First We Have to Engage Them: A Mixed Methods Assessment of Low-Income Parents' Preferences for and Barriers to Receiving Child Health Promotion Information

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ABSTRACT

Introduction: The aim of this study is to understand low-income parents' preferences for and barriers to receiving child health promotion information.

Methods: A mixed-methods approach was used. Data were collected in an urban pediatric primary care setting serving predominantly low-income African American families. Parents (n = 190) of 3- to 8-year-old children completed a survey; a randomly selected subset participated in focus groups.

Results: The quantitative and qualitative samples differed with regard to whether they would like to get parenting information from their doctors. The most commonly cited obstacles to attending parenting classes were time (50.6%), work schedule (40.6%), transportation (37.7%), and own health (22.4%).

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Discussion: New and creative methods are needed to promote child health and development that do not increase the burden associated with raising children in the context of limited resources. J Pediatr Health Care. (2015) *29*, 501-508.

KEY WORDS

Health promotion, parenting, health education, primary care, low-income families

The importance of the early childhood period on later child outcomes has been established (Bornstein & Bradley, 2003; Brooks-Gunn, Linver, & Fauth, 2005; Day, 2011; Hanson et al., 2011; Lee, Huang, Halpern, & Newsschaffer, 2007; Ramey and Ramey, 2004; Sameroff, 2010). Because parents are largely responsible for structuring the physical and psychosocial environments in which their children grow and develop, promoting positive parenting behavior during early childhood has tremendous implications for a child's quality of life, lifelong health and development, and health care resource utilization (Bornstein & Bradley, 2003; Bradley, 2002; Dumas et al., 2005; Sameroff, 2009).

Evidence shows that some parenting programs are successful in improving child outcomes for some children. However, parental attendance has been suboptimal even for parents whose children have documented or perceived behavior problems (Dumas, Nissley-Tsiopinis, & Moreland, 2007; Perrin, Sheldrick, McMenamy, Henson, & Carter, 2014; Thornton & Calam, 2011). For example, Thornton and Calam (2011) found that only 9% of the parents who indicated an intention to attend a parenting group through their local school actually attended the group. Additionally, they found that parents who attended reported higher child problem behavior scores than did those who did not attend the parenting class. Similarly, parents whose children had screened positive for behavior problems were enrolled into another study to evaluate a parent intervention program in a primary care setting (Kolko, Campo, Kelleher, & Cheng, 2010). Of the 573 eligible families, 70% actually enrolled and were randomized (Kolko et al., 2010). Despite monetary incentives, only 112 initiated treatment and only 89 completed treatment within the 6-month study period. In yet another program, Perrin and colleagues (2014) enrolled parents of 2- to 4-year-old children who screened positive for disruptive behavior problems. Of the 830 parents who agreed to be contacted, 33% were enrolled in the intervention or wait-list group. An additional 29% of the enrolled parents dropped out of the study prior to completion (Perrin et al., 2014). The study demonstrated the feasibility of offering a parenting program in a primary care setting with nurses, nurse practitioners, and social workers, and the intervention was successful in reducing behavioral problems in a diverse sample. Thus, data from several studies indicate some success with recruiting parents for interventions related to their child's behavior problems. These recruitment and retention rates may not be sustainable without grant funding to support the inclusion of incentives and the staff necessary to encourage participation.

BACKGROUND

The importance of health promotion of children is well known. However, few data are available regarding attendance at health-promotion programs or use and effectiveness of other health-promotion methods (e.g., written materials, Web sites, social media, and text messages). A better understanding of the preferences for and barriers to receiving parenting education is needed so that health promotion and prevention content can be more widely accessible, acceptable, and effective in promoting positive parenting behavior that supports children's optimal development.

It has been reported that parents are more likely to intend to attend a parenting class if they believe that their children have behavior problems than they are to intend to attend a parenting class to prevent problems (Dempster, Wildman, & Keating, 2013). Richerson (unpublished data, 2013) discovered that parents prefer to have enrichment and parent support activities in their communities rather than take parenting classes.

Poverty, minority status, and low levels of education of parents are well-documented risk factors for adverse outcomes in children across multiple domains (Bornstein & Bradley, 2003; Bradley & Corwyn, 2002; Brooks-Gunn, Rouse, & McLanahan, 2007). Parents with less education may not have the health literacy skills needed to act upon the knowledge that is given to them. Additionally, much health information that is provided to patients is not suitable or is at a reading level that is not appropriate for many U.S. adults (Freda, 2005; Ryan et al., 2014). In one study, parents with a high school education or less indicated that they did not receive education or did not understand the education that was provided on important anticipatory guidance topics to a greater extent than their more educated peers (Davis, Jones, Logsdon, Ryan, & Wilkerson-Memahon, 2013). More data are needed to ensure that appropriate strategies are developed and implemented to communicate with parents in ways that they find acceptable so they can truly be partners in their children's care.

Nurses and nurse practitioners in primary health care settings are obvious choices for supporting the family's optimal functioning because they are consistently involved in the lives of children from birth. The premise of the patient-centered medical home is that health care providers and the patient or family are integral partners and that the family is actively involved in the health care decision-making process (Yin et al., 2012). However, parent preferences for receiving educational messages frequently are not solicited. Support of parents in