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Breaking Barriers: Enhancing Access and Outcomes in a Community-Based Parenting Intervention for At-Risk Families

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Prevention of behavioral and emotional problems in early childhood is essential to promote healthy development and reduce risky behaviors, academic failure, delinquency, and social difficulties. Evidence-based parenting interventions, such as the Incredible Years Toddler Basic program, are known to effectively address these challenges. However, access to such programs remains limited for many caregivers, especially those in ethnically diverse and at-risk families, due to structural, attitudinal, and interpersonal barriers. This study describes the implementation of the Incredible Years Toddler Basic parenting intervention, highlighting strategies to recruit, retain, and engage a predominantly Hispanic (68.3%), at-risk population while addressing participation barriers. Data from 301 families were collected using validated measures, including the Parental Stress Scale and the Adult and Adolescent Parenting Inventory, second edition. Of the participants, 262 (87%) met attendance requirements, significantly exceeding retention rates for comparable programs. Caregivers reported significant reductions in parental stress and improvements in parenting attitudes. Findings highlight the success of addressing structural, attitudinal, and interpersonal barriers to improve participation and outcomes in community-based parenting programs. This study serves as a model for leveraging community partnerships and tailoring programming to advance public health and support in ethnically diverse and at-risk families.

Keywords: early intervention, community-based interventions, Incredible Years Parenting Program, cultural adaptation, recruitment and retention

Prevention of behavioral and emotional problems in early childhood is critical to safeguard healthy child development, promote long-term behavioral health, and reduce the risk of future challenges such as engaging in risky behaviors (e.g., delinquency, substance use) and experiencing academic failure and social difficulties (Zarra-Nezhad et al., 2024). The consequences of untreated behavioral problems are vast and can last well into adolescence and adulthood (Goulter et al., 2024). Untreated behavioral and emotional difficulties in early childhood extend far beyond the child and family grappling with these issues. Research shows insufficient behavioral health support imposes significant societal costs, including school disruptions, strain on health care systems, and legal consequences (Goulter et al., 2024; Romeo et al., 2006). The ripple effects of untreated behavioral and emotional challenges don't just impact the individual, and they are widespread, affecting the community and economy (Goulter et al., 2024; Romeo et al., 2006).

Early intervention programs focused on parenting behaviors can play a vital role in preventing behavioral and emotional problems.

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Specifically, Behavioral Parent Training (BPT) programs are the most extensively researched and effective psychosocial interventions for families aiming to prevent and/or address early behavioral and emotional challenges, and support healthy child development (Arruabarrena et al., 2022; Kaminski & Claussen, 2017; Mingebach et al., 2018). Research on BPTs has consistently shown success in preventing the escalation of disruptive behaviors among diverse at-risk families (Kaminski & Claussen, 2017; Reid et al., 2001). These programs typically include a range of strategies such as parent training, skills practice for caregivers and children, and supportive resources. Additionally, BPT programs foster safe, supportive environments that build resilience and positive family coping skills, promote healthy caregiver–child interactions, and reduce stress within the family (Kaminski & Claussen, 2017). Long-term, preventing behavioral and emotional problems in early childhood benefits not only the child but society as a whole (Geelhoed et al., 2020). Children who receive support early on are more likely to succeed academically, avoid criminal involvement, and contribute positively to their communities (Geelhoed et al., 2020). Thus, investing in early prevention is a crucial step toward creating a healthier, more equitable future.

Despite significant investment in BPT programs and their success in addressing early child behavioral and emotional difficulties, their effect is not universal and largely depends on caregivers' access to and active engagement in these services (Quetsch et al., 2020). Families from marginalized racial and ethnic backgrounds face elevated risks of experiencing inequities across various social determinants of health. These include difficulties navigating the health care system, limited access to transportation and childcare, language barriers, and systemic issues like discrimination and racism (Jent et al., 2023). These challenges place families at a higher risk for being a teen parent, raising a child with disabilities, living with a low-income status, parenting a child with behavioral challenges, being involved in the dependency system, experiencing mental health or substance abuse issues, and lacking social support (Robbins et al., 2012). These concerns have been identified as barriers to BPTs, encompassing structural (e.g., access to transportation, competing demands, childcare needs, and location and time of services), attitudinal (e.g., fear of judgment related to receiving help and lack of trust), and interpersonal factors (i.e., mismatch between caregiver and provider, limited availability of services, lack of information or awareness of services, and difficulties with agency referral processes; Green et al., 2020; Smokowski et al., 2018; Weisenmuller & Hilton, 2021). The impact of these barriers is evident in well-established BPTs (e.g., Incredible Years, Triple P), which consistently have reported higher dropout rates among diverse, at-risk families (McCabe et al., 2020), highlighting ongoing challenges in engaging vulnerable populations in preventive interventions.

Incredible Years (IY) is an extensively studied BPT group parenting intervention, with robust evidence supporting its efficacy as both a treatment and preventive intervention for children with disruptive behaviors (Menting et al., 2013). IY aims to strengthen caregiver–child interactions and attachment, reduce harsh discipline and foster caregivers' ability to promote children's social and emotional competence and language development. The program's comprehensive and evidence-based framework has garnered significant recognition for its impact on child and family outcomes. The IY Training Series has been designated as a "Model Program" and a promising "Blueprints" program by the Office of Juvenile Justice Delinquency Prevention (Mihalic et al., 2001; U.S. Department of Justice, 2000). Additionally, it has been rated as an "Effective" program by Crime Solutions (National Institute of Justice, Crime Solutions, 2011), highlighting the program's strong empirical foundation and capacity to address risk factors associated with negative long-term outcomes. Extensive research has shown IY's effectiveness in improving children's social skills (Sebastian et al., 2019), emotion regulation (Webster-Stratton et al., 2018), problem-solving abilities (Gaspar et al., 2024), and academic preparedness (Chuang et al., 2020).

Despite IY's effectiveness, several critical gaps remain in the literature, particularly regarding its nuanced application across diverse cultural backgrounds. For example, most research on the IY program has focused on non-Latinx children ages 3–12, leaving Latinx families with toddlers largely underrepresented. This underrepresentation is especially problematic given the unique developmental needs during early childhood and the significant barriers Latinx families face in accessing culturally and linguistically appropriate behavioral health services (Leijten et al., 2017). Notably, Latinx families have historically been underrepresented in IY research, despite being the nation's largest racial and ethnic minority group (i.e., 19.5% of the total population; Leijten et al., 2017; U.S. Census Bureau, 2024). This gap in research limits the ability to assess whether the Incredible Years Toddler Basic (IYTB) program can effectively reduce disparities in access and improve outcomes for this growing population. Emerging research suggests shared cultural backgrounds between facilitators and families, including language, immigration experiences, and values, may enhance engagement and outcomes, yet this promising direction remains relatively underexplored (Kapke & Gerdes, 2016; Leijten et al., 2017; Smokowski et al., 2018). In addition, despite IY's inclusion of numerous recommendations to retain families, many studies to date use only a few strategies in isolation (e.g., offering childcare or transportation) rather than evaluate the effectiveness of comprehensive, multilevel strategies that address the complex and intersecting barriers faced by ethnically and socioeconomically diverse families (Dunn, 2012; Morpeth et al., 2017). Moreover, while external stressors such as housing insecurity or immigration concerns are known to impact attendance and attrition, parenting programs less commonly integrate navigation services or resource linkage into their delivery models. Opportunities to build community and connection outside of the formal curriculum through technology also remain underutilized. For example, tools such as group messaging platforms or text communication in families' preferred languages hold promise for enhancing engagement (Nichols et al., 2024). Further, most group parenting programs continue to target families with children who meet diagnostic criteria for specific mental health conditions, such as attention-deficit hyperactivity disorder or conduct disorder, thereby excluding families whose children may be at-risk due to elevated stress or negative parenting practices but do not meet clinical thresholds (Campbell et al., 2000; Izett et al., 2021). In addition, the literature on effectively engaging broader family systems, such as fathers, grandparents, and other extended caregivers within IY implementation among Latinx communities remains limited, despite the cultural importance of collective caregiving in these communities. Expanding this focus could help ensure programs are more inclusive and culturally responsive. Finally, studies rarely incorporate culturally meaningful or skill-reinforcing incentives (e.g., Spanish-language children's books) or intentionally create informal spaces that foster connection and belonging, which are known drivers of sustained engagement in collectivist cultures. Together, these gaps

highlight the need for more inclusive, culturally grounded, and holistic approaches to engaging Latinx families in parenting interventions.

Given the critical need for early, community-based parenting interventions that engage all families, this study focused on the implementation of the IYTB parenting program for caregivers of children ages 1–3, the majority of whom were Latinx (68.3%). The program incorporates a framework for addressing structural, attitudinal, and interpersonal barriers to enhance recruitment and retention in IYTB groups (Smokowski et al., 2018). Participating families were identified as at-risk due to one or more of the following factors: teen parents, families of children with disabilities, low-income households as defined by the Miami-Dade Housing and Urban Development guidelines (Miami-Dade County, n.d.), children with emerging behavior problems, families involved in the dependency system, caregivers with limited social support and/or those with mental health or substance use issues. Specifically, we describe recruitment and retention strategies, staff training procedures, cultural considerations in program delivery, and fidelity of implementation to ensure culturally responsive, accessible, and evidence-based care for families primarily of Latin descent. In addition, we examined family level outcomes such as parental stress and parenting attitudes. By describing concrete strategies that have been effective with populations facing significant barriers, we aim to offer clinicians actionable insights for working with Latinx families and improving engagement in critical early intervention services.

Method

Participants

Participants were 301 caregivers and their 1–3-year-old children enrolled in the IYTB parenting program from December 7, 2017 to March 15, 2020. Enrollment for the purpose of this study was defined as completing preintervention measures and attending one session. The majority of participants who completed the IYTB program were the biological parent (93.5%), female (79.4%), and over 31 years of age (80.5%). Over half of the participants were Latinx (68.3%), and 69.5% of the participants had a bachelor's degree or higher. Demographic characteristics are presented for all participants in Table 1.

Procedure

Recruitment

The IYTB parenting program is an evidence-based group curriculum for caregivers of children ages 1–3. The present study was

Table 1
Caregiver Descriptive Characteristics

Characteristics of caregiver	Completed pretest and ≥1 session $N = 301$ *n* (%)	Completed pretest and posttest $N = 262$ *n* (%)	Completed pretest only $N = 39$ *n* (%)	$\chi^2(df)$, p[a]
Primary language				
English	192 (63.8)	163 (62.2)	29 (74.4)	2.3(2), .319
Spanish	92 (30.6%)	84 (32.6)	8 (20.5)	
Other	17 (5.6%)	15 (5.7)	2 (5.1)	
Gender				
Female	241 (80.1)	208 (79.4)	33 (84.6)	0.58(1), .446
Male	60 (19.9)	54 (20.6)	6 (15.4)	
Race				
Asian	16 (5.3)	13 (5.0)	3 (7.7)	14.5(4), .006
Black/African American	52 (17.3)	40 (15.3)	12 (30.8)	
White	187 (62.1)	173 (66.0)	14 (35.9)	
Multiracial	22 (7.3)	16 (6.1)	6 (15.4)	
Other	24 (8.0)	20 (7.6)	4 (10.3)	
Ethnicity				
Hispanic	200 (66.5)	179 (68.3)	21 (53.9)	3.2(1), .074
Non-Hispanic	101 (33.5)	83 (31.7)	18 (46.1)	
Education level				
High school/General Equivalency Diploma or <High school	49 (16.3)	38 (14.5)	11 (28.2)	11.2(3), .011
Some college or associate's degree	53 (17.6)	42 (16.3)	11 (28.2)	
Bachelor's degree	89 (29.6)	79 (30.2)	10 (25.6)	
Graduate degree	110 (36.5)	103 (39.3)	7 (18.0)	
Marital status				
Married	201 (66.8)	182 (69.5)	19 (48.7)	7.3(2), .027
Divorced or separated	26 (8.6)	22 (8.4)	4 (10.3)	
Never married	74 (24.6)	58 (22.1)	16 (41.0)	
Age group				
18–25 years	18 (6.0)	14 (5.3)	4 (10.3)	11.5(2), .003
26–30 years	50 (16.6)	37 (14.1)	13 (33.3)	
Age 31 years or above	233 (77.4)	211 (80.5)	22 (56.4)	
Caregiver relationship				
Biological parent	283 (94.0)	245 (93.5)	38 (97.4)	0.93(1), .335
Nonbiological parent	18 (6.0)	17 (6.5)	1 (2.6)	

[a] The "completed pretest and ≥1 session" group combines both the "completed the pretest and posttest" and "completed pretest only" groups to provide an overall picture of the demographic characteristics of the sample as a whole. The chi-square test results are from comparison of completed both pre and post versus completed pretest only.

approved by the University of Miami Human Subject Research Office Institutional Review Board (Protocol No. 20043435). Recruitment was county-wide and facilitated by over 20 community partners, including childcare sites, health care centers, and places of worship. Partners provided referrals, childcare, and free space for on-site hosting of parenting groups. Collaborative partnerships were maintained and strengthened by the program director and staff who engaged in regular communication with partners, by phone and face-to-face, to obtain feedback and suggestions regarding program implementation and to address issues as they arose. Additional recruitment efforts consisted of presentations at collaborating sites, annual community expositions and health fairs, as well as university publications and occasional TV/radio coverage. Other methods included culturally sensitive flyers distributed in English and Spanish throughout the community, a website hosted by the university, and social media accounts (i.e., Facebook and Instagram) that distributed bilingual information about upcoming group availability and registration. A significant number of word-of-mouth referrals were also received through recommendations by caregivers who had previously completed our IYTB parenting program. Advertising materials were translated into Spanish by native Spanish-speaking staff and supervisors and underwent back-translation to ensure accuracy. Materials featured images of Latinx families to enhance cultural relevance and inclusivity. In addition, the language utilized was intentionally destigmatizing (e.g., program instead of intervention). Last, Latinx individuals reviewed the flyers to ensure cultural accuracy, appropriateness, and effective communication with the target population.

Screening and Enrollment

Participants registered for groups by phone, online, or by mailing or emailing a self-referral form. Potential participants were administered a phone-based individualized needs assessment to enable participants to feel more comfortable and avoid stigma tied to clinical assessments, such as fears of diagnosis or parenting criticism. Nonstigmatizing intake procedures were intentionally implemented given that mental health services have historically been stigmatized or mistrusted by the Latinx population (Newberry et al., 2024). Individualized needs assessments were implemented to identify at-risk factors at the family and environmental levels (e.g., child developmental delays, child-protective services involvement, food and housing insecurity) and additional needs for psychosocial services. The only eligibility criteria included having a child between the ages of 1 and 3 years and residing in Miami-Dade County, Florida, United States.

To ensure participation, barriers to accessing our services were identified at first contact (e.g., childcare, transportation) and program staff worked individually with each family to problem-solve these barriers (i.e., recruitment director directly communicated with each eligible family, referral linkage, and provision of incentives). Families were given the option to choose the group that best fit their geographic location, preferred language, and schedule. Those ineligible for enrollment were referred to other community resources when appropriate. We leveraged strong partnerships with local organizations to ensure follow-up and improve the likelihood of successful linkage and support. Furthermore, being situated within an academic medical center afforded us the unique opportunity to make direct referrals to relevant health care services within our institution, streamlining access and ensuring a more seamless transition for families requiring medical or mental health support. Prior to or during the first group session, participants completed consents, demographic forms, and preintervention assessments in English or Spanish based on their preference. Trained program staff offered to read forms aloud to ensure understanding among all participants. Consents were explained in a language understandable to participants and according to informed consent procedures.

The IYTB parenting program taught positive parenting and discipline strategies, promoted school readiness, and focused on building nurturing parent–child relationships. It also aimed to strengthen family functioning and improve caregiver knowledge. The program was offered to caregivers of children ages 1–3 in Miami-Dade County, Florida, United States (Webster-Stratton, 2011; see Table 2 for curriculum details).

Two trained facilitators conducted each group session in either English or Spanish. IYTB groups addressed family beliefs and traditions and encouraged rituals and routines that supported each individual family through participant-generated examples (e.g., when discussing discipline and bedtime routines, families shared their own beliefs). Facilitators also shared experiences that reflected the group's diverse cultural values, fostering inclusion and connection. They utilized a combination of engaging and interactive teaching methods including video vignettes featuring culturally diverse families engaging in real-life scenarios. These vignettes served as discussion points on effective and ineffective parenting strategies. Facilitators also utilized role-plays to enable participants to practice new skills learned during sessions in a supportive environment. Group discussions, facilitator-guided activities, and reflection exercises further enhanced learning, encouraging participants to share experiences and apply concepts to their daily interactions with their children. Last, facilitators promoted skills practice by assigning specific weekly activities (e.g., child-directed play) to be implemented at home with their children. Childcare was provided during sessions to reduce barriers to attendance and allow caregivers to effectively engage with the content, skill practices, and discussions. During the study duration, a total of 33 IYTB groups were conducted, 18 of which were in Spanish. Groups consisted of 12–15 parents who met 2 hr weekly for 12 sessions.

Cultural Considerations

To address the multifaceted barriers faced by Latinx families, our study implemented several strategies such as targeted outreach within their neighborhoods and through trusted community networks. Language and cultural differences were mitigated by employing native Spanish-speaking facilitators with similar cultural backgrounds. Program materials were also provided in the families' preferred language. Additional materials, including bilingual resources and culturally relevant role-playing scenarios that aligned with Latinx values such as *familismo* and *respeto*, were added to ensure greater cultural responsiveness. These materials incorporated real-life examples, storytelling, and traditions that reflected the experiences of Latinx families. In addition, facilitators shared relevant examples from their own lived experiences, fostering a genuine connection among caregivers and facilitators. Resource limitations were addressed by providing childcare, meals, and transportation and by soliciting input on convenient group scheduling. To

Table 2
Summary of Incredible Years Parents and Toddlers Program Content

Content	Objective	Content	Objective
	Toddler program 1–3 years		
Part 1: Child-directed play promotes positive relationships	• The value of attention to increase positive child behaviors • Promoting imaginary and pretend play • Developmental needs and milestones • Balancing parent–child power dynamics • Building children's self-esteem and creativity through child-directed play	Part 2: Babies as intelligent learners (3–6 months)	• How to model and prompt language development • How to coach preschool readiness skills • "Descriptive commenting" and child-directed coaching • "Persistence coaching" to build children's persistence
Part 3: Social and emotion coaching	• Using emotion coaching to build children's emotional vocabulary • How to prompt social coaching to encourage children's social skills • How to coach sibling and peer play and apply principles in other settings • Developmental stages of play	Part 4: The art of praise and encouragement	• Labeling praise and handing resistance to praise • Modeling self-praise and promoting positive self-talk • Praising social and self-regulation skills • Building self-esteem
Part 5: Spontaneous incentives for toddlers	• Shaping behaviors in the direction you want "small steps" • Unexpected and spontaneous rewards • Recognizing the "first-then" principle • Setting up programs for problems (i.e., not dressing, noncompliance)	Part 6: Handling separations and reunions	• Establishing routines for separating and greeting children after time apart. • Understanding object and person permanence • Toddler-proofing home safety checklist and providing adequate monitoring
Part 7: Positive discipline—effective limit setting	• The importance of distractions and redirections • The value of giving children choices • Politeness principle and modeling respect • Commands should be clear, brief, respectful, and action oriented	Part 8: Positive discipline—handling misbehavior	• Use of distractions and redirections with the ignoring technique • Parents using calm-down strategies and positive self-talk • How to help toddlers practice calming down

Note. Adapted from *The Incredible Years Parents, Teachers, and Children's Training Series: Program Content, Methods, Research, and Dissemination 1980–2011* (pp. 59–60), by C. Webster-Stratton, 2011, Incredible Years (https://www.incredibleyears.com). Copyright 2011 by Carolyn Webster-Stratton. Adapted with permission.

combat distrust of the system and providers, we leveraged decade-long relationships with community partners, relied on trusted referrals, individually addressed families' concerns, and provided accessible information, thereby improving mental health literacy and awareness of developmental needs. Moreover, the intervention inherently countered reliance on potentially inaccurate familial advice by providing evidence-based information on development, parenting, and behavior. The group setting facilitated bonding and the program was tailored to enhance families' comfort level through collaborative rule-setting. Extended family members were also invited to attend the group to respond to Latinx' values of *familismo* and to increase families' sources of support. Last, IY video vignettes were preselected to reflect the diversity of the population served.

Training

Facilitators were university staff, all with a master's degree or higher, who received curriculum-specific expert-training. Training for the IYTB parenting program included a 3-day workshop conducted by a certified IY trainer. The certified trainer also provided consultation as needed to discuss issues, provide feedback, and ensure evidence-based practice (EBP) fidelity requirements were met. Staff then cofacilitated groups with other experienced facilitators until proficiency was demonstrated. Facilitators were culturally and linguistically representative of the Miami-Dade community (83% Latinx facilitators compared to 75% Latinx residents) in Florida, United States. Facilitators were assigned to specific groups by the program director, ensuring that those conducted in Spanish were led by native Spanish-speaking facilitators and groups in English were led by fluent English-speaking staff. Facilitators participated in implicit bias training to recognize and address personal beliefs that could influence their interactions with families. This was further explored during reflective supervision. Facilitators were encouraged to utilize a nonjudgmental approach during the groups. Due to their shared cultural and linguistic background, facilitators were in a unique position to empathize with the experiences of the families (e.g., language barriers), build trust and rapport, and provide culturally responsive support (Barnett et al., 2018).

Engagement and Retention: Structural, Attitudinal, and Interpersonal Approaches

Strategies utilized to increase engagement and retention in IYTB groups were evidence-based and consisted of structural, attitudinal, and interpersonal methods (Smokowski et al., 2018), some of which addressed barriers in multiple domains simultaneously. Each strategy is described below in only one domain to minimize redundancy.

Structural

Groups were free and scheduled with collaborating community partners to address structural barriers to participation. Families interested in enrolling were surveyed to identify the best time, day, and location for group sessions. Since groups took place over multiple weeks, and attendance at each session was critical to ensuring programmatic effectiveness, it was essential to receive community partner and caregiver feedback when scheduling groups. To facilitate wider access, groups were offered in English and Spanish at a variety of times, including evenings, to accommodate diverse family schedules and preferences. Preferred language was prioritized when completing assessments and throughout the intervention. In addition, program curricula and marketing materials were designed to be family friendly, culturally relevant (e.g., using images of Latinx families and their communities in advertising), and engaging. Groups offered fellowship and support opportunities and meal- or snack-time during each session. Staff also worked with participants to problem-solve other possible barriers (e.g., transportation and childcare) to participation when needed by offering bus tokens, public transportation reimbursement, and childcare.

Other retention methods included phone calls for session reminders, and identification/coordination of service referral needs. If a participant was absent from the group, immediate phone contact and supportive problem-solving strategies were employed, both during the session to see if they could join, and after to check in and/or offer options for make-up sessions. As an incentive for attendance and a tool to practice skills at home, participants received topic-related educational items at the end of each session (e.g., stickers to promote positive reinforcement).

Attitudinal

Recruitment and retention strategies were also implemented to address misconceptions and foster positive attitudes about participation. The recruitment director reached out to each participant interested in enrolling and individually assessed the caregiver's expectations and goals for the group to ensure program appropriateness. Clear and accurate information about the benefits and outcomes of the program were provided and any concerns were addressed.

During the first group session, facilitators aimed to create a safe and supportive environment by collaboratively establishing group rules that encouraged shared experiences to be respected, which aligns with typical practices in the first sessions of the IY program. In addition, the importance of listening, being nonjudgmental, and supporting one another throughout the sessions was promoted. Facilitators also emphasized the value of each participant's contribution through incentives and consistent praise. They acknowledged and validated caregivers' questions and responses, using positive reinforcement to encourage continued participation. In addition, facilitators normalized common parenting challenges, which let participants know they were not alone in their struggles, making it easier for them to share openly. Facilitators were culturally responsive, encouraging caregivers to share their individual beliefs about parenting and the strategies taught. These discussions aimed not only to overcome attitudinal barriers but also to cultivate a positive and engaging experience that encouraged ongoing involvement throughout the program's duration.

Interpersonal

Each session caregivers shared parenting successes and struggles experienced the previous week, engaged in parenting topic discussions, worked in small groups to role play and practice skills, and shared a snack or meal. These activities promoted bonding among group members and some even continued meeting after the program ended. A family friendly, optional, encrypted group chat (i.e., WhatsApp) to discuss parenting concerns was also created. This enabled caregivers to further increase their social support by

developing relationships with one another outside of the group. Caregivers were informed about the limits of confidentiality related to the chat and were instructed to restrict comments to parenting topics. Facilitators monitored the chat to ensure that comments were appropriate. They also checked in with caregivers before and throughout the group to assess and address comfort level and any individual needs or interpersonal concerns. In addition, facilitators built trust, prioritized cultural differences and norms, and celebrated individual and group accomplishments, further contributing to an accepting and supportive environment. Participants were encouraged to provide feedback, including suggestions for improvement regarding content, process, and dynamics following sessions and anonymously upon group completion. This strategy conveyed that their input was welcomed and valued.

Measures

Intervention Engagement and Retention

Attendance. A standardized attendance log and sign-in sheets were used to collect data on participant attendance throughout the intervention. The log tracked the frequency of attendance, which was utilized to gauge participant engagement and retention.

Intervention Completion. Retention in the program was calculated by examining the proportion of participants who completed the pre- and postintervention assessment and completed at least 10 of 12 sessions of the intervention. Completing this number of sessions aligned with the evidence-based practice (EBP) guidelines, which identified this duration as optimal for improved outcomes (Webster-Stratton, 2011).

Family Level

Parental Stress Scale. The Parental Stress Scale (PSS; Berry & Jones, 1995) is a questionnaire assessing caregivers' feelings about their parenting role. The English version has 18 items. The Spanish version has 12 items. The PSS has different numbers of items in the English and Spanish versions due to cultural adaptations and psychometric evaluations. Specifically, certain items from the original English version were modified or removed in the Spanish version to ensure cultural relevance and maintain the scale's reliability and validity within Spanish-speaking populations (Oronoz et al., 2007). Both versions include positive statements (e.g., emotional benefits, personal development) and negative perceptions of parenting (e.g., demands on resources, feelings of stress). Respondents rate how much they agree or disagree with each statement. Items are scored and then summed. The English version total scores range from 18 to 90 with higher scores indicating higher levels of parental stress. Scores for the Spanish version range from 12 to 60. Chronbach's α was .79 and .86 for the English and Spanish versions, respectively, indicating generally stable and consistent results. In this study, caregivers completed the PSS at enrollment and postintervention, and it was used to measure improvement in parenting stress. The PSS has been demonstrated to be valid and reliable in Spanish (Oronoz et al., 2007) and English (Abidin, 2012).

Adult and Adolescent Parenting Inventory, Second Edition. The Adult and Adolescent Parenting Inventory, second edition (AAPI-2) is a 40-item inventory of parenting attitudes for adult and adolescent caregivers (Bavolek & Keene, 2010). It is available in English and Spanish and can be used to assess pre- and postintervention effectiveness and identify caregiver strengths and weaknesses. Total, raw, and standard tens (sten) scores, derived from raw scores and divided into 10 standard units each representing a standardized point on a scale of 1–10, are provided across these subscales: *Expectations of Children* (measures unrealistic expectations regarding children's developmental abilities), *Parental Empathy Toward Children's Needs* (assesses the caregivers ability to empathize and respond to their children's emotional needs), *Use of Corporal Punishment* (evaluates the extent to which parents support the use of physical discipline), *Parent–Child Family Roles* (identifies parents who expect children to fulfill their emotional needs), and *Children's Power and Independence* (measures the degree to which parents attempt to control and limit their child's independence; Bavolek & Keene, 2010). Scores on each of the five subscales have been shown to discriminate between caregivers who are abusive or neglectful and those who are believed to be nonabusive or nonneglectful, with higher scores indicating more appropriate parenting and child rearing practices (Bavolek & Keene, 2010). Analyses presented for the present study only include raw and total scores. Chronbach's α was .80 and .84 for the pre- and postintervention assessments, respectively, indicating good internal consistency. IYTB participants completed the AAPI-2 at enrollment and postintervention.

Program Fidelity

Fidelity Checklists. Quarterly fidelity observations were conducted by doctoral-level programmatic supervisors using a curriculum-specific fidelity checklist. Following each observation, facilitators received immediate feedback, and any identified concerns were addressed to ensure full adherence to curriculum standards. Group facilitators also completed the fidelity checklists as a self-evaluation following each session, reinforcing a comprehensive approach to maintaining fidelity during all sessions.

Program Delivery Effectiveness

Intervention Implementation. Implementation was defined as the degree to which an intervention can be successfully delivered to the intended participants by measuring rates of intervention and assessment completion and session attendance (Carroll et al., 2007).

Analytic Plan

To assess retention, attendance logs and sign-in sheets were used to determine which participants met the evidence-based practice (EBP) retention requirements (i.e., attending 10 of 12 sessions). When examining pre- and postintervention improvement only those who completed both the pre- and postassessments and attended the minimum number of weekly sessions (i.e., 10) were included (n = 262). Only completers were included in the analyses because the focus of the present study was to better understand the implementation of the IYTB parenting program within community-based settings. Descriptive and chi-square analyses were conducted to measure family engagement and retention. Paired t tests were used to compare pre- and posttest scores on the PSS and AAPI-2. Chi-square tests were used to evaluate relationships between change in pre- and postassessment scores, participant demographics, and

session factors such as attendance. Results were deemed significant at $p < .05$.

Transparency and Openness

We reported how we determined our sample size, all data exclusions, all manipulations, and all measures in the study, and we followed JARS. All data, analysis code, and research materials are available in the data repository at https://miami.app.box.com/s/rdjizm3l3cpevcj752lajyqs18o3ulc9.

All statistical analyses were completed using Statistical Analytic Software (SAS Institute, Inc., 2008). This study's design and its analysis were not preregistered.

Results

Access to Intervention

Access to IYTB program services was robust, with high retention rates among enrolled participants. Three hundred one caregivers completed the preintervention assessment and attended at least one session. When evaluating differences between those who completed the program versus those who did not, completers were more likely to be White, married, have higher education, and be older in age (31 or above). For more demographic details regarding enrolled families and families that met curriculum completion requirements see Table 1.

Intervention Engagement and Retention

Participant engagement and retention rates exceeded typical rates for community-based interventions (Joo & Liu, 2021, p. 20; Smokowski et al., 2018; Kapke & Gerdes, 2016). Out of the 301 caregivers who completed the preintervention assessment, 262 (87.0%) met the EBP attendance requirement of 10 or more sessions.

Family Level Outcomes

Parental Stress

The PSS forms in English and Spanish were analyzed separately. Table 3 presents the means and standard deviations of pre- and postintervention scores for families who completed the IYTB program. Paired *t* tests comparing pre- and postintervention scores revealed significantly lower caregiver-reported parenting stress at postintervention compared to preintervention for participants who completed the PSS in English, $t(189) = 8.8$, $p < .0001$, as well as for participants who completed the PSS in Spanish, $t(63) = 6.1$, $p < .0001$.

Parenting Attitudes

Participating families ($N = 262$) reported significant improvements in their total raw scores, $t(261) = 16.6$, $p < .0001$, and on each subscale of the AAPI-2. Families reported significantly higher scores at postintervention compared to preintervention on the *Expectations of Children* subscale, $t(261) = 13.2$, $p < .0001$, indicating more appropriate expectations following the intervention. Higher scores were also evidenced at postintervention for the *Parental Empathy Toward Children's Needs* subscale indicating increased empathy for their children, $t(261) = 11.8$, $p < .0001$. Scores on the *Use of Corporal Punishment* subscale were significantly higher at postintervention as well, $t(261) = 12.7$, $p < .0001$, indicating decreased use of corporal punishment and greater use of alternative discipline strategies for both groups. Significantly higher scores were also found at postintervention for the *Parent–Child Family Roles*, $t(261) = 13.2$, $p < .0001$, and the *Children's Power and Independence* subscales, $t(261) = 9.1$, $p < .0001$. Higher scores at postintervention for these scales indicate that caregivers maintained appropriate roles for themselves and their children and encouraged their children to make independent decisions with support, respectively (see Table 3).

Discussion

Despite growing recognition of the benefits of early parenting interventions for young children and their families, high-quality, affordable parenting programs are not readily accessible in many communities, especially those serving at-risk and diverse populations (Smokowski et al., 2018). This study described the implementation and outcomes of the IYTB parenting program for primarily Latinx caregivers with at-risk children ages 1–3 using a framework that addresses structural, attitudinal, and interpersonal barriers. Results

Table 3
Caregiver Pre- and Postintervention Scores for Incredible Years Toddler

Measure	Pretest *M* (*SD*)	Posttest *M* (*SD*)	Difference (*SD*)	*t*	*df*	*p*
Parental Stress Scale						
English form ($n = 190$)	35.1 (8.6)	30.8 (7.5)	4.3 (6.7)	$t = 8.8$	189	<.0001
Spanish form ($n = 64$)	23.9 (8.0)	20.2 (6.0)	3.7 (4.9)	$t = 6.1$	63	<.0001
AAPI ($N = 262$)						
A: Expectations of children	22.4 (5.6)	26.9 (5.7)	4.5 (5.5)	13.2	261	<.000
B: Parental empathy toward children's needs	40.3 (5.8)	44.1 (4.8)	3.8 (5.2)	11.8	261	<.0001
C: Use of corporal punishment	42.6 (6.8)	47.4 (6.1)	4.8 (6.1)	12.7	261	<.0001
D: Parent–child family roles	26.9 (5.1)	30.6 (4.4)	3.7 (4.5)	13.2	261	<.0001
E: Children's power and independence	21.0 (2.5)	22.4 (2.3)	1.4 (2.4)	9.1	261	<.0001
Total raw	153 (19.9)	171 (18.9)	18 (17.7)	16.6	261	<.0001

Note. AAPI = Adult and Adolescent Parenting Inventory.

suggested this study may serve as a model for programs seeking to implement community-based parenting groups with predominantly Latinx families, with retention rates (87%) surpassing those documented in the literature (e.g., 30%–75%; Joo & Liu, 2021; Kapke & Gerdes, 2016). Findings indicated the IYTB parenting program was feasible to implement, and recruitment and retention strategies were effective in addressing barriers commonly cited in the literature (Holtrop et al., 2023; Rostad et al., 2018; Smokowski et al., 2018). Staff employed a variety of strategies, drawing from existing studies and incorporating innovative approaches that specifically targeted barriers, resulting in increased rates of enrollment, engagement, and retention. This discussion explores the implications of our findings, focusing on how the use of the structural, attitudinal, and interpersonal framework contributed to the program's effectiveness and outcomes.

Scientific literature highlights the importance of working closely with the community and families during all stages of program development and implementation to retain participants in services and have successful outcomes (Nguyen et al., 2021). Within the present study, structural barriers were effectively addressed through strategic planning, community collaboration, and family-centered approaches. By providing free and culturally responsive sessions in the family's preferred language, at varied times to accommodate caregiver needs, the program demonstrated a commitment to inclusivity. Efforts such as asking families their preferred group schedule, offering transportation and childcare assistance, and integrating culturally appropriate materials may have further reduced participation challenges.

Retention strategies were equally robust. Personalized phone calls for session reminders and immediate follow-ups for absences supported ongoing engagement. These efforts, combined with fellowship opportunities (including ongoing out-of-session contact with other group members), snacks or meals, and problem-solving individual barriers likely contributed to high retention rates and participant satisfaction. The program's approach to recruitment and retention aligned with best practices to promote attitudinal engagement.

In addition, consistent with recommendations in the literature (Rostad et al., 2018; Smokowski et al., 2018), interpersonal barriers were addressed by intentionally promoting group cohesion, cultural responsiveness, and honest communication. For example, facilitators encouraged families to share personal successes and challenges, which likely fostered a sense of belonging and mutual support by highlighting shared experiences. Cultural sensitivity and inclusivity were also emphasized throughout the sessions' content and discussion, helping caregivers feel validated and understood, as recommended by previous research (Joo & Liu, 2021). Furthermore, gathering participant feedback and caregiver-generated real-life examples enriched discussions and activities, further contributing to group engagement and cohesion. Notably, several families reported developing lasting friendships with other group caregivers, reflecting the strong connections built during the program.

Findings not only demonstrated high retention rates, exceeding those of most community-based parenting interventions (Smokowski et al., 2018), but also significant gains in positive parenting practices and reductions in parental stress. These improvements directly enhance the quality of life for both caregivers and children. Caregivers who gained knowledge of child development and adopted more appropriate parenting practices, as evidenced by improved AAPI-2 scores, may be better equipped to foster healthier and more secure relationships with their children. Strengthened caregiver–child relationships are known to lead to stronger attachment, improved emotional regulation in children, and long-term developmental benefits (Arruabarrena et al., 2022; Jeong et al., 2021). Moreover, reductions in parental stress have profound implications for families too. Specifically, lower stress levels related to parenting may have enhanced caregivers' ability to respond calmly and positively to their children, reducing the likelihood of negative interactions and creating a more nurturing home environment. Such changes also contribute to a family environment that fosters children's development, behavioral, emotional well-being, and resilience with the goal of deterring psychopathology later in life.

Limitations and Future Directions

Study findings should be interpreted in the context of certain limitations. While significant improvements in parental stress and attitudes were observed, the lack of a control group prevents causal inferences. Future studies should utilize randomized-controlled or quasi-experimental designs. It may also be beneficial for outcome measures to include behavioral observations of parent–child interactions and measures of child social and behavioral adaptation.

In addition, we only included treatment completers in analyses as our focus was to discuss the implementation of IYTB in community-based settings. Despite this, completers differed from noncompleters on various variables, potentially skewing our findings. Specifically, our analyses revealed that program completers were more likely to be White, married, older (age 31+), and more highly educated. These demographic differences suggest some barriers may not have been fully mitigated by the strategies implemented, particularly as it relates to effectively retaining families with the greatest risk and need. This limits the generalizability of findings and underscores the need for more targeted retention strategies among families facing greater adversity. Future research could pair the retention and engagement strategies in this study with other evidence-based methods (e.g., the recruitment of paraprofessional natural helpers from the communities which has been demonstrated to recruit and retain non-White, younger families of diverse structures at higher rates into parenting programs; Garcia et al., 2023). In addition, conducting long-term follow-ups would help determine whether improved family level outcomes translate to sustained child behavioral changes and improved family dynamics over time. Further, future research should collect data on utilization rates of support services (e.g., childcare, transportation) to determine the role they play in fostering retention and engagement.

While this study relied on self-reported data, systematic reviews have demonstrated that parenting interventions delivered during the first 3 years of life improve parenting knowledge, practices, and parent–child interactions (Jeong et al., 2021). These findings also align with the Families First Prevention Services Act (U.S. Congress, 2018), which underscores the importance of investing in preventive, community-based parenting interventions that support family stability and child well-being. This study also highlights how to reduce challenges when serving marginalized populations. High retention rates may reflect both the program's efforts to address barriers and its services in neighborhoods with primarily Latinx families. Future research should explore the program's scalability in other ethnically diverse or underserved populations.

Conclusions

From a public health perspective, the program's success with a primarily Latinx population, emphasizes the critical role of accessible, culturally responsive, evidence-based parenting programs to reduce health disparities. Retrospectively, key lessons learned about cost-effective program implementation include leveraging existing community resources and partnerships to reduce barriers and recruiting bilingual staff to diversify the workforce. Providing access to culturally adapted materials and offering flexible, group-based sessions in trusted community spaces also helped lower costs while maintaining accessibility. By strengthening family relationships, reducing parental stress, and promoting positive parenting, these interventions contribute to healthier communities and reduced societal costs associated with behavioral and emotional problems. To sustain and expand such efforts, it is imperative to influence policy, secure state and federal funding streams, and continue evaluating program impact through research. This study serves as a model for leveraging community partnerships and tailored programming to advance public health and support at-risk and diverse families.

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