Advances in School Mental Health Promotion
Vol. 5, No. 3, July 2012, 194–207

Embedding the Family Check-Up and evidence-based parenting programmes in Head Start to increase parent engagement and reduce conduct problems in young children

Stephanie Shepard[a,b]*, Laura Marie Armstrong[a,b], Rebecca B. Silver[a,b], Rebecca Berger[b] and Ronald Seifer[a,b]

[a]*The Warren Alpert Medical School of Brown University, Providence, USA*
[b]*Bradley/Hasbro Children's Research Center, Providence, USA*

Parent engagement (i.e. enrolment, ongoing attendance, participation quality) remains a major obstacle to fully realizing the benefits of evidence-based preventive parent management training in community settings. We describe an approach to parent engagement that addresses the myriad motivational, cognitive and pragmatic barriers parents face by embedding services in Head Start and applying a parent engagement model, the Family Check-Up, as a pre-intervention to augment parent training. In this article, we present the rationale for applying FCU to advance parent readiness for engagement and describe the process by which we partnered with the community to modify FCU to be most impactful for enhancing parent engagement in one specific programme, the Incredible Years Parenting Series. We conclude with preliminary data from our ongoing pilot trial that support our approach.

Keywords: parent engagement; parent management training; school-based prevention; early childhood

Adverse developmental outcomes such as conduct problems, substance use and academic failure are related to a cascade of events and factors with roots in the early lives of children. Prevention and early intervention services targeting parents as the agents of change are effective in breaking this negative spiral, and accumulating evidence indicates that these programmes lead to substantial reductions in costs associated with youth violence, delinquency and substance use (Aos et al., 2011). There has been a proliferation of empirically supported, skill-based behavioural parent management training (PMT) programmes that decrease conduct problems in young children, and disseminating PMT in groups in community contexts like schools is one cost-effective approach with potential to serve large numbers of families (see Kazdin, 2005; Webster-Stratton, 1998). However, real-world applications typically yield smaller effect sizes relative to well-controlled efficacy trials (Domitrovich & Greenberg, 2000; Durlak & DuPre, 2008), and are far less successful with respect to parent engagement. Typically only a small percentage of parents enrol, and few are exposed to sufficient dosage due to inconsistent attendance, poor programme compliance and premature dropout (e.g. Baker, Arnold, & Meagher, 2011). Substantial time and resources are wasted supporting poorly attended groups, diminishing the promise of this approach.

*Corresponding author. Email: stephanie_shepard@brown.edu

ISSN 1754-730X print/ISSN 2049-8535 online

http://dx.doi.org/10.1080/1754730X.2012.707432
http://www.tandfonline.com

Parent engagement (i.e. enrolment, ongoing attendance, participation quality) remains a major obstacle to fully realizing PMT benefits, especially as programmes are disseminated in community contexts and offered on a preventive basis. Devoting serious attention to identifying strategies that promote enrolment and ongoing, quality participation is critical to increasing the effectiveness of preventive parenting services, particularly among low-income, high-risk families. Participation barriers are disproportionately present in these families, impeding the participation of families most in need of services. Programmes therefore invest significant resources in providing transportation, childcare and meals as well as providing extrinsic rewards (e.g. gifts, money, discounting childcare costs) to support high-risk families. These attempts typically result in minimal gains in enrolment or sustained participation (Dumas, Begle, French, & Pearl, 2010; Stormshak, Kaminski, & Goodman, 2002), arguably because they do not address the full range of barriers families face. Individuals often experience motivational and cognitive barriers to participating in mental health services (Miller & Rollnick, 2002; Nock & Ferriter, 2005), barriers that may be especially heightened when parents are recruited to participate on a preventive basis.

Our approach to parent engagement addresses motivational, cognitive and pragmatic barriers parents face in three ways. First, it embedded PMT within a familiar and trusted service delivery system, Head Start (HS). Second, it engaged HS programmes and families in all stages of a research project to identify the problem (i.e factors that account for engagement) and the solution (i.e. implementation planning, delivery and evaluation). Third, it applied a parent engagement model, the Family Check-Up (FCU; Dishion & Stormshak, 2007), to augment PMT. In this article, we present the rationale for the FCU and describe how we partnered with the community to modify FCU to be most impactful for enhancing parent engagement in one specific PMT programme, the Incredible Years (IY) Parenting Series (Webster-Stratton, 2011). Finally, we present preliminary data from our ongoing pilot trial that supports our approach.

Embedding evidence-based preventive parenting interventions in Head Start

Early educational settings such as HS are ideal for proactive identification and recruitment of families who would benefit from preventive family-centred programmes. Family support, parent involvement and home visiting are integral to the HS mission and are required by HS performance standards. Yet, HS capacity to promote parent engagement and family wellness has not been realized. HS family service providers often are ill-equipped to support the significant needs of families they serve, and delivery of evidence-based parent education is rare (Yoshikawa, & Zigler, 2000). Embedding staff training and evidence-based approaches such as FCU and PMT would allow HS to be most effective with their resources for meeting their mission and maximizing benefits for families. In turn, offering these services in HS would leverage the feelings of safety and community they foster to increase parent access to, and reduce stigma associated with, these programmes. Promoting positive experiences in HS may also set the stage for long-term parent engagement in children's school and mental health services.

Embedding services in HS also allows access to large numbers of families at high risk for maladaptive parenting practices and child conduct problems due to the presence of multiple risk factors associated with poverty. By definition, virtually all children in HS are 'at risk' due to their poverty status. Up to 48% of children in HS have elevated behaviour problems, many with externalizing behaviour problems in the clinical range (Webster-Stratton & Hammond, 1998). This population also shows high rates of harsh, critical and inconsistent

parenting, and low levels of parental warmth. Compared with the general population, parents in HS report higher rates of risk factors known to compromise parenting, including parental psychopathology, low educational attainment, single-parent status, history of substance abuse and/or criminal activity, minimal social support, stressful life events and depression. Approximately 35% of families in HS have three or more major risk factors (Webster-Stratton & Hammond, 1998).

Early identification and recruitment can be facilitated by capitalizing on HS mandates for conducting initial screening and ongoing assessment. Parents can therefore be recruited proactively when children are young, concerns are relatively small and family patterns are more amenable to change. Engaging parents early increases likelihood of parents experiencing success in the use of positive strategies that can substantially alter their children's trajectory. In addition, HS entry often represents children's initiation into organized service structures and first formal opportunity for socialization outside the home. These new demands can exacerbate child adjustment problems and family stress, and parents may begin receiving negative feedback from professionals. HS enrolment therefore is a major developmental transition that can serve as a cue to action for families.

The Bradley/Hasbro Children's Research Center (BCRC) has longstanding research and practice partnerships with two local HS programmes. Our child clinical psychologists have provided mental health consultation in HS to expand access to quality mental health services for children and families for over 15 years. Over time, HS has become keenly aware of their need to adopt evidence-based programmes to build parenting competences and to use systematic approaches to addressing historically poor parent engagement. We describe our collaborative approach to addressing these needs, guided by community-based participatory principles (e.g. Franco et al., 2007; Israel, Schulz, Parker, & Becker, 1998) and the emerging implementation science literature (e.g. Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Rohrbach et al., 2006).

The Incredible Years Parenting Series

Both HS programmes chose IY because of the strong evidence supporting the effectiveness of this group-based PMT in similar populations. When offered in HS and other applied settings for families with children exhibiting early onset behavioural problems or as a selective prevention programme for low-income, high-risk families, IY participation is associated with improvements in parent–child interactions, increases in use of positive behaviour management skills, reductions in use of harsh parenting strategies and reductions in parenting stress (Brotman et al., 2008; Gardner, Burton, & Klimes, 2006; Webster-Stratton, 1998). Programme details are described in numerous other publications (e.g. Webster-Stratton, 2011) and are therefore not elaborated here.

Implementation planning

The HS programmes were eager to offer IY in a way that: (1) optimized parent engagement; (2) could be implemented with fidelity; and (3) was maximally sustainable within their particular setting. Collaborative Working Groups (CWGs) were established to attend to the complexity of the implementation process to accomplish these goals (Fixsen et al., 2005). CWGs coordinated all activities associated with a 5-year research project to embed and evaluate parent engagement and IY services. Our approach was based on our awareness that attending to and enhancing organizational capacities, as they relate to the programmes being implemented, can increase likelihood that the setting will be successful in their implementation and sustainability efforts (Fixsen et al., 2005).

CWGs involved HS directors, family involvement coordinators and other family support staff, mental health services managers, and education managers, as well the BCRC project principal investigator (first author). Regular meetings were held to provide project oversight, to maximize enthusiasm and commitment, and to align all aspects of the project with HS standards and practices and with family needs and values. The groups also executed plans to build agency and staff capacity to adopt and support service delivery by: (1) building infrastructure including material and space resources; (2) identifying key support staff; (3) selecting HS staff to facilitate IY groups; (4) devising a plan for HS staff training and consultation on IY recruitment and delivery; and (5) initiating sustainability planning to build HS capacity to support independent IY delivery long term. Finally, CWGs provided input into the research questions and methods, and formative feedback loops were established so HS programmes would benefit from findings about ways to improve parent engagement as they became available.

Another primary mission of the CWGs was to facilitate parent engagement. Historically, parent engagement concerns lead community settings to change the delivery format, re-sequence content and/or reduce programme dosage. This is problematic to the extent that core programme components are compromised and effects are diluted (Fixsen et al., 2005). In the absence of research demonstrating comparable outcomes for these adaptations, we argued for increased attention to engaging parents in the proven programme, with core components and dosage intact, to be assured of measurable gains once parents do engage (Fixsen et al., 2005).

Towards this end, we followed standard IY engagement recommendations including offering groups at no-cost and providing child care, transportation and family meals (Webster-Stratton, 2011). Because involving familiar and trusted agency staff in service delivery enhances positive programme perceptions (Calzada et al., 2005), HS staff co-facilitated IY groups. They received IY training and ongoing consultation from a certified IY mentor, and each co-facilitated her first group series with an experienced IY-trained BCRC clinician. Finally, home visits were conducted prior to the first IY session with the explicit goal of enhancing parent engagement. We applied the FCU model as an empirically supported framework to guide these preparatory visits.

Augmenting IY to enhance parent engagement

Rationale

Most recruitment and intervention strategies are designed assuming that the target population is ready and able to take action and equally motivated to acquire new behaviours (Prochaska, DiClemente, & Norcross, 1992). However, many low-income, highly stressed families targeted for PMT may not be not ready for their skill-based, behavioural strategies and high demands. Low enrolment and high dropout rates may persist due to a mismatch between parents and typical PMT strategies (DiClemente & Velasquez, 2002; Nock & Ferriter, 2005). Lack of attention to individual differences in parents' readiness for engagement and other associated parental beliefs is believed to be a major impediment to engaging families.

Family-focused applications of Motivational Interviewing (MI) have been developed as treatment supplements to address these oversights, advancing parents' readiness to initiate and comply with child or family treatment (e.g. Nock & Kazdin, 2005). MI promotes engagement in health-promoting behaviours and encourages initiation and compliance with services by building individuals' intrinsic motivation to change and by heightening awareness of clients' internal resources to be change agents (DiClemente &

Velasquez, 2002). This client-centred, non-confrontational approach to exploring ambivalence about taking action for change is respectful of client's autonomy, making it an especially good fit for high-risk families who may hold negative expectations about services and their capacity for change (Miller & Rollnick, 2002; Nock & Kazdin, 2001). MI therefore holds great promise for addressing motivations and beliefs that may promote or hinder parent engagement in preventive PMT like IY.

The Family Check Up

FCU is an innovative approach that uses MI techniques to engender parents' motivation to change maladaptive practices and to target family risk and protective factors (Dishion & Stormshak, 2007). Core FCU components are child and family assessment, data-based feedback and goal-setting (Dishion & Stormshak, 2007). Tailored feedback is provided to emphasize individual family strengths, areas of growth and parenting values (Dishion & Stormshak, 2007). Designed as a brief intervention (two or three home visits) to enhance motivation to take action, it may be especially appealing to busy or high-risk families who face a number of competing demands that undermine parent engagement. Attrition from FCU is low, and families at highest risk are most likely to participate and benefit (Shaw, Dishion, Supplee, Gardner & Arnds, 2006; Stormshak et al., 2009). FCU has been found to reduce parent depression, change parents' beliefs about their child's behaviour, improve parent involvement and increase follow-through on referral recommendations (Shaw et al., 2006; Shaw, Connell, Dishion, Wilson, & Gardner, 2009).

The FCU framework also is well-suited for HS given its current infrastructure and practices, capitalizing on HS performance standards requiring regular home visiting and data collection for screening and ongoing assessment purposes. Embedding this evidence-based approach to assessment, feedback and family support has great potential for enhancing the quality of HS services. Its brief format also makes it ideal to precede and prepare parents for skills-based behavioural PMT groups.

The original FCU model is described in detail in numerous other publications (see Dishion & Stormshak, 2007). Here, we focus on a modification of FCU to explicitly assess and target parent readiness to engage in IY during the preschool years. First, we outline our research approach for determining underlying beliefs that predict parent engagement to identify FCU targets. Second, we describe how we modified FCU based on our findings. Third, we describe how we aligned FCU assessment and feedback with IY goals to specifically build parent engagement in IY.

Identifying FCU targets for an engagement-enhancing pre-intervention

Several theoretical models (e.g. Transtheoretical Model [TTM], Health Beliefs Model [HBM]) and emerging research suggest that parental beliefs, attitudes and motivations contribute to whether parents are ready for PMT (Prochaska et al., 1992; Rosenstock, 1990; Spoth & Redmond, 1995). However, few studies have examined specific parental beliefs among high-risk families targeted for preventive parenting programmes during preschool years. We conducted focus groups with HS parents who attended a PMT group or other parenting workshops ('attenders') and groups of 'non-attenders' to explore the relevance of specific beliefs in this population (Berger & Shepard, 2011). Here, we review the beliefs derived from TTM and HBM and provide illustrative quotes from focus groups.

Theory and research on parent engagement suggest that parents' inclination or readiness to engage is partially determined by their perceived need to take action (Bloomquist et al., 2009). Perceived need may involve current child concerns or concern

about vulnerability to future problems. Perceived need is likely to be low among parents recruited for preventive PMT, particularly when children are young (*'You don't want to think about the future when they are 4 . . . you don't want to think about what they are going to be like when they are 14')*. Without concerns (e.g. *'That's just what children do at that age [i.e. Fighting, biting]. Kids are kids'*), parents will be less inclined to participate because they do not see the relevance of taking action (Redmond, Spoth, Shin, & Hill, 2004).

Perceived need also involves perceptions about parents' own knowledge, skills and/or confidence in parenting. According to a 'non-attender', *'Parents don't want to admit that something is wrong or that they need help'*. In contrast, an 'attender' reported '*I didn't know what to do . . . My mom, my friends – they give me advice I don't want, like telling me to hit him with a stick or broom across the legs.'*

Realizing programme relevance also depends upon an awareness of circumstances that put the child at risk (Redmond et al., 2004), and parents' beliefs about their role in promoting strengths and protecting against those risks (i.e. parental influence). This includes the extent to which parents make connections between family functioning, parenting behaviours and child adjustment. Parents who underestimate their influence because they think their child will 'grow out of' the behaviour or do not see it as within their capacity to change are difficult to engage in services that require their involvement as change agents (Miller & Prinz, 2003). Low-income, highly stressed parents in particular often report feeling demoralized and helpless to positively influence their child's future (Lengua et al., 1992). 'Non-attending' parents told us '*Kids can do whatever they want nowadays. As parents, we have no control or ability to be a positive influence'* and *'We don't have control over what they can do, what they are capable of*'. In contrast, parents who perceive themselves as influential to their child's adjustment are more likely to enrol in family-based services to enhance parenting skills (Telleen, 1990).

Awareness of risk factors within the family context and feelings of low parenting efficacy may at once help parents appreciate the need for PMT and diminish their ability to initiate action (Telleen, 1990). Regardless of positive perceptions of programme relevance and benefits, families face many additional barriers that undermine parent engagement (Spoth & Redmond, 1995). For example, negative expectations about services and service providers and low expectations for improvement (see McKay et al., 2004; Nock & Kazdin, 2001). Expecations of 'non-attenders' included *'[They] look at you like you created the problem. A lot of people will blame you'* and *'I wouldn't go to a counselor. My daughter was in counseling for 2 years and it wasn't any help. The lady didn't have children. She tried to give me advice and it didn't work so I just took her out'*. Expectations regarding attitudes of important others also may hinder participation (Thornton & Calam, 2010), such as *'I did have some problems with my mom and his dad for coming to the group. They wanted to know why I was going . . . They were like 'our kid isn't crazy'. Where I come from you only do that stuff if your kid is crazy'*.

Parents' insights had important implications for recruiting and engaging parents. Their feedback informed developing everything from IY recruitment materials and initial contacts with parents to the wording of parental belief measures developed (see below). To the extent that these parents' beliefs account for parents' readiness to participate and engage, they also offer intervention targets preparatory to PMT. Indeed, when parents view content and goals as relevant for meeting their needs, are motivated to take action, and have positive expectations for success, they may be more likely to overcome pragmatic barriers to attendance and to engage (McKay et al., 2004; Nock & Ferriter, 2005). This suggests that rather than investing resources to resolve pragmatic barriers

(e.g. providing childcare, transportation), strategies that target parent beliefs about their child, family circumstances, their role as parents and their expectations about services may be a more cost-effective, empowering approach to engaging parents.

Next, we investigated which beliefs predicted parent attendance to identify FCU targets and to inform our FCU modification. We prospectively collected self-reports of parental beliefs from a unique set of 127 parents from the two HS programmes. Over the year, we tracked parent attendance at parent education activities (i.e. monthly workshops on specific parenting topics and, when available, PMT groups).

Parents completed measures of perceptions of *child risk for future conduct problems* (e.g. school failure, deviant peer associations, delinquency), *confidence about parenting* (e.g. 'I feel good about my ability to set limits with my child and follow through'), *knowledge* about how to respond to specific parenting situations (e.g. 'I know what to do when my child acts up'), and *parental influence* (i.e. attributing child behaviours to parenting choices vs. dispositional characteristics or context). They endorsed anticipated participation *barriers* (i.e. competing demands, negative beliefs about services), *benefits* (i.e. learning strategies for addressing specific parenting challenges and personal benefits like getting a break from the child) and *intentions* (e.g. 'Attending will be a top priority'). Finally, they completed two Stages of Change ladders, one to reflect *readiness to change parenting behaviors* (e.g '*I haven't thought much about my parenting' to 'I am ready to learn new parenting techniques*') and one to reflect *readiness to engage* in parent education programmes at HS (e.g. '*I haven't thought much about going to parenting workshops' to 'I am ready to go to parenting workshops*').

Results supported the predictive value of these beliefs and underscored their importance as parent engagement targets (full study details and results are reported in Shepard, Armstrong, Seifer, & Berger, 2012). Compared to 'non-attenders', parents who attended were significantly more likely to perceive their child to be at risk for future problems [$t(122) = -2.72$, $p < 0.01$], less likely to attribute child behaviours to contextual factors [$t(33.28) = 2.85$, $p < 0.01$], and less likely to know what to do in response to parenting challenges [$t(19.90) = 2.24$, $p < 0.05$]. Parents who attended saw more benefits [$t(55.96) = -5.14$, $p < 0.001$] and fewer barriers to participation (competing demands [$t(111.02) = 6.00$, $p < 0.001$] and negative service beliefs [$t(75.53) = 4.29$, $p < 0.001$]). Finally, parents who attended reported stronger intention to participate [$t(122) = -3.54$, $p < 0.01$] and were further go along with respect to readiness to change parenting behaviours [$t(122) = -2.93$, $p < 0.01$] and engage in parent education programmes [$t(122) = -6.00$, $p < 0.001$].

A logistic regression was used to test whether parent attendance could be predicted from these parental beliefs to identify their unique and cumulative predictive value. The model was significant, $X^2(10, N = 127) = 55.42$, $p < 0.001$, and the Nagelkerke pseudo-R^2 was 0.64. Predictors that distinguished attending and non-attending parents were perceived parenting knowledge, barriers related to competing demands, and readiness to engage in parent education programmes. These findings are an important piece of a larger integrative model of parent engagement under investigation (Shepard et al., 2012), and they validate targets for modifying the FCU as an engagement-enhancing pre-intervention.

FCU modifications

We used findings as the basis for modifying FCU to have a stronger focus on assessing and addressing relevant parental beliefs and motivations. For current purposes, we also

collapsed FCU into 2 home visits. During the first visit, we collect self-reports of the parental beliefs described above and also conduct a standard FCU family assessment. The second visit is a feedback session conducted by an Early Childhood Parent Consultant. It culminates in establishing individualized goals and developing an action plan that incorporates strategies for overcoming identified barriers. Each session is described in detail below.

Assessment phase

The multilevel assessment involves collecting standardized data from multiple informants (i.e. parent and teacher reports, objective ratings) about family context, parenting practices and child functioning. Constructs selected for the family assessment were based on developmental knowledge of risk and protective factors associated with early child problem behaviours (see Table 1). Dimensions also were selected to align with IY goals and targets.

In addition to collecting questionnaire data, parent–child interactions are videotaped during challenging tasks and free play. The parent consultant makes global ratings of parent, child, and dyadic behaviours from videotapes and uses ratings in conjunction with questionnaire data to develop a family conceptualization to guide the FCU feedback phase. Portions of the interaction are selected for viewing during the feedback. This standard FCU approach is supported by research demonstrating that providing feedback on current child and family functioning, and aligning results to the benefits of participating in services, improves enrollment and compliance with treatment recommendations (Sanders & Lawton, 1993).

In addition to these standard FCU assessment procedures (Dishion & Stormshak, 2007), we collect measures of parent readiness to engage and key parental beliefs and attitudes. We also ask parents to report on pragmatic issues that could serve as barriers to participation (see Table 1). Parent baseline readiness and underlying parental beliefs are

Table 1. Assessment phase: parental beliefs and family assessment measures.

Constructs	Parent report	Teacher report	Observer rating
FCU targets: parental beliefs			
Child risk perception	X		
Parenting confidence and knowledge	X		
Parental influence	X		
Barriers to participation	X		
Benefits of participating	X		
Intention to participate	X		
Readiness to change parenting behaviours	X		
Readiness to engage in parent programmes	X		
Family assessment measures			
Home environment			X
Coping with family stress	X		
Parent depression	X		
Parenting stress	X		
Social supports	X		
Inter-parental conflict	X		X
Parent–child relationship	X		X
Family management	X		X
Child adjustment	X	X	X

the targets of FCU feedback. Parent consultants individualize feedback using parent reports to select specific MI strategies that address beliefs that are serving as barriers to engagement and promote beliefs that are known to facilitate enrollment.

Feedback session and action planning

Parents meet with the parent consultant for feedback during a second home visit. Sessions are designed to build parent motivation to address current child or family concerns and/or to encourage parents to take actions to prevent future problems. Feedback is delivered using MI techniques in order to address beliefs and attitudes that appear to be maintaining established practices and preventing change. The basic premise is that parents' perceptions of programme relevance and motivation to overcome barriers can be advanced by helping parents (a) develop accurate appraisals of current functioning and vulnerability to future problems (b) appreciate their potential for supporting a positive developmental trajectory, (c) improve perceptions of services, and (d) build confidence in their ability to carry out plans and effect change (Table 2).

Sessions begin with a 'Get to Know You' period to elicit parents' hopes and dreams for the child and current concerns. Parent consultants then provide personalized feedback to help parents consider child and family functioning relative to desired states and risks for future problems. For parents with low-risk perceptions, this includes comparing current functioning to norms, highlighting discrepancies between parents and teachers and/or

Table 2. Integrated parent engagement and preventive parenting programmes in Head Start.

Source	Goal	Components
	Session 1	
Family Check-Up (Dishion & Stormshak, 2007)	Family assessment	Parent and teacher reports Videotaped interactions
	Parental beliefs assessment	Parent reports
	Session 2	
Family Check-Up (Dishion & Stormshak, 2007)	Personalized feedback	'Get to Know You' interview Individualized feedback Tailored to parent beliefs Motivational Interviewing
	Goal setting	Family Profile Goal setting Menu of options Linking goals to IY
Participation Enhancement Intervention (Nock & Kazdin, 2005)	Participation enhancement	Barrier identification Problem solving
	Sessions 3–16	
The Incredible Years (Webster-Stratton, 2011)	Barrier reduction	Childcare, transportation, meals Held at HS Co-facilitated by HS
	Skill development	Individualized goal setting and monitoring Video modelling Active practice and feedback
	Social support	Group process Buddy calls

building awareness of the impact of family circumstances on the child's developmental trajectory. Or, forecasting the future if no action is taken (e.g. '*If Taylor continues to be out of control and to defy rules, what might happen at school? What will her teenage years be like?'*). Among parents with low perceived parenting knowledge and/or confidence, reflective listening could elicit change talk (e.g. *'You feel bad when you yell, but you're at the end of your rope and don't know what else to do'*). Parent consultants also could facilitate positive imagery in parents who see few benefits (e.g. *'what would it be like for you if Sara could sleep through the night in her own bed?'*). Parent consultants show positive videoclips to build parent confidence, elicit positive affect about the child, and help parents realize their potential as positive influences for their child's development (Sanders & Lawton, 1993).

Goal setting is facilitated by completing a 'Family Profile', which involves parent self-assessment in response to feedback. Parents rate each domain as a strength to maintain, a moderate concern that needs improvement, or a serious concern needing immediate attention. The Family Profile is used to help parents establish change goals that are tied to their values and perceived need to take action.

Visits end by planning next steps to address change goals. Parents select from a menu of options that includes, for example, consulting with their HS family worker, initiating or maintaining adult treatment, seeking support from friends, and participating in parenting programmes. IY is offered as one menu choice, and parent consultants review ways in which IY can address parents' stated goals. Parent consultants address parent expectations about services and other anticipated pragmatic barriers. This approach is adapted from Nock and colleagues' Participation Enhancement Intervention, which has been found to advance parents' readiness to engage and improve attendance in child treatment (Nock & Kazdin, 2005). Parents complete a 'participation enhancement action plan' to identify obstacles that could impede participation and to establish concrete proactive plans for overcoming barriers.

FCU pilot study

We argue that participating in the modified FCU and completing a 'participation enhancement action plan' enhances IY by building parent motivation to participate and empowering families to overcome barriers. This brief pre-intervention prepares parents for the demands of PMT in order to support sustained, quality participation. In turn, delivering IY in conjunction with FCU enhances FCU benefits by capitalizing on the motivation it builds to learn and practice specific parenting skills within the context of supportive social networks. Pairing FCU with this more intensive skill-building approach is expected to bolster the modest effects found when FCU is used as a stand-alone, brief intervention (e.g. Dishion et al., 2008).

A randomized pilot study of this modified FCU is currently underway. We are testing whether FCU enhances IY enrolment, attendance, and participation quality above and beyond an introductory home visit to build rapport and learn about IY. For the purposes of this initial efficacy trial, BCRC clinicians served as parent consultants. However, long-term plans include examining whether HS staff can be trained as parent consultants to deliver FCU feedback. Preliminary results based on the first 30 families enrolled are promising. Approximately 53% of parents randomized to FCU enrolled and participated in IY, which exceeds typical prevention programme engagement rates. Among parents in the control condition, 33% participated in IY. Parents tell us they enjoyed FCU because it was their first opportunity to reflect on how things are going and to think about their child and

family's future. Our preliminary results suggest that FCU feedback may be a cue to action, where parent goals are linked to feedback and aligned with services offered.

Summary and future directions

We describe our systematic and collaborative approach to addressing the significant challenge of parent engagement, guided by community-based participatory principles and implementation science. Our first approach to engaging parents was to embed evidence-based parenting programmes in a trusted community system, HS. We involved key stakeholders in all stages of the implementation process from programme selection to attending to organizational capacities and building internal staff resources to recruit and deliver IY. HS staff were provided IY training, experience co-facilitating IY groups with trained BCRC clinicians, and consultation during independent IY delivery to maximize the likelihood of embedding a high-quality, self-sustainable service delivery model. We view this approach of attending to the implementation elements that instilled HS ownership over and capacity for service delivery as critical for engaging families. Disentangling the effects of our approach on the ultimate success of FCU and IY is an area for future inquiry, however.

We also targeted parent engagement by modifying FCU as a pre-intervention to augment PMT in order to addresses the myriad motivational, cognitive and pragmatic barriers derived from theory, literature and our own qualitative and quantitative data. Our goal for conducting all phases of FCU modification, implementation and evaluation in HS (i.e. focus groups, testing the predictive validity of parental beliefs, conducting a randomized pilot trial) was to develop a contextualized parent engagement strategy that was responsive to the local population and feasible for the local context, and could easily be integrated into ongoing HS services. To the extent that we demonstrate its efficacy, a similar strategy will be used to train and support indigenous HS staff in FCU as well as to collaborate with HS to integrate FCU in ways that best promote their mission.

Preliminary data suggest that our approach to modifying FCU and contextualizing these parenting services met with some success. FCU may be an effective first step to motivate parents to take action and facilitate IY engagement in order to ultimately develop more effective family management skills. To the extent that FCU participation improves the quality of parents' sustained participation, the integrated FCU/IY approach may have a synergistic effect. We are monitoring changes in motivation and quality of participation during IY sessions, and will examine differences among parents in FCU and control conditions. In larger future studies we will test whether the effects on parenting and child behaviour are more powerful when FCU and IY are offered as a continuum of services than they are when either programme is offered alone.

Alternatively, FCU potential may be optimized to the extent that it can be used to engage families in their choice of a range of PMT services varying in intensity and service delivery format to best fit a family's individualized goals and life circumstance (Dishion & Stormshak, 2007). Group-based PMT is a good fit for some parents because of the social support they derive from a group setting, whereas home-based PMT delivery is a better fit for others (Stormshak et al., 2002). Many have argued for a more flexible approach to service delivery rather than the one-size-fits-all approach we describe, yet most community service delivery systems like HS do not have capacity for a suitably large array of options. Our modified FCU approach maintains the core flexible spirit of FCU (e.g. Dishion & Stormshak, 2007), yet we demonstrate here how it can be effectively applied with enough

specificity to optimize engagement in the specific PMT that is available in a given service delivery setting.

Acknowledgements

This work was supported by grant no. K01MH77097 from the National Institute of Mental Health to the first author.

References

Aos, S., Lee, S., Drake, E., Pennucci, A., Klima, T., Miller, M., … Burley, M. (2011). *Return on investment: Evidence-based options to improve statewide outcomes*. Olympia, WA: Washington State Institute for Policy Research.

Baker, C.N., Arnold, D.H., & Meagher, S. (2011). Enrollment and attendance in a parent training prevention program for conduct problems. *Prevention Science*, *12*(2), 126–138.

Berger, R.H., & Shepard, S.A. (2011). Parent engagement in child and family treatment: Considering the barriers. *Brown University Child and Adolescent Behavior Letter*, *27*(2), 1–5.

Bloomquist, M.L., Horowitz, J.L., August, G.J., Lee, C.S., Realmuto, G.M., & Klimes-Dougan, B. (2009). Understanding parent participation in a going-to-scale implementation trial of the Early Risers Conduct Problems Prevention Program. *Journal of Child and Family Studies*, *18*, 710–718.

Brotman, L.M., Gouley, K.K., Huang, K., Rosenfelt, A., O'Neal, C., Klein, R.G., & Shrout, P. (2008). Preventive intervention for preschoolers at high risk for antisocial behavior: Long term effects on child physical aggression and parenting practices. *Journal of Clinical Child and Adolescent Psychology*, *37*(2), 386–396.

Calzada, E.J., Caldwell, M.B., Brotman, L.M., Brown, E.J., Wallace, S.A., McQuaid, J.H., & O'Neal, C.R. (2005). Training community members to serve as paraprofessionals in an evidence-based prevention program for parents of preschoolers. *Journal of Child and Family Studies*, *14*(3), 387–402.

DiClemente, C.C., & Velasquez, M.M. (2002). Motivational interviewing and the stages of change. In W.R. Miller & S. Rollnick (Eds.), *Motivational interviewing: Preparing people for change* (pp. 201–216). New York: Guilford Press.

Dishion, T.J., Shaw, D., Connell, A., Gardner, F., Weaver, C., & Wilson, M. (2008). The Family Check-Up with high risk indigent families: Preventing problem behavior by increasing parents' positive behavior support in early childhood. *Child Development*, *79*, 1395–1414.

Dishion, T.J., & Stormshak, E.A. (2007). *Intervening in children's lives: An ecological, family-centered approach to mental health care*. Washington, DC: American Psychological Association.

Domitrovich, C.E., & Greenberg, M.T. (2000). The study of implementation: Current findings from effective programs that prevent mental disorders in school-aged children. *Journal of Educational and Psychological Consultation*, *11*, 193–221.

Dumas, J.E., Begle, A.M., French, B., & Pearl, A. (2010). Effects of monetary incentives on engagement in the PACE parenting program. *Journal of Clinical Child and Adolescent Psychology*, *39*, 302–313.

Durlak, J.A., & DuPre, E.P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal of Community Psychology*, *41*, 327–350.

Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies.

Franco, L.M., McKay, M.M., Miranda, A., Chambers, N., Paulino, A., & Lawrence, R. (2007). Voices from the community: Key ingredients for community collaboration. *Social Work in Mental Health*, *5*, 313–331.

Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: Outcomes and mechanisms of change. *Journal of Child Psychology and Psychiatry*, *47*(11), 1123–1132.

Israel, B.A., Schulz, A.J., Parker, E.A., & Becker, A.B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, *19*, 173–202.

Kazdin, A.E. (2005). *Parent Management Training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*. New York: Oxford University Press.

Lengua, L.J., Roosa, M.W., Schupak-Neuberg, E., Michaela, M.L., Nourse Berg, C., & Weschler, L.F. (1992). Using focus groups to guide the development of a parenting program for difficult-to-research, high-risk families. *Family Relations*, *41*, 163–168.

McKay, M.M., Hibbert, R., Hoagwood, K., Rodriguez, J., Murray, L., Legerski, J., & Fernandez, D. (2004). Integrating evidence-based engagement interventions into ''real world'' child mental health settings. *Brief Treatment and Crisis Intervention*, *4*, 177–186.

Miller, G.E., & Prinz, R.J. (2003). Engagement of families in treatment for childhood conduct problems. *Behavior Therapy*, *34*, 517–534.

Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed). New York: Guilford Press.

Nock, M.K., & Ferriter, C. (2005). Parent management of attendance and adherence in child and adolescent therapy: A conceptual and empirical review. *Clinical Child and Family Psychology Review*, *8*(2), 149–166.

Nock, M.K., & Kazdin, A.E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies*, *10*, 155–180.

Nock, M.K., & Kazdin, A.E. (2005). Randomized trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology*, *73*, 872–879.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, *47*, 1102–1114.

Redmond, C., Spoth, R., Shin, C., & Hill, G.J. (2004). Engaging rural parents in family-focused programs to prevent youth substance abuse. *The Journal of Primary Prevention*, *24*, 223–242.

Rohrbach, L.A., Grana, R., Valente, T.W., & Sussman, S. (2006). Type II translation: Transporting prevention interventions from research to real-world settings. *Evaluation in the Health Professions*, *29*, 302–333.

Rosenstock, I.M. (1990). The health belief model: Explaining health behavior through expectancies. In K. Glanz, F.M. Lewis, & B.K. Rimer (Eds.), *Health behavior and health education: Theory, research, and practice* (pp. 39–62). San Francisco, CA: Josey Bass.

Sanders, M.R., & Lawton, J.M. (1993). Discussing assessment findings with families: A guided participation model of information transfer. *Child and Family Behavior Therapy*, *15*, 5–33.

Shaw, D.S., Connell, A., Dishion, T.J., Wilson, M.N., & Gardner, F. (2009). Improvements in maternal depression as a mediator of intervention effects on early childhood problem behavior. *Development and Psychopathology*, *21*(2), 417–439.

Shaw, D.S., Dishion, T.J., Supplee, L., Gardner, F., & Arnds, K. (2006). Randomized trial of a family centered approach to the prevention of early conduct problems: 2-year effects of the Family Check Up in early childhood. *Journal of Consulting and Clinical Psychology*, *74*(1), 1–9.

Shepard, S., Armstrong, L.M., Seifer, R., & Berger, R.H. (2012). *Predicting engagement in preventive parenting interventions during early childhood: Links among family risk, parental beliefs and readiness to change*. Manuscript in progress.

Spoth, R.L., & Redmond, C. (1995). Parent motivation to enroll in parenting skills programs: A model of family context and health belief predictors. *Journal of Family-Psychology*, *9*, 294–310.

Stormshak, E.A., Connell, A., & Dishion, T.J. (2009). An adaptive approach to family-centered intervention in schools: Linking intervention engagement to academic outcomes in middle and high school. *Prevention Science*, *10*, 221–235.

Stormshak, E.A., Kaminski, R.A., & Goodman, M.R. (2002). Enhancing the parenting skills of Head Start families during the transition to kindergarten. *Prevention Science*, *3*, 223–234.

Telleen, S. (1990). Parental beliefs and help seeking in mothers' use of a community-based family support program. *Journal of Community Psychology*, *18*, 264–276.

Thornton, S., & Calam, R. (2010). Predicting intentions to attend and actual attendance at a universal parent-training programme: A comparison of social cognitions models. *Clinical Child Psychology and Psychiatry*, *16*(3), 365–383.

Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parenting competencies. *Journal of Consulting and Clinical Psychology*, *66*, 715–730.

Webster-Stratton, C. (2011). *The incredible years parents, teachers, and children training series: Program content, methods, research and dissemination, 1980–2011*. Seattle, WA: Incredible Years, Inc.

Webster-Stratton, C., & Hammond, M. (1998). Conduct problems and level of social competence in Head Start children: Prevalence, pervasiveness, and associated risk factors. *Clinical Child Psychology and Family Psychology Review*, *1*, 101–124.

Yoshikawa, H., & Zigler, E. (2000). Mental health in Head Start: New directions for the twenty-first century. *Early Education and Development*, *11*, 247–264.