Fawcett et al. 2012), distributing collateral and intensive media engagement to reframe public discourse (Evans, Falconer et al. 2012).

The literature is very limited in identifying the role or potential role of social media and other technologies in social marketing and community education campaigns, as many of those included in publications have taken place when social media was just emerging. It has been noted that those who may be the primary targets of social media and education campaigns delivered by new technologies may be the least likely to have access to those technologies (e.g. low availability or affordability of the internet and mobile phone coverage in regional, remote or low socio-economic areas) or be likely to use such technologies (e.g. grandparents in the community, parents with substance misuse, mental health or intellectual difficulties).

More needs to be known if this is the case for adults, young people and children in the NT, particularly given the advent of smartphone technology, social networking sites with free access from mobile phones, the emergence of e-health practices and the distribution of computing devices through schools to every child. These may significantly increase the potential reach of a social campaign.

What do social marketing and community education campaigns that target diverse audiences look like?

Australia has one of the most ethnically diverse populations in the world (Smallbone and Rayment-McHugh 2013). The NT has a unique multi-ethnic and multicultural population, including a significant proportion of Aboriginal Australians (Silburn, Robinson et al. 2010). As previously discussed, Aboriginal children in the NT are over-represented in reports of child maltreatment and substantiated cases (Guthridge, Ryan et al. 2012; Smallbone and Rayment-McHugh 2013) so a Territory-wide campaign promoting child safety and wellbeing must sensitively and effectively engage this population group.

The limited academic research on social marketing campaigns and community education programs aimed at Australian Aboriginal audiences primarily focuses on smoking behaviours and alcohol use practices (Boyle, Shepherd et al. 2010; Stewart, Bowden et al. 2011; Bond, Brough et al. 2012; Conigrave 2012; Johnston, Westphal et al. 2012). One study looks at a social marketing campaign on hand washing behaviour (McDonald, Slavin et al. 2011) and only one examines the effectiveness of a behavioural parenting intervention (Turner, Richards et al. 2007). All but two of these focus on urban or regional populations, thus application of findings to the remote settings in the NT is limited.

There is some research on social marketing and community education initiatives in multiethnic and indigenous populations outside of Australia, with some salient findings (Buchthal, Doff et al. 2011; Hanson, Winberg et al. 2012; Houlding, Schmidt et al. 2012). Two of these address particular protective or risk factors for child wellbeing (Hanson, Winberg et al. 2012; Houlding, Schmidt et al. 2012).

Of the nine papers identified three related to community education (Turner, Richards et al. 2007; Conigrave 2012; Houlding, Schmidt et al. 2012). Two were studies on culturally tailored versions of the positive parenting program Group Triple P, an early intervention behavioural program.

In the randomised clinical trial of the Triple P program in suburban Brisbane the cultural appropriateness and effectiveness of the intervention was explored with 61 families in two rounds. Of the families who expressed interest however, only 16 of the 26 families completed the first round of delivery, and 7 of 25 families on the wait list commenced and completed the second round. The attrition was largely due to changes in personal circumstance. This suggests that strong engagement strategies are required to create demand and meet carer interest in any such program. Participants provided positive feedback to the cultural appropriateness of modified resources (video content with Indigenous actors, a plain English workbook), delivery models (longer facilitated group sessions) and content (discussions of the place of culture, practical strategies). No change was found in parental adjustment outcomes (i.e. stress factors were unchanged) and partial change in use of dysfunctional parenting behaviours.

A retrospective qualitative study was conducted on a similar trial in an Aboriginal community in North-western Ontario, Canada (Houlding, Schmidt et al. 2012). Although small scale and localised, the study gathered rich description on the experience of participants. Like the Australian study, families with multiple or chronic difficulties were least likely to benefit from the program. Use of role plays, visual strategies and modified workbooks received positive feedback, although participants expressed that the program would have value regardless of whether culturally tailored resources were used. Success of the program was linked to parents' sense of self-efficacy. Positive personal experiences of the program motivated participants to encourage others to join. This highlights the potential use of personal testimony (word of mouth) in spreading learning through informal networks.

Some of these findings mirror other research in to education programs, for example that hard to reach families with multiple life stressors will require different kinds of supports, possibly more tailored or intensive (Turner, Richards et al. 2007).

There is no peer reviewed published research on the use and effectiveness of social marketing campaigns to promote child safety and well-being for Indigenous audiences in Australia. Aboriginal audiences may have been exposed to nationwide campaigns, but no research has been conducted on their efficacy or effectiveness in Aboriginal communities. There is a similar gap relating to broader multicultural audiences. This may be in part because social marketing and mass media community education campaigns often take a universal approach. The sensitivities around child maltreatment may be a further contributing factor. There is grey literature that indicates efforts to direct communication components of broader campaigns to Indigenous and culturally and linguistic diverse audiences (Donovan 2005) however this is beyond the scope of this paper.

Six papers focused on the efficacy and effectiveness of mass media and social marketing on health risk behaviours, five in Australia and one in Hawaii.

The effectiveness of social marketing and community education campaigns

Social marketing has shown promise to shift levels of awareness, knowledge, attitudes and behaviours in public health and health promotion domains. The paucity of evaluation of social marketing as applied to the prevention of child maltreatment however leaves much unknown (Wurtele 2009; Horsfall, Bromfield et al. 2010). The impact of social marketing in general may be limited by the complexity and intractability of behaviours, the fact that target audiences may be harder to reach, have much higher needs and poorer health, and may be less likely to change their behaviour than might be the case in commercial marketing campaigns. (McFadyen, Stead et al. 1999) Involving these audiences in the development of social marketing campaigns can also be difficult and requires care particularly if the behaviours of interest are the subject of criminal or social sanctions.

In the field of health promotion, there is evidence of small but significant positive effects of social marketing campaigns. For example, a meta-analysis of 48 health promotion campaigns in the US, estimated that these campaigns were associated with a nine per cent level of behaviour change (Gordon, McDermott et al. 2006). This amount of change may seem small when examined at the individual level, but when seen at the population level, this has a large effect on the health of the population and on the demand for tertiary services in the health system (Preventative Health Taskforce 2008).

Differential effects of social marketing campaigns have been noted. The effectiveness of campaigns has been linked to their ability to garner sufficient government attention and funding and thus achieve sustainability (van Bueren 2010). Issues such as smoking, road safety and HIV/AIDS have successfully captured the attention of both state and national governments and have seen remarkable impacts on the prevalence of these phenomena; over 30 years there have been decreases in smoking rates from 40 to 20 per cent, and in road deaths from 30 per 100,000 to a third of that figure. More recently, successful campaigns for nutrition, substance misuse and to a lesser extent physical activity have also demonstrated considerable promise (Preventative Health Taskforce 2008). On the other hand, issues such as domestic violence and child abuse receive intermittent and short-term funding in terms of efforts to address them at a population level, and as such have seen no impact, and in fact increases, in the rates of these phenomena over time.

The limited impact of social marketing campaigns for issues such as child abuse and neglect may also be due to the intractable and stigmatised nature of such problems. There is evidence however, that when developed effectively, multimedia child sexual abuse prevention campaigns can increase knowledge about child sexual abuse while provoking only low levels of discomfort or anxiety on exposure to the communication materials (Self-Brown, Rheingold et al. 2008). Sustained longer term efforts may be needed if the intention is to do more than increase short term knowledge and awareness (Saunders and Goddard 2002).

The varied impact of campaigns may also be associated with the types of messages conveyed. This is particularly true of campaigns that use hard hitting messages. In smoking cessation, alcohol use and road safety campaigns for example, hard hitting messages that highlight the fatal consequences of a behaviour seem to have a strong impact on target audiences (Boyle, Shepherd et al. 2010; Donovan and Henley 2010; Stewart, Bowden et al. 2011). In the case of child abuse however, particularly child sexual abuse or family violence, there are concerns that "threat appeals" depicting the behaviours they seek to change, may in fact have the opposite effect of inadvertently promoting such behaviour or of (re)traumatising audiences (Horsfall, Bromfield et al. 2010). Social marketing campaigns in the field of children's safety and wellbeing have used hard and soft hitting messages, however the effectiveness of one over the other is not fully known (Horsfall, Bromfield et al. 2010).

Community education programs that promote positive interactions within families and provide alternatives to inappropriate behaviours seem to be most effective for facilitating behaviour change (Tomison 2000). A number of community-based parenting programs that have led to a reduction in cases of child maltreatment, use positive promotion and messaging as the key to change (Sanders 2003; Prinz, Sanders et al. 2009).

Evaluation of social marketing and community education campaigns

Evaluation should occur across the lifespan of a social marketing campaign. This could include formative evaluation, pilot or efficacy studies, process evaluation, impact and outcome evaluations (Horsfall, Bromfield et al. 2010). Many studies have focused on the efficacy of campaign messages (Andrews, McLeese et al. 1995; Rheingold, Campbell et al. 2007; Buchthal, Doff et al. 2011; Bond, Brough et al. 2012; Evans, Falconer et al. 2012). This is particularly important in the development and testing of messages and channels (Evans, Uhrig et al. 2009).

Evaluating campaigns designed to promote the safety and wellbeing of children is particularly hampered by the absence of robust measures of child abuse and neglect. The tendency of campaigns which raise awareness, for example, is to increase a reliance on statutory child protection systems (at least in the short term) rather than reducing this pressure (Horsfall, Bromfield et al. 2010). Other forms of child abuse and neglect prevention or treatment (e.g. group or individual based psychosocial interventions) are able to provide more robust outcome assessments than are media campaigns and mass educational programs (Rubin, Lane et al. 2001). In social marketing campaigns there may be no further links with the target audience to assess behaviour change through follow-up assessments, thus rendering outcomes assessment very difficult. When outcome information is obtained, it usually relates to whether parents understand the information, and offers little information about the future actions of those parents (Rubin, Lane et al. 2001).

In the review by Horsfall et al. of social marketing campaigns designed around the prevention of child abuse and neglect, only 15 of the 21 campaigns had an evaluation, with only 12 of these having an impact or outcome evaluation (Horsfall, Bromfield et al. 2010). Australian campaigns were less likely than international campaigns to have an evaluation component.

Of the outcomes measured, campaign awareness was measured in five studies and ranged from high (95 per cent of the *It's Not OK* domestic violence prevention campaign) to low levels (22 per cent for *Fathering the Future* campaign) and around 50 per cent for the NZ *Breaking the Cycle* campaign regarding the impact of parental behaviours on children (Horsfall, Bromfield et al. 2010). For those studies that reported the level of awareness, knowledge gain and attitude change about the topic explored in the campaign, only very small increases were noted, and in one case, no impact was seen. This may have been because of a "ceiling effect" in that respondents may have already had high levels of awareness, knowledge and attitudes about the topics (emotional and verbal abuse, the effects of domestic violence on children). Mass media advertising is particularly useful when there is a lack of awareness about an issue (Horsfall, Bromfield et al. 2010), although as Horsfall and colleagues note: *A social marketing campaign that includes, for example, advertising and a community capacity building component or advertising and the provision of practical support is likely to be more effective at bringing about population-wide changes than an advertising campaign alone.*

Of the intermediate behaviour change examined in these campaigns, the target for a number of them was calls to helplines providing support or more information. While calls to the helpline increased during the campaigns, some services had difficulties dealing with the influx of calls, and once the campaign ended, the number of calls sharply declined (Horsfall, Bromfield et al. 2010). Of the two studies which included self-reported measures of behaviour change, they saw moderate changes in behaviour towards children or their partners, with increased reports of intentions to change behaviour (Horsfall, Bromfield et al. 2010).

The most effective campaigns, that is those which have led to heightened awareness, attitudinal change, and increased help-seeking behaviour, are those in which there are clear links to services and supports to support

behaviour change about a particular issue (Gibbons and Patterson 2000; Prinz, Sanders et al. 2009). These programs do not necessarily have explicit and specific key messages regarding the prevention of child abuse and neglect, but rather aims and objectives relating to promoting positive parent-child interaction, learning strategies to manage children's behaviour, ensuring a safe, engaging environment for children, maintaining reasonable expectations for children's behaviour and taking care of oneself (Prinz, Sanders et al. 2009).

The examples given in Chapter Five have clear strategies which can be implemented with minimal expertise or support on the part of the individual (such as effective hand washing techniques, help seeking for family violence through a phone helpline, reporting sexual assault). Raising public awareness needs to be matched by increases in responses from and availability of services. These must be established before an awareness campaign is run that might encourage disclosure or prompt people to seek help, otherwise campaigns run the risk of being counter-productive to their aims (Saunders and Goddard 2002) (Andrews 1996; Horsfall, Bromfield et al. 2010; Northern Territory Government 2010).

Multiple influences require multiple strategies

Media campaigns, television, radio, print and billboards can help increase public awareness and knowledge of child abuse and neglect, however more intensive social marketing interventions are more likely to be needed to reach at risk groups because of their complex and multiple needs (such as high rates of mental health problems, drug and alcohol abuse, domestic violence, poverty, poor education and prior histories of abuse) (Tyler, Allison et al. 2006). Thus these target groups should be a particular focus of formative research and market testing. Communication alone is unlikely to have a significant and direct influence on parenting and protective behaviours of the highest risk individuals; rather it can be used to shape the attitudes of children, young people, parents, family members, significant others, workers, teachers, peers who have more power to influence the behaviour of the highest risk individuals (Andrews Aldridge and Fuel Data Strategies 2009).

As identified, successful programs for complex issues tackle multiple levers of influence, engage multiple audiences (children, young people, parents, grandparents) and systematically structure primary, secondary and tertiary supports and sanctions (Smallbone, Marshall et al. 2008; Prinz, Sanders et al. 2009).

Smallbone and colleagues have developed a framework for conceptualising the role of community education and social marketing within a larger system of preventive intervention for child sexual abuse (see Table 3). This framework is based on an understanding of the biological, developmental and situational influences on the development of sexually abusive behaviours, identification of the targets for prevention, and knowledge of the effectiveness of programs to support victims and their families, and to change the behaviour of perpetrators. In order for community education to be effective it must be accompanied by information about, the services and supports which can prevent child abuse and neglect.⁴⁶

Table 3. Twelve points of focus for preventive action for youth sexual violence and abuse (taken from Smallbone et al, p.199)

| | Primary prevention | Secondary prevention | Tertiary prevention |
|--------------------|--|---|---|
| Offenders | General deterrence | Confidential helplines | Early detection |
| | Developmental prevention | Counselling for at-risk individuals | Specific deterrence |
| | | Developmental prevention | Selective incapacitation Offender treatment |
| Victims | Personal safety programmes | Counselling and support for at-risk children | Early detection |
| | Resilience building | | Harm minimisation Preventing repeat victimisation |
| Situations | Extended guardianship | Situational interventions in at-risk places and organisations | Safety plans |
| | Situational prevention in institutional and public setting | | Relapse prevention Situational interventions with organisations where CSA has occurred |
| Communities | Public education | Support for at-risk families | Interventions with high-prevalence communities |
| | Community services | Interventions with at-risk communities | |
| | Community capacity-building | | |

Key Learnings

- While awareness can assist, it is not always sufficient to change behaviour particularly in situations where behaviours are entrenched or people feel powerless.
- Community education strategies need to go beyond raising awareness to also focus on changing attitudes, beliefs and behaviours that will keep children safe and strong.
- Effective social marketing includes strategies that remove barriers, such as change in social environments, communities, social policy and legislation, rather than solely relying on individuals to change their behaviour
- The potential for social marketing to influence all parts of a social system is of particular importance for the prevention of child abuse and neglect in the NT, where socio-political, historical, demographic, economic and geographic factors play a significant role in the prevalence of child neglect as does the behaviour of individuals
- Market research is central to social marketing and assists with identifying issues to be targeted, identifying priority target segments, developing and testing messages and strategies that resonate with these target segments and evaluating the effectiveness of campaigns
- A number of social marketing strategies have been developed with the aim of preventing child abuse and neglect, with most demonstrating moderate knowledge, attitude change
- Social marketing campaigns in the field of children's safety and wellbeing have used hard and soft hitting messages, however the effectiveness of one over the other is not fully known. Concerns that "threat appeals" may have opposite effect of inadvertently promoting such behaviour or of (re)traumatising audiences
- Social marketing strategies which incorporate evidence-based service provision and supports are more likely to be effective than strategies which incorporate a multimedia component alone
- The use of social media and new technologies is likely to enhance the reach of social marketing campaigns, and identifying the level of access to and the types of use of these technologies is essential for a context such as the NT
- Evaluation should occur across the lifespan of a social marketing campaign. This could include formative evaluation, pilot or efficacy studies, process evaluation, impact and outcome evaluations
- Multiple and multi-level intervention strategies that work best target children, parent (potential offenders), neighbourhoods and/or communities, practitioners and professionals and organisations.
- High risk populations will require different strategies to achieve behaviour change compared with the general population. Providing support to others in their social and community network may be an effective strategy
- Child sexual abuse prevention media campaigns will likely be most effective when implemented in conjunction with other prevention methods based on an understanding of the developmental, biological and situational precursors of child sexual abuse

4. who should community education and social marketing campaigns target?

"...knowing one's audience is critical. Being aware of all the influences on the current state of affairs will help create realistic expectations about how much change is possible and the barriers to address. Furthermore, the application of communication theories depends on an understanding of how willing and able is the audience to process the change message. Specifically, the message must be conveyed in a more entertaining way if the audience is less willing and able."(Aboud and Singla 2012)

Successful campaigns for child abuse and neglect target multiple influences and multiple contexts in which behaviour to promote children's safety and wellbeing can occur. Target audiences for social marketing and community education campaigns are selected based on a combination of evidence based research and formative market research. In research on child safety and wellbeing, a number of potential actors or influential groups in the prevention of child abuse and neglect have been identified. The majority of efforts have targeted adults in a community, with a specific focus on parents as the primary caregivers of children. What follows is an overview of these groups.

Parents and caregivers in general

Research has identified that parents receive multiple and sometimes conflicting messages about parenting and child development (MCEECDYA 2010). The sheer number and inconsistencies in messaging can lead to parents "switching off" and adopting a trial and error approach, which may or may not be consistent with promoting children's safety and wellbeing (MCEECDYA 2010).

Parents learn when they are engaged, active, through being shown (role modelling) and practising what they have learnt. Parents are also more likely to engage with information and support if it is seen as practical, relevant and addressing problems confronting them at different stages of their parenting careers. For example, strategies aimed at helping parents deal with their children's behavioural or developmental problems are more likely to be successful than strategies marketed as being focused on "parenting" per se (MCEECDYA 2010).

The primary prevention strategies targeting parents and families consist of nurse home visiting programs, parent support programs and parent training and education programs (Silburn, Nutton et al. 2011). Such programs aim to increase and enhance parents' knowledge of child development, improve attitudes and beliefs about parent-child relationships and develop skills in parenting behaviour (Nelson et al., 2001)(Silburn and Walker 2008). Programs and supports offered to parents and families as a broad target group generally include one or a combination of the following foci:

- improving family functioning;
- providing emotional support;
- providing concrete support and addressing basic needs;
- promoting nurturing, attachment and responsive care; and
- sharing knowledge of parenting and child development (Counts, Buffington et al. 2010) (Silburn and Walker 2008).

Parents' general knowledge of the importance of early childhood development is relatively strong and most parents understand the importance of supporting that development through opportunities for attention, play and learning. However, a number of parents have unrealistic expectations for children's behaviour and ability to self-regulate at early ages. (MCEECDYA 2010) The need for parents to be provided with information about how early childhood environments influence gene expression, critical and sensitive periods of development, and subsequent adjustment throughout the lifespan has been emphasised repeatedly. (Silburn and Walker 2008)

In the NT, the Department of Education and Training together with Menzies School of Health Research have developed the *It's Just so Important* campaign in recognition of the need to share messages about the factors which contribute to enhanced early child development (Silburn, Hanning et al. 2011). This campaign links to the dissemination of the results of the Australian Early Development Index (AEDI) which focuses on five domains of child development:

- physical health and wellbeing
- social competence
- emotional maturity
- language and cognitive development
- communication skills and general knowledge.

Brief digital community service announcements were developed focusing on key messages about early childhood development and these are accompanied by a *Your Child, Your Community* resource which includes a DVD and facilitator's guide to facilitate talking about early child development in local communities. The NT AEDI report also accompanies this information and gives details of AEDI results for five-year old children in regions across the NT (Silburn, Hanning et al. 2011). In recognising that the brain development story is a new story, these combined resources can then be used to engage community members in informed discussions and information sharing, to reinforce and generate actions which will support the development of children in the early years (Silburn, Hanning et al. 2011).

The NT Government has also invested in the World Health Organisation – UNICEF (WHO/UNICEF) Intervention Package on *Counsel the Family on Care for Child Development* (CCD) (Department of Child and Adolescent Health and Development 2004; Arney, Bowering et al. 2010). This is a population level early childhood development intervention designed to foster optimal caregiver-child interactions and relationships by improving caregiver responsiveness. The CCD package provides simple tools that can be used by those working with caregivers of infants and young children in a variety of community settings. The training approach offers guidance to health workers and others in how to support parents to strengthen bonding and attachment.

New parents

What helps keep children safe is ensuring health services, parenting education and social support are provided to parents preferably during the prenatal period that extends after birth into early childhood (Guterman 1997; Eckenrode, Ganzel et al. 2000; Donelan–McCall, Eckenrode et al. 2009). This is because infants are at greater risk of abuse and neglect than older children and because families with newborn babies and especially first time mothers are highly receptive to efforts to guide them to achieve better lives for their children and themselves. For first time mothers, in learning about ‘improving their prenatal health, caring for their firstborns and life course, they are likely to apply those skills to subsequent children’ (Donelan–McCall, Eckenrode et al. 2009). According to O’Donnell, Nassar, Leonard, Mathews, Patterson and Stanley, pregnancy provides a unique and opportune time to assess the needs of a mother and family, and put in appropriate supports that may be required.

Receiving information, support and resources through trusted professionals (e.g. nurses and midwives) and in settings where the behaviours are able to be practiced (e.g. home-based support) during this time is highly effective (Donelan–McCall, Eckenrode et al. 2009). The information and supports included in services for new parents include:

- providing education and support to help parents learn to care for the new child
- linking families with internal and external support
- support for parents that addresses their emotional needs and coping with being a parent, concrete needs, family functioning, nurturing and attachment and knowledge of parenting and child development. (Silburn and Walker 2008)

Fathers

Fathers have often been excluded from efforts to promote the safety and wellbeing of children, although there is increasing recognition of the impact of fathers in the lives of their children. Historically, there has been a limited assessment of the needs of fathers providing safe parenting practices and in protecting small children, and their involvement in planning these services. As a result, fathers may feel under-supported in their roles as there have not been specific initiatives which target them in their fathering capacity (MCEECDYA 2010) (Greif, Finney et al. 2007; Coles 2008). A number of reviews have highlighted that fathers and fatherhood should be included in child protection efforts as a matter of urgency (Daniel and Taylor 2005; Northern Territory Government 2010).

The NT Board of Inquiry into the Child Protection System highlighted that in the NT, men in prescribed communities in particular, but Aboriginal men more generally, had felt humiliated and marginalised under the NT Emergency Response, described as *“the palpable hurt of these men who saw the outside world as believing they were harming their children, when their role has been one of protectors, teachers and nurturers...”* (Northern Territory Government 2010).

Strategies that engage men in community education include highlighting these protective and nurturing roles. Family violence prevention efforts have also highlighted cycles of violence and the effects of witnessing violence on children. In particular, providing positive images of men and fathers in service delivery has been highlighted as a key engagement strategy and as pivotal in helping fathers, particularly new ones, develop self-efficacy (Daniel and Taylor 2005). Reinforcing the roles of fathers, even if they are not living in the same households as their children, can also provide a protective function for children through enhanced attachment and additional supports in child development (Daniel and Taylor 2005).

Aboriginal caregivers

In supporting and communicating with Aboriginal caregivers it is essential to recognise the socio-political and historical impact of colonisation, forced removal of children, and other socio-political factors, including contemporary social welfare practices on parenting (Silburn and Walker 2008) (Arney, Bowering et al. 2010). The impact of multiple experiences of grief and loss, and the identified increased stressors in the lives of Aboriginal families may mean that messages regarding healing, recovery and identity are especially important in a community education campaign regarding the role of Aboriginal caregivers in the lives of their children. As described earlier, the protective and nurturing roles of Aboriginal men should also feature.

Research and consultation with Aboriginal families has also highlighted the need for families to be provided with information about parenting and child development that includes both contemporary knowledge as well as recognition of cultural strengths, experience and childrearing practices in Aboriginal families which promote child safety and wellbeing (Silburn and Walker 2008). As with any family, it is important to identify the goals and strengths of parents and to recognise that there is both diversity and similarity within families, particularly those from urban, regional and remote areas of Australia.

The Secretariat of National Aboriginal and Islander Child Care (SNAICC) has developed a childrearing matrix, which draws on stories of caregiving in Aboriginal families from a range of sources (SNAICC 2004). This includes information about the concept of childhood, children's identity, care in pregnancy and early childhood, the developing child and the role of male and female caregivers. Reflecting these messages about caregiving concepts and strengths in a community education campaign for Aboriginal families will be a useful starting point. Also recognising that family and extended family are cornerstones of life and that obligations to family members can both enhance and place a strain on parenting (Arney, Bowering et al. 2010).

Families from migrant and refugee backgrounds

While many of the parenting values, needs and challenges of parents and caregivers from migrant and refugee backgrounds will be the same as those from mainstream backgrounds, research has identified additional considerations for this target group (Lewig, Arney et al. 2010). Parents from migrant and refugee backgrounds may experience significant communication and language barriers; pre-migration experiences which may lead to mental health problems and distrust of government; cultural differences in parenting style (particularly for families from collectivist backgrounds) and misunderstandings about the legality of certain parenting practices; inadequate family supports and social isolation; changing family roles (e.g. divorce, absent parents and grief and loss); and a lack of information about parenting and supports (Lewig, Arney et al. 2010).

Parents from migrant and refugee backgrounds may have had less exposure to knowledge about the science of early childhood development and may be more likely to endorse stricter parenting styles than parents from mainstream backgrounds (Lewig, Arney et al. 2010; MCEECDYA 2010). Messages which describe and emphasise the importance of early childhood development may be particularly valuable for these groups, along with information and assistance with strategies that support positive parenting techniques and reinforce cultural strengths, while encouraging parents to communicate with their children and young people (Lewig, Arney et al. 2010). Families from culturally and linguistically diverse (CALD) and refugee backgrounds may not have dense social networks in Australia (MCEECDYA 2010) and it is important to emphasise the role of outreach to families and the supporting role that other individuals can provide to families.

Parents involved (and those at risk of being involved) in the care and protection system

While universal strategies are important, targeted approaches are also needed especially for high risk groups such as those families known to the child protection system and perpetrators of domestic violence (Gibbons and Patterson 2000). The literature about the key messages and strategies to engage families who are involved in the care and protection system in community education campaigns is limited. These parents are more likely than others to be socially isolated, to have mental health, drug and alcohol problems, be in situations of family violence and to have intellectual or physical disabilities. Research has demonstrated that group-based and individual supports provided by skilled, empathic and non-judgemental practitioners can enhance home environments, parenting skills and self-efficacy, (Gershater-Molko, Lutzker et al. 2003; Dawe, Atkinson et al. 2006; Salveron, Lewig et al. 2010) but little research has been done on broader strategies which could target families in the care and protection system.

Resources developed by parents for parents who have had their children removed from their care, recognise that parents in similar situations may not understand or want to acknowledge the impacts of their behaviour on their children (Family Inclusion Network of South Australia Incorporated (FIN SA) and the Child and Family Welfare Association of South Australia (CAFWA-SA) 2012). The use of other parents who have been in the care and protection system as sources of information and support is a key consideration for community education campaigns, as they can reduce the sense of stigma experienced by parents and their situations may resonate with others living through similar experiences (Family Inclusion Network of South Australia Incorporated (FIN SA) and the Child and Family Welfare Association of South Australia (CAFWA-SA) 2012)

Consistent with research from the field of domestic violence, messages which blame or stigmatise parents are less likely to be effective in promoting positive changes. Messages which demonstrate the impacts of behaviours on children and which provide links to help and support for parental issues are more likely to provide motivation for change (Gibbons and Patterson 2000).

The Family Inclusion Network of South Australia has prepared a resource which contains messages from parents involved in the care and protection system to other parents in the same situation (Family Inclusion Network of South Australia Incorporated (FIN SA) and the Child and Family Welfare Association of South Australia (CAFWA-SA) 2012). These messages include:

- 'Are you prepared to make changes requires for your children?'
- 'What you do has an effect on your children'
- 'Children live what they learn'
- 'Do what it takes – get help if you need it'.

Communities

Targeting a neighbourhood or community offers the chance to engage parents who would not otherwise have sought assistance. However the literature highlights that there is limited evidence that focusing at the community level alone improves parenting behaviour and decreases the risk of child maltreatment. Effective locally based strategies identify community needs and provide evidence-based practices to enhance social and economic supports and cohesion for troubled families and children by providing formal and informal services for individuals. (Flynn 2008; Kimbrough-Melton and Campbell 2008)

Parents prefer to receive information about parenting through informal sources of support such as family, friends and other parents (MCEECDYA 2010). They are less likely to criticise the usefulness of information which comes from friends and other parents although information provided by family members is not always rated as useful (MCEECDYA 2010).

It is important that information provided to the general public is consistent, and includes messages about how friends, extended family members, other parents and the general community can support parents in their parenting roles (MCEECDYA 2010). This is particularly important in situations in which extended family may have specific parenting obligations and responsibilities for their grandchildren, nieces and nephews, cousins, and brothers and sisters.

Creating a fundamental change in communities will have challenges. However, by normalising safe, strong and happy communities (and promoting open and honest discussions about them), a broader cultural change can help tackle child abuse and neglect in remote and regional Aboriginal communities. In addition, regional social marketing programmes suggest the potential for local campaigns to reach at risk groups who are not easily engaged by more conventional forms of marketing and communication (Horsfall, Bromfield et al. 2010).

Messages such as the protection of children being “everyone’s responsibility” may have limited impact in changing the behaviour of community members. This may be because people are unaware of what role they can play in ensuring the safety of children, they may be uncertain about whether their concerns are justified, they may be uncertain about the impact of their intervention on the safety of children or their own safety, and the ‘bystander effect’ may lead people to assume that someone else will or has taken action and provided support if this is everyone’s responsibility (Horsfall, Bromfield et al. 2010). Research from the UK has demonstrated that most people wait longer than a month before reporting their concerns about suspected child abuse and neglect (AAP 2012).

Messages about the role of wider community members need to be concrete about the actions they can take and to include actions which will lead to clear outcomes (Horsfall, Bromfield et al. 2010) for children’s safety. For example, if people are asked to call a hot line, they need to see a tangible response or the hotline’s effectiveness will be limited.

Young children

There are limitations to including young children as targets of campaigns to promote children’s safety. Protective behaviours programs focus on providing children with skills to avoid unsafe situations with strangers, to recognise and respond to their own unease about specific individuals, to distinguish between “good touch” and “bad touch”, and encourage children to tell a trusted adult if they have been touched inappropriately (Smyth and Eardley 2008). These programs usually have high transfer of knowledge and skills to children, (Smyth and Eardley 2008) but are often limited in their ability to prevent child sexual abuse in that most child sexual abuse is intra-familial, uses sophisticated grooming behaviours, depends on the abuse of power in an otherwise trusted relationship and often involves significant threats of harm to the child or their family members (Smyth and Eardley 2008; Horsfall, Bromfield et al. 2010).

Other forms of messaging for young children rely on promoting disclosures (e.g. it’s ok to tell) and in safety planning for children (such as in instances of ongoing domestic violence, getting children to identify safe places they can go to) (Turnell and Edwards 1997; Turnell 2005). Given that these strategies place a high degree of responsibility on children and are reactive, they are obviously limited in their ability to prevent child abuse, but may at least promote intervention to stop ongoing abuse.

Of greater promise among strategies that target young children, may be those which promote self-regulation, empathy and resilience as long-term primary prevention strategies, in combination with programs that build strong attachment relationships between caregivers and children (Smallbone, Marshall et al. 2008).

Young people

With regard to programs which target young people as victims, effective strategies include the use of multimedia communication to promote the role of young people as agents of social change as well as programs which promote health behaviours regarding teen pregnancy and sexual health.

An example of a targeted communications and marketing strategy pertaining to young people is a UK Department of Health initiative addressing teenage pregnancy and sexual health (Partners Andrews Aldridge and Fuel Data Strategies 2009). Drawing on behaviour change theory, the strategy focused on the mediating influence of preparatory sexual behaviours such as talking or communicating with one's partner, accessing free contraception and carrying condoms rather than influencing young people's sexual behaviour directly. The strategy not only tackled multiple levers of influence but also engaged multiple audiences such as young people, their parents, health care professionals, teachers and the wider youth workforce to create open and honest discussions and build a culture that frames sexual behaviour among young people as a normal part of their development (Partners Andrews Aldridge and Fuel Data Strategies 2009).

The objectives of the strategy were to prevent teenage pregnancies and poor sexual health and promote safer sexual practices, and protect individuals from the consequences of risky sexual behaviour through screening and effective contraception methods. Furthermore, the strategy differentiated between more intense social marketing interventions tailored to support the needs of the highest risk groups. This is because these individuals presented with multiple risk factors such as poor school engagement, poor relationships with parents, misuse of alcohol and illicit drugs and risky sexual behaviours. As it was recognised that communication on its own would not influence the sexual behaviour of high risk young people, the strategy focused on supporting and shaping the attitudes of parents, teachers and peers who play more influential roles in behaviours of the highest risk individuals.

The five campaign strategies included a focus on knowledge and understanding (providing facts about sexual health, dispelling myths and misperceptions), communication and negotiation (promoting discussion within and between audience groups), chlamydia screening (especially for 15–24 year olds) and promoting contraceptive choice and condom use. The effectiveness and overall impact of the communication and marketing strategy is yet to be determined but include key performance indicators such as number of under 18 conceptions per 1000, positivity rate of chlamydia among 15–24 year olds, screening rates among 15–24 year olds and within settings, behavioural intention and perceived ease of access to condoms.

Young people can be victims and offenders of child abuse. Young offenders accounted for 25% of sexual offences reported to Queensland police in 2010–2011 (Smallbone and Rayment-McHugh 2013). This is a heterogeneous population and emerging evidence advocates for treatment that is socio-ecological in scope, thus taking in to account factors beyond the individual.

Practitioners

Practitioners are both a target group for receiving information about supporting parents and caregivers in the promotion of children's safety and wellbeing, as well as being a conduit for information and key messages for parents. The literature highlights the importance of practitioners being informed about working with parents and giving appropriate advice e.g. about child development and positive parenting practices, and coping strategies (Coles, 2008). Consistent messaging and support for families is essential in supporting behaviour change and in providing environments in which children can flourish (MCEECDYA 2010). Targeting workers and practitioners is especially important in reaching high risk parents and families who may not receive messaging delivered through universal channels such as schools and health clinics.

A number of social marketing and community education campaigns (see Chapter Five) have relied on practitioners as the agents of social change. The trusted place of practitioners such as family and community health care workers, family support workers, teachers and other education workers, enhances their ability to share key messages with families in that they already have established communication channels and their professional roles and expertise provide the authority for their messages to be taken seriously by families.

Developing positive relationships with parents of children at risk of child abuse and neglect has emerged as an important strategy when delivering parent training, intervention and support (Girvin, Depanfilis et al. 2007; Russell, Gockel et al. 2007; Krysik, LeCroy et al. 2008). Parents learn to be more confident and competent in the parenting role within supportive relationships. A study by Russell, Gockel and Harris (2007) that sought the perspectives of parents involved in intensive multi-level parenting support revealed the significance of intervention processes (in comparison to content) such as affirming parent self-worth, non-directive instruction, promoting social connections and empowering communication as key ingredients to engagement, especially with high-risk families. Although a majority of the studies have been qualitative in nature, findings have demonstrated that the building and development of such alliances and relationships were key to the success of home-visitation programs in preventing child abuse and neglect. (McGuigan, Katzev et al. 2003)

In particular, these programs have highlighted the following skills, abilities and qualities of practitioners in supporting families:

- home visitor should be able to model effective parenting (observing and suggesting alternative ways of managing the situation)
- home visitor to not lose sight of child's need
- providing concrete services and practical support to families is important (high risk families need help in organising their lives, housing) involvement of fathers is critical
- home visiting should be tailored to family's needs
- clinical skills of the practitioner such as empathy, rapport building, effective communication and session structuring are necessary for establishing therapeutic relationships (Sanders and Pidgeon 2011).

Key Learnings

- Fathers need to be included in preventive efforts
- Education and services provided to parents should begin early, preferably during the prenatal and period or shortly after birth
- Informal supports for caregivers are an important source of information. Parents prefer to receive information about parenting through networks of family, friends and from parents in similar circumstances
- Neighbourhoods and communities have a role to play in protecting and keeping children safe
- Involving and engaging parents is crucial and is the vehicle for parent behaviour change
- Parents learn through being engaged, active and practising what they have learnt
- Messages regarding healing, recovery and identity are especially important in Aboriginal communities experiencing grief and loss
- Messages which describe and emphasise the importance of early childhood development may be particularly valuable for migrant and refugee groups
- Messages which demonstrate the impacts of behaviours on children and which provide links to help and support for parental issues are more likely to provide motivation for change
- The use of multimedia communication to promote the role of young people as agents of social change as an effective strategy

5. key case studies

The following case studies highlight a number of successful community education and social marketing campaigns relating to parenting, domestic violence and child maltreatment. A further case study relates to a successful public health campaign in remote Aboriginal communities in the NT to highlight strategies that may be translatable to a child safety campaign in this context.

Triple P Population Trial

The prevention of child abuse and neglect requires a public health approach that reduces the prevalence of risk factors and addresses poor parenting practices. Research indicates that official rates of substantiated child maltreatment represent only “the tip of the iceberg” in terms of parenting difficulties and adverse child wellbeing because many episodes of abusive or neglectful parenting may not get reported (Sedlak 2001). Further, inadequate parenting practices that have a detrimental impact upon child development may not necessarily reach thresholds for official notifications.

A key assumption of a population approach to addressing this issue is for parenting intervention strategies to be more widely accessible (universal) in the community. The US Triple P System Population Trial is the first study to randomise geographical areas and show preventive impact on child maltreatment at a population level using evidence-based parenting interventions (Prinz, Sanders et al. 2009). This trial was conducted in 18 rural to semi-urban counties in the United States with population sizes between 50,000 and 175,000. Although multiple agencies delivered services to the families in these counties, these were often disconnected, had inadequate referral pathways and relied on conflicting approaches. The counties also had little or no prior exposure to evidence-based parenting programs.

The Triple-P Parenting Program developed by Sanders and colleagues is a multi-level preventive intervention system designed for families with at least one child under 12 years of age. All level of Triple P have intervention manuals, systematic training for practitioners and resource materials developed for parents. The five core principles that underpin the model are ensuring a safe, engaging environment, promoting a positive learning environment, using assertive discipline, maintaining reasonable expectations and taking care of oneself as a parent. Parents learn how to apply these according to the appropriate developmental level of their child.

During the first two years the trial key elements of the population-wide dissemination were the training of 649 service providers across the Triple-P system levels and the implementation of universal media and communication strategies (positive parenting newspaper articles, media releases, local newspaper stories, newsletters to parents, radio public service announcements and community events). Results showed large effects in all three population indicators – in a community of 100,000 results translated to 668 fewer cases of child maltreatment, 240 fewer out-of-home care places and 60 fewer children with injuries requiring hospitalisation or emergency room placement. (Prinz, Sanders et al. 2009)

Freedom from Fear Campaign

Freedom of Fear was an innovative, non-punitive community education campaign to tackle domestic violence in Western Australia by focusing primarily on perpetrators (and potential perpetrators)(Gibbons and Patterson 2000). The logic behind this campaign was that if a violent man could voluntarily change his behaviour this would not only decrease the incidence of violence, but also reduce the fear experienced by their partners and children. Campaign elements included mass media supported by a combination of strategies that reinforced key messages and provided a supportive environment for behaviour change.

Underpinning this unique campaign, was extensive formative research whereby interviews with perpetrators and the general population of males (aged 15 to 40 years of age) were conducted to examine i) the awareness, knowledge, attitudes, perceptions and behaviours of men in regard to domestic violence and ii) the acceptability and potential effectiveness of the five suggested 'message themes'. The promotion of reporting suspected domestic violence cases (community intervention), social disapproval and criminal sanctions were not recommended for the intended mass media campaign. A strong focus on consequences of domestic violence and support available were preferred. Specifically, it was suggested that key strategies for the initial phases of the campaign focus on the impact of domestic violence on children and the awareness of help available. Subsequent social marketing strategies followed including 30 second television commercials (and also 15 second cut down versions), newspaper advertisements, public relations activities (official media campaign launch, resource displays at public venues, participation in radio interviews), Men's Domestic Violence Helpline, a range of publications and a campaign website (see Figure 7) .



Figure 7. The Freedom From Fear Campaign (taken from Gibbons & Paterson (2000)) (Gibbons and Patterson 2000)

Process, impact and outcome measures of various strategies revealed that spontaneous awareness of advertising about domestic violence increased over the three time points, reached the intended target audience (perpetrators and potential perpetrators) and changed specific beliefs around the impact of domestic violence on the family and particular behaviours (such as occasional slapping not ever being justified). Campaign awareness was 91 per cent, and the ads were rated as highly believable (van Bueren 2010) Calls to the Men's Helpline exceeded expectations, with 6000 calls received in the first 21 months. Of these calls, 64 per cent were men in the primary target group for the campaign – perpetrators or men 'at risk'.

This campaign was not without its challenges and the researchers identified a number of factors that contributed to its success including: bipartisan support within government to develop an integrated response to domestic violence; seeking the advice and support of the sector from the early stages; provision of services (i.e., Helpline and counselling to promote and sustain behaviour change); and undertaking extensive research, consultation and planning to inform the campaign design and facilitate broad community acceptance.

Florida Winds of Change Campaign

The Florida Winds of Change campaign was a primary and universal prevention strategy targeting the general public to prevent child maltreatment (Falconer 2009; Evans, Falconer et al. 2012). The campaign was developed and launched as part of the state and nation-wide Child Abuse Prevention Month in the USA. The campaign was developed and delivered in partnership between Prevent Child Abuse Florida, the Ounce of Prevention Fund of Florida, and the Florida Department of Children and Families as well as communications consultants, community leaders and media. Whilst a time limited campaign, it connected to existing and continuous services, for example a government run public helpline and community based parenting programs.

The campaign adopted a communications approach to reframing the issue of child maltreatment in the public sphere. This approach was underpinned by Strategic Frame Analysis, a theory developed by The Frameworks Institute (Falconer 2009) and used for changing public discourse. Messages developed for the campaign focused on increasing knowledge about child development and the community supports available. The campaign took a marketing approach whereby behavioural 'products' were presented to consumers (parents) that were designed to appeal to their needs. This 'product' was recommendations and action steps for how to prevent child abuse and neglect in community settings before it occurs to avoid the 'price'. It was promoted using various components in multiple places.

Campaign components included:

- distribution of Community Resource Packets that contain:
 - an Advocate Guide
 - a Parenting Guide and
 - a dual-sided bilingual poster (target audience is service agencies and families)
- public Service Announcements (PSAs)– radio and TV – three PSAs (target audience for two PSAs are young parents families), the other PSA targets the retirement community, encouraging them to reach out to a family in their neighbourhood).
- state-wide press conference to launch campaign
- pinwheels as a visual aid and long time signature of campaign were distributed to the public and planted randomly or in 'gardens'.
- local events – community led activities such as fairs, group walk, radio show discussion, public forum, child-friendly activities and resource distribution.

The program had a clear program logic that linked inputs, activities, outputs and outcomes (see Figure 8). Evaluation was built in to the campaign at formative, pilot and outcome phases, although final research is forthcoming. In an efficacy evaluation of the campaign it was shown that two components, PSAs and parent resource materials, 'were efficacious and had a positive effect on relevant prevention knowledge, attitudes and beliefs, motivation and behaviour' (Evans, Falconer et al. 2012). This same study showed positive changes in all knowledge and behavioural outcomes, but one the knowledge and practice of child disciplinary techniques that are nonviolent and developmentally appropriate. The impact of the campaign on long-term behaviours or child maltreatment incidences is not known.

Winds of Change Logic Model

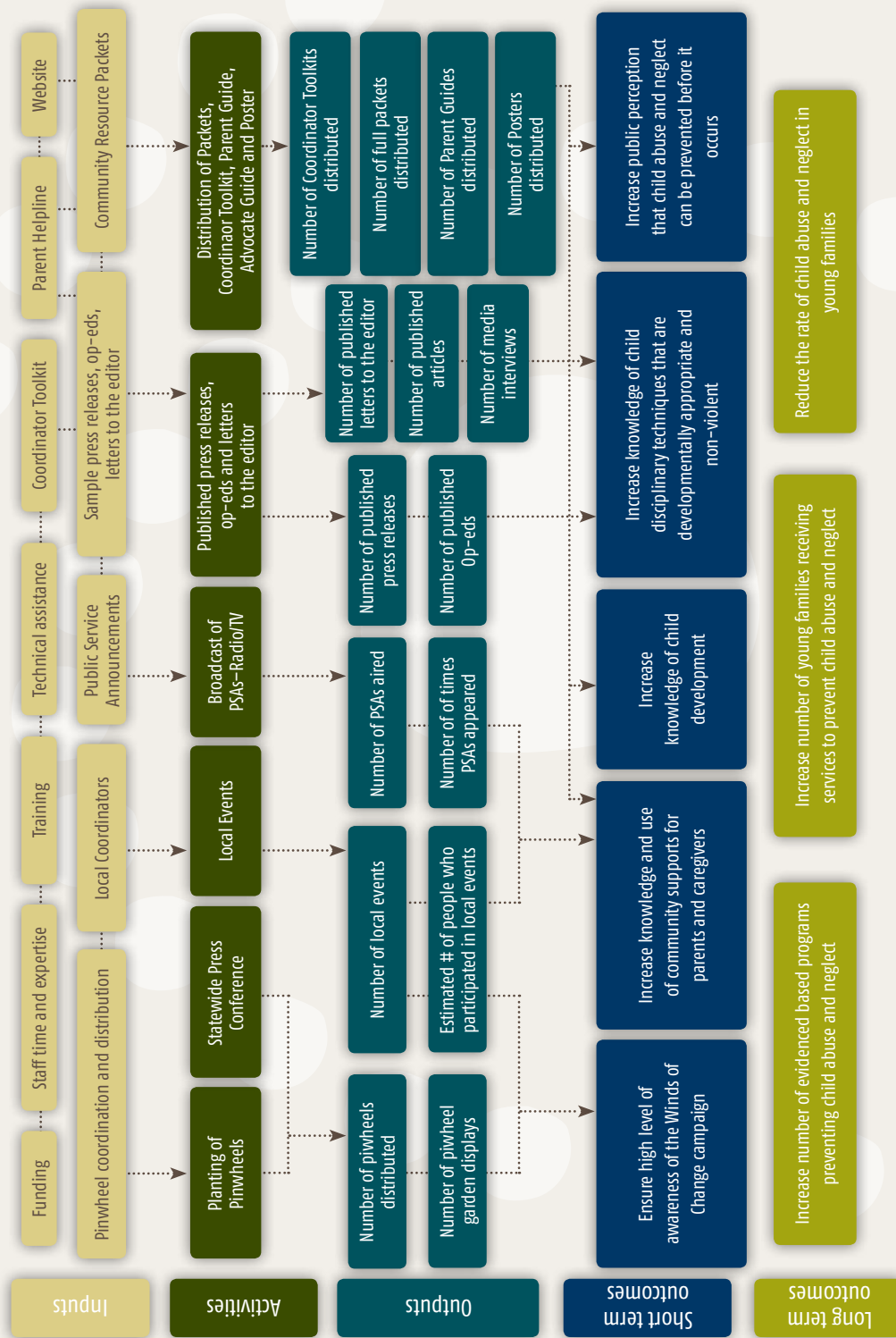


Figure 8: Winds of Change Program Logic (taken from Winds of Change Campaign Evaluation Report 2008-2009(Falconer 2009))

Goal: To promote the prevention of child abuse and neglect through a better understanding of child development, positive parenting practices and community action.

Using social marketing to increase reporting and treatment of child sexual abuse in small communities

As described in previous chapters, social marketing techniques have been used to increase the reporting of child sexual abuse in the general population and to assist help seeking after disclosures of sexual abuse. ^(Horsfall, Bromfield et al. 2010) One study has examined the use of social marketing techniques as a means of increasing reporting and treatment of sexual assault in a specific geographic and cultural setting: an ultra-orthodox isolated Jewish community of about 800 families in Israel (Boehm and Itzhaky 2004). This process was developed to address the “informal campaign of silence” and of shame which had developed within the community regarding sexual assault. Of particular importance was developing a sophisticated understanding of the sociocultural factors and social networks which perpetuated and defended the silence, and which hampered recovery efforts on the part of victims (through not being able to talk about their abuse, the healing and recovery process could not progress). This understanding enabled the targeting of behaviour change efforts over the course of time, and the development of alternative communication channels for victims to report what had happened to them, to receive support and which could help them counter threats of aggression and violence from perpetrators or others in the community.

This multidisciplinary social marketing response was developed in response to disclosures of child sexual abuse by a teacher in the community, and related sexual abuse by one of the victims to other children in the community. The response involved the development of an action team, established by a community worker, and included social workers with expertise in child sexual abuse and working with at-risk teenagers as well as an educational psychologist, family therapist and an educational counsellor. The team also received extensive external supervision. In recognition that the community had developed its own informal campaign to silence disclosures and discussion of abuse, a counter strategy was developed by the team. The campaign met with initial resistance from the community, with its silencing campaign initially strengthening as the professional team began their work.

The marketing team identified five interest groups in the community: a) previously unidentified victims; b) the assailants; c) the victims’ families; d) the general public; and e) the officeholders in the town, particularly religious leaders. Each of these had different needs (e.g. understanding, forgiveness, fear of the silence being broken, fear that the public image of the community would be damaged, ostracism).

The marketing team developed a strategy based on segmentation of the community into three groups: a) the undecided (mainly victims and their families); b) opponents (mainly the assailants, their families and religious leaders); and c) passive participants (who chose silence).

The team chose social ideas to be reinforced through the campaign:

- a. it is necessary and possible to prevent sexual abuse
- b. reinforcing perceptions of those assaulted as victims and not guilty
- c. recognition that being a victim of sexual assault is not a disgrace
- d. identifying that professional therapy is consistent with Jewish values
- e. reporting abuse is like fulfilling a religious obligation
- f. proper professional care for victims and perpetrators can and does help them and can improve a community's image.

The campaign was designed to promote actions and behaviours such as more open discussion about the subject, increased reporting, take-up of professional therapy and fewer victims. Messages were conveyed through central locations such as synagogues and schools and were reinforced in family homes and small groups. Rabbis and professionals in the human services in the community were recruited to be the “central agents of public relations”. In order to avoid the potential shaming of those who broke the silence about sexual assault, the marketing team served a protective role for these individuals.

Despite initial resistance on the part of religious leaders and family members of assailants, the end of the campaign saw increased disclosures and reporting, community action and discussion about sexual assault, families and victims were engaged in therapy, and the community was determining the actions to be taken against young assailants.

No Germs on Me

There is limited evidence of social marketing campaigns that have been utilised in remote and rural communities. One example is the *No germs on me* hand washing campaign which has been shown to help in addressing the high rates of infectious disease among Aboriginal babies and children in the NT (McDonald, Slavin et al. 2011). The aim of the campaign is to motivate men, women and children to regularly wash their hands with soap after going to the toilet, after changing babies' nappies and before touching food.

Rather than relying on traditional health education methods such as teaching people about the benefits of handwashing, the campaign uses the principles of social marketing, which have been found to be a more effective means of encouraging behaviour change especially at a population level. Focus groups and in-depth interviews were conducted in Indigenous communities in the Top End and Central Australia to determine the barriers and drivers to people routinely washing their hands with soap. Information gathered during this formative research stage was used to guide the development of the social marketing campaign.

The final campaign includes four television commercials in a top and tail format, four posters, a 'how to' sticker and point of sale materials to encourage the purchasing of soap. The catch cry 'didya wash ya hands?' and logo with the response 'no germs on me' effectively brand all campaign materials. The campaign is designed to stimulate thinking about the benefits of hand washing while still allowing the viewer to come to their own conclusions about the behaviour. The television commercials have a light hearted humorous tone and feature Indigenous talent.

Feedback on the campaign has been overwhelmingly positive. Initial message recall questionnaires indicated that the campaign was successful at reaching the target audience. The slogan 'No Germs on Me' was well understood by the majority of respondents. Discussions with community members indicated that people appreciated the humorous tone of the campaign and found that they could ask each other 'did ya wash ya hands?' without being seen as being too bossy or rude.

Following on from the success of the Indigenous campaign additional resources were developed targeting adolescent males and young adults in an urban context. Research indicated that routine handwashing decreases in the teenage years especially amongst young men.

The urban campaign has a similar style to the Indigenous campaign. The key difference was the adoption of a new key phrase - 'Washed your hands?' The phrase was changed based on comments from focus groups who felt 'Did ya wash ya hands?' was not marketable where as 'Washed your hands?' was more synonymous with the language idiosyncrasies in the urban population. Campaign resources include two television commercials, a poster, a 'how to' sticker, a radio commercial and table top advertising material that was distributed in shopping centres, airports, and cinemas. Overall, the urban handwashing campaign was well received with several requests received to run school programs and provide resources and education sessions in workplaces.

6. conclusion

Community education aims to facilitate collective problem solving by community members by equipping them with the knowledge to facilitate action, and through promoting citizen participation and shared decision making (Akande 2007). Social marketing is the, “*application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary or involuntary behaviour of target audiences in order to improve the welfare of individuals and society*” (Donovan and Henley 2010). Community education initiatives that employ social marketing principles can inform and persuade the audience to change or consider behaviour change. By taking a consumer perspective rather than a subject expert perspective such efforts can address the barriers and motivations for change rather than framing the behaviour as a lack of knowledge.

While knowledge acquisition alone can assist, it is not always sufficient to change behaviour particularly in situations where behaviours are entrenched or people feel powerless. Community education and social marketing strategies need to go beyond raising awareness to also focus on changing attitudes, beliefs and behaviours towards keeping children safe and strong. Families, communities and practitioners require more information about what constitutes child abuse and neglect, its impact and how it can be prevented. Due to the over-representation of Aboriginal children in the NT statutory child protection system it is imperative that these strategies resonate with Aboriginal families and communities. They also need to be aligned with a coordinated service system which can predict and respond to the needs of caregivers and the broader community/ies.

Research highlights that to keep children safe and well it is important to identify risk and protective factors in family and community environments and understand their impact. Early experiences of childhood abuse and neglect can adversely impact on brain development, impairing cognition, emotional functioning, physical growth and mental health throughout the life course of a child (Middlebrooks and Audage 2007; O’Connell, Boat et al. 2009). This highlights the need for support services to not only intervene early, but early in the life of the child to promote their healthy development (Barth 1991; Eckenrode, Ganzel et al. 2000; Donelan–McCall, Eckenrode et al. 2009; Howard and Brooks–Gunn 2009; Zielinski, Eckenrode et al. 2009). Research also highlights adaptive parenting, which involves the ability to tune in and respond flexibly to children is learned through direct experience, from watching others and from other information sources and that young parents may require additional assistance in this area. Protective factors for child wellbeing include delaying pregnancy until after adolescence and spacing between births. However, more research is needed to better understand Aboriginal child rearing practices in the context of the NT.

Further, children of different developmental ages and stages have different safety needs as well as different levels and types of vulnerability. Children and young people with higher care needs may have a greater likelihood of experiencing maltreatment.

There is no peer reviewed published research on the use and effectiveness of social marketing campaigns to promote child safety and well-being for Indigenous audiences in Australia. Indigenous audiences may have been exposed to nationwide or campaigns, but no research has been conducted on their efficacy or effectiveness in Aboriginal communities. There is a similar gap relating to broader multicultural audiences. This may be in part because social marketing and mass media community education campaigns often take a universal approach. The sensitivities around child maltreatment may be a further contributing factor. However a number of Australian and overseas social marketing strategies preventing child abuse and neglect have demonstrated moderate knowledge and attitude change. Evidence for effectiveness has therefore been drawn from these (Horsfall & Bromfield, 2010).

Social marketing strategies which incorporate evidence-based service provision and supports are more likely to

be effective than strategies which incorporate a multimedia component alone. The use of social media and new technologies is likely to enhance the reach of social marketing campaigns, and identifying the level of access to and the types of use of these technologies is essential for a context such as the NT. Multiple and multi-level intervention strategies that work best target children, parent (potential offenders), neighbourhoods and/or communities, practitioners and professionals and organisations.

Social marketing campaigns in the field of children's safety and wellbeing have used hard and soft hitting messages, however the effectiveness of one over the other is not fully known. Concerns that "threat appeals" may have opposite effect of inadvertently promoting such behaviour or of (re)traumatising audiences.

Understanding the target audience, their behaviours, needs, and motivations, is a key component of effective social marketing. Contemporary evidence highlights there are a number of key groups that community education and social marketing strategies to prevent child abuse and neglect could target in the NT including parents, particularly young parents, young people, communities as a whole, Aboriginal communities and practitioners working with families and children. As the primary target group, community education strategies to support parents should begin early, preferably during the prenatal and period or shortly after birth with active engagement of fathers in preventive efforts. Parents prefer to receive information about parenting through networks of family, friends and from parents in similar circumstances. Messages which demonstrate the impacts of behaviours on children and which provide links to help and support for parental issues are more likely to provide motivation for change. Neighbourhoods and communities also have a strong role to play in protecting and keeping children safe. Messages regarding healing, recovery and identity are especially important in Aboriginal communities experiencing grief and loss.

While social marketing strategies have been evaluated through means such as concept testing and market research, there remains limited academic research into this field. As such there is limited evidence about their effectiveness in preventing child abuse and neglect, even less for strategies targeting Australian Aboriginal communities. However, what is clear from the literature is campaigns which have led to heightened awareness, attitudinal change, and increased help-seeking behaviour, are those in which there are clear links to existing programs and continuous supports to facilitate behaviour change about a specific issue (Gibbons and Patterson 2000; Prinz, Sanders et al. 2009).

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appendix a: social marketing template
by michels warren munday

| SOCIAL MARKETING TEMPLATE - based on Kotler, Roberto and Lee (2002) | |
|--|--|
| WHERE ARE WE? | Social marketing environment |
| <p>Step 1 What is the social issue this campaign is addressing?</p> | <p>Determine program focus Evaluate potential approaches and determine the most appropriate focus based on:</p> <ul style="list-style-type: none"> • behaviour change potential • market demand (how many people will benefit) • market supply (is the issue already being addressed) • organisational match (with the sponsoring organisation) • funding sources and appeal. <p>Eg underage drinking and driving, air pollution</p> |
| | <p>Identify campaign purpose The ultimate impact/benefit of adopting the behaviour to the target audiences, groups and/or society. Eg reduced teenage pregnancies, reduced injuries from drinking and driving</p> |
| | <p>Conduct SWOT (strengths, weaknesses, opportunities, threats)</p> <ul style="list-style-type: none"> • what internal strengths will your plan maximise • what internal weaknesses will your plan minimise • what external opportunities will you take advantage of • what external threats will you plan and prepare for |
| | <p>Review past and similar efforts</p> |

WHERE DO WE WANT TO GO?

Target audiences, objectives and goals

| | |
|--------|---|
| Step 2 | <p>Select target audiences Segment into similar groups using variables such as:</p> <ul style="list-style-type: none"> • demographics (age, income, gender, occupation, family size, generation, nationality) • geographics • psychographics (social class, personality, lifestyle) • behavioural (occasions, benefits, whether a user or non user, level of loyalty, readiness stage, attitude towards product –) <p>Choose target segments based on size, reachability and readiness for behaviour change.</p> |
| Step 3 | <p>Set goals (specific, realistic, measurable –what level of change is realistic?) Eg increased by 25% in 24-month period the percentage of women aged over 50 who get an annual mammogram.</p> |
| | <p>Set objectives</p> <ul style="list-style-type: none"> • behaviour (what do we want our target audience to do, eg buy bulk goods (to reduce waste), five give hours a week to volunteering; • knowledge (relating to statistics, facts, information and skills the target audience would find motivating and important – eg facts on attractive alternatives, statistics on risk, where to get help, where to buy goods or services, an understanding of current laws and fines) • beliefs (relating to attitudes, opinions, feelings or values held by the target audience – eg audience needs to believe they will personally benefit from desired behaviour, that they will be able to successfully perform behaviour, that their behaviour can make a difference, that they won't be viewed negatively by others and that there will be minimal negative consequences) |
| Step 4 | <p>Analyse target audiences Need to know:</p> <ol style="list-style-type: none"> 1. What would they rather do than the behaviour we are promoting and why? (what benefits and costs do they see in their current behaviour) 2. What do they know about the desired behaviour (do they know the law or where to get help?) 3. What do they believe? 4. What are their values and attitudes in relation to the desired behaviour (what benefits and costs do they perceive in adopting the target behaviour, what are the barriers?) <p>Using primary and secondary research, determine:</p> <ul style="list-style-type: none"> • decision to support (eg what approach should be the focus of the campaign, what creative concepts would work best) • informational objective • audience • technique |
| | <p>Analyse the competition</p> <ol style="list-style-type: none"> 1. Behaviours and associated benefits our target audience would prefer over the ones we are promoting (eg taking longer showers) 2. Behaviours they have been doing for ever that they would have to give up (eg driving alone to work) 3. Organisations and individuals who send messages that counter or opposed the desired behaviour (alcohol ads) |

| HOW WILL WE GET THERE? | | Social marketing strategy |
|---|--|--|
| Step 5 | Product: Design the market offering The desired behaviour and benefits of that behaviour (can include tangible objects that facilitate that behaviour such as organic compost) | |
| | Price: Manage costs of behaviour change Identify what the target audience will have to give up by adopting new behaviour Determine what incentives could be offered or said that will decrease actual or perceived costs of the desired behaviour and/or increase the actual or perceived benefits | |
| | Place: Make the product available Where the behaviour will be performed, receive services associated with the campaign and learn more about performing the behaviour – how to enhance access. | |
| | Promotion: Create messages Choose media (communication) channels What will you say to influence your target audience to know, believe and do What you have established in your objectives? Where will your messages appear (channels)? | |
| HOW WILL WE STAY ON COURSE? | | Social marketing program management |
| Step 6 | Develop a plan for evaluation and monitoring What benchmarks will tell us how we are doing and whether we have made any change? | |
| Step 7 | Establish budgets and find funding sources | |
| Step 8 | Complete an implementation plan | |
| Key tips for successful campaigns (p 52) | <ol style="list-style-type: none"> 1. Take advantage of what is known or has been done before 2. Start with target markets that are most ready for action 3. Promote a single, doable behaviour explained in simple clear terms 4. Consider incorporating and promoting a tangible object or service to support the target behaviour 5. Understand and address perceived benefits and costs (emotional benefits are powerful) 6. Make access easy 7. Develop attention-getting and motivational messages 8. Use appropriate media and watch for and exploit opportunities for audience participation 9. Provide response mechanisms that make it easy and convenient for inspired audiences to act on recommended behaviours 10. Allocate appropriate resources for media and outreach 11. Allocate adequate resources for research 12. Track results and make adjustments | |
| Tips for making campaigns sustainable | <ol style="list-style-type: none"> 1. Integrate messages into existing infrastructure (eg litter messages on bins) 2. Get commitments from target adopters (eg certificates) 3. Develop prompts in the environment (car bells to remind you to put seatbelt on) 4. Create norms and make offenders visible (stickers on cars to report bad driver behaviour) 5. Remove barriers (do it yourself equipment) 6. Reward audiences (day off for adopting desired behaviour) 7. Support audiences tempted to return to old habits (electronic messages of encouragement) | |

