

Engaging Urban Parents of Early Adolescents in Parenting Interventions: Home Visits vs. Group Sessions

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Abstract

Interventions targeting parents of young children have shown effectiveness, but research is lacking about best practices for engaging parents of early adolescents. Low levels of enrollment and attendance in parenting interventions present major problems for researchers and clinicians. Effective and efficient ways to engage and collaborate with parents to strengthen parenting practices and to promote healthy development of early adolescents are needed. This exploratory mixed methods study examined the feasibility of three methods of engaging parents in positive parenting activities. Participants were parents of youth ages 11–13 enrolled in three urban, public middle schools in neighborhoods characterized by high rates of community violence. Families ($N = 144$) were randomized into one of three interventions: six home sessions, two home sessions followed by four group sessions, or six group sessions. The majority of parents were single, non-Hispanic, African American mothers. Urban parents of middle school students were more likely to participate in home visits than in group sessions; offering a combination did not increase participation in the group sessions. As only 34% of those who consented participated in the intervention, qualitative data were examined to explain the reasons for non-participation.

Key Words: parent engagement, adolescents, urban, involvement, home visits, group sessions, parenting interventions, African American, mothers

Introduction

Parents are the primary socialization agents, remaining central to all aspects of adolescent development, including the formation of attitudes and behaviors related to academic engagement and aggression. For early adolescents growing up in low-income, urban, African American communities, family can be a critical asset. Behavioral parent training programs have been established as an effective way to address behavior problems in children (Dretzke et al., 2009). These programs are usually manualized, short-term interventions, often presented in a group format, which teach parents how to build positive relationships with their children and learn consistent, appropriate responses to aggression and other discipline problems.

Parental involvement in prevention interventions is important for early adolescents' academic success (Eccles & Harold, 1993; Jeynes, 2007). Enhancing parent involvement can lead to improvement in academic engagement and family communication skills while contributing to decreased aggressive behaviors (Centers for Disease Control, 2013). In addition, some research demonstrates that low parent involvement is directly related to school violence indicators such as school aggression or conduct problems (Hill & Tyson, 2004).

There has been limited research conducted on whether or not the mode of delivery for parent education programs and/or prevention interventions has an impact on parents' adherence to the intervention, especially among parents of early adolescents. For example, little research examines whether group formats, home visitation programs, or formats that combine home visiting with group intervention components influence parental participation in prevention programs. In addition, behavioral parent education programs have been plagued with low enrollment and attendance thereby limiting the contributions which they could make both to participants and to prevention research as a field.

Intervention Delivery Modality

Very little research has examined whether or not the mode of delivery for parent education programs has an impact on parental engagement. In their comparison of three variants of individualized sessions in a behavioral family intervention—enhanced, standard, and self-directed—Sanders and colleagues found no differences in rates of completion across groups (Sanders, Markie-Dadds, Tully, & Bor, 2000). Home visitation and group-based programs are two common parenting intervention delivery modes. Home visitation has been considered to be optimal for low-income families who may otherwise experience transportation and other obstacles that are associated with seeking services outside of the home and has been used primarily with prospective

parents and parents with young children (Sweet & Appelbaum, 2004). Child Trends (Kahn & Moore, 2010) recently conducted a literature review of home visiting programs segmented by target population (infants, early childhood, middle childhood, adolescents). Twenty-one home visiting programs targeting adolescents (ages 12–17) were identified, compared to 51 programs for infants and early childhood (ages 0–5; Kahn & Moore, 2010). Group-based interventions are also widely used and may be considered a more cost-effective alternative to individualized or home-based formats (Cunningham, Bremner, & Boyle, 1995; Gardner, Burton, & Klimes, 2006). There is very little research examining whether enrollment and attendance in sessions varies as a function of delivery modality (group versus home-based), especially among parents of adolescents.

Enrollment and Attendance in Prevention Interventions

Risk and protective factors associated with youth engagement in health risk behaviors often are influenced by parents' caregiving practices (Brody, Murry, Chen, Kogan, & Brown, 2006). Therefore, parenting behaviors are often the target of many prevention programs designed to address risky behavior among youth. Parents invited to enroll, defined here as consenting to participate in a study, usually have children at risk for developing problems. However, as prevention work does not target existing problems, it may not be viewed as needed by potential participants. Low enrollment limits the reach of the program.

Thus, the first challenge to prevention programs is getting participants enrolled. Recent studies of parents of toddlers or early elementary school-aged children have reported that only about 30% of families invited to participate in prevention projects for behavior problems actually enroll (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005; Spoth & Redmond, 2000, 2002). The authors were unable to locate any studies which examine the enrollment of parents with early adolescents in prevention programs. Initial participation and maintaining participation in the intervention once enrolled are additional challenges. For the purposes of this paper, attendance is defined as the percentage of sessions attended for those who have enrolled in the program (i.e., enrolled in the study). Most of the studies which examine enrollment and attendance are primarily group interventions with parents of young children (Irvine, Biglan, Smolkowski, Metzler, & Ary, 1999; Spoth & Redmond, 2000). Attendance rates in universal family-focused interventions and parent training programs are typically around 20%–25% (Spoth & Redmond, 2000). Once parents agree to enroll in such programs, attendance is often poor and attrition is high, with many studies reporting dropout rates of 50% or higher (e.g., Irvine et al., 1999). Families at highest risk for suboptimal parenting behaviors are more

likely to drop out of parent training programs; however, consistent attendance is crucial for achieving parenting behavior change (Brody et al., 2006). Attendance among minority families from low-income communities is particularly poor (Brody et al., 2006; Coie & Jacobs, 1993; McKay, McCadam, & Gonzales, 1996). For example, in a skills-building program for African American parents, Myers et al. (1992) reported participation rates as low as 13%. In a longitudinal preventive intervention for youth at risk for conduct problems, Orrell-Valente and colleagues (1999) reported comparable rates of participation between African American and Caucasian parents; however, the quality of participation was lower for African American parents. Low attendance and participation rates among subsets of the population pose a threat to large-scale adoption and the overall public health impact of prevention interventions.

A variety of structural and attitudinal barriers to participating in family-focused interventions have been identified. Time constraints, scheduling conflicts, child care needs, and transportation difficulties are frequently cited as structural barriers in the literature (Brody et al., 2006; Lamb-Parker et al., 2001; Spoth & Redmond, 2000, 2002). In addition, for many families residing in urban areas, the pervasive threat of community violence (Gorman-Smith, Henry, & Tolan, 2004) may lead to social isolation, which may limit parents' knowledge of or access to prevention programs offered in their community.

Attitudinal factors that may limit parent enrollment and attendance include beliefs about utility of services or research and lack of perceived need. For example, the extent to which parents perceive their children's behavior as problematic influences enrollment and participation (Heinrichs et al., 2005). Concerns about privacy also may limit parent enrollment (Spoth, Redmond, Hockaday, & Shin, 1996). For example, Spoth et al. (1996) found that lower income and less educated individuals were more likely to cite concerns about being videotaped as a barrier to participation. In addition, for low-income and minority families, cultural mistrust (Whaley, 2003) resulting from previous negative or discriminatory experiences may discourage enrollment in prevention programs.

Participant characteristics such as family structure, stressful life events, and family disorganization have been found to be associated with attrition (Spoth & Redmond, 2000). For example, dual parent family status has been associated with higher participation rates (Spoth & Redmond, 2000). In addition, participation in prevention programs may not be a priority for families who are faced with managing multiple daily stressors.

Child characteristics may impede intervention attendance or enhance parents' motivation to attend (Brody et al., 2006). In addition, there is research that suggests that program characteristics, particularly those related to

implementation, contribute to variability in participation. Higher attendance has been reported in studies in which the group leader and participants were from comparable socioeconomic and ethnic backgrounds (Dumas, Moreland, Gitter, Pearl, & Nordstrom, 2006) and when there is a match between the participants' and the program's goals (Gross et al., 2008). As the majority of the extant literature focuses on parent and child characteristics, more research on program factors including mode of delivery is needed.

Study Aims

Behavioral training programs have been established as an effective way to treat behavior problems, and researchers have begun to investigate the effectiveness of these programs in prevention contexts (Baker, Arnold, & Meagher, 2011). Yet, the low levels of parent enrollment and attendance in these programs are challenges to implementation. A better understanding of the modality of delivery of behavioral training programs is necessary to ensure the applicability and usefulness of these as prevention interventions. The overall goal of the research was to investigate and determine the best practices to engage urban parents in interventions designed to increase parental monitoring and involvement. The aims of the study were (1) to assess the feasibility of three different combinations of home visitation, telephone contacts, and group sessions; and (2) to identify the predictors of adherence to a prevention intervention. Given the dearth of empirical studies examining the impact of delivery modality on engagement, we made no a priori hypothesis regarding differences in participation and engagement across the three formats.

Methods

Study Design

An original randomized control trial of youth aged 11–13 enrolled in three urban public middle schools in neighborhoods characterized by high levels of community violence was conducted by the senior author. Students at these schools were invited to participate in a school-based intervention designed to prevent aggressive and deviant behavior among early adolescents. Parents consenting their families ($n = 659$) for the youth intervention were informed that they may be contacted to participate in further related research. For the current study, a random selection of families ($n = 307$) recruited into the youth intervention was invited to participate in a parenting intervention research study. Inclusion criteria were that parents/guardians were English-speaking and had resided in their neighborhoods for at least six months. Trained health educators called parents to explain the study and schedule them for baseline interviews

which involved both the parent and the child. Informed consent specific to this study was obtained prior to the baseline interview. Parent participation was monitored and program satisfaction was assessed at six months post-baseline. All assessments were administered in participants' homes. Monetary incentives were provided for baseline and follow-up assessments only. The Institutional Review Boards of the Johns Hopkins University and the National Institute of Child Health and Human Development (NICHD) approved this study.

Participants ($N = 144$) were randomized post-baseline interview in order for the health educators conducting data collection to remain blind to study status. Cards were produced by the study coordinator in batches of 15 with one of three group assignments and placed in individual sealed unmarked envelopes. At the conclusion of the baseline interview, participants received one card chosen at random by the interviewer which placed them in one of three interventions: six home sessions (Group A), two home sessions followed by four group sessions (Group B), or six group sessions (Group C). All participants received phone coaching between sessions. The home and group sessions were led by the same health educator. Sessions were conducted in homes and community sites.

Parenting Intervention

Guided by the authoritative parenting conceptual model (Darling & Steinberg, 1993; Simons-Morton & Crump, 2003) and using a community-based participatory approach to development (Israel, Eng, Schulz, & Parker, 2005), this intervention was designed to encourage parents to reinforce and enhance early adolescents' attitudes and behaviors promoting academic engagement and against aggression. The aims of the parent intervention were to influence parents' attitudes, expectations, and involvement, particularly as related to the reinforcement and promotion of adolescents' school engagement and prosocial (not aggressive or deviant) behaviors.

Research has shown that families with low socioeconomic status tend to receive less benefit from parent training than those with higher socioeconomic status (Lundahl, Risser, & Lovejoy, 2006). This may be attributed to economic disadvantage; however, it is possible that it is due to the perception that these programs are not geared to the immediate concerns of parents raising children and adolescents in stressful environments (Gross et al., 2008). In light of this literature, the intervention sessions were designed to be culturally and contextually relevant using the input of a parent community advisory board comprised of African American parents from a range of economic backgrounds.

This advisory board met nine times over four months to offer advice on recruitment, retention, and the intervention's approach and messages. The board adapted sessions from a preexisting evidence-based intervention, the Adolescent Transition Program (ATP), for use in intervention sessions. ATP is a multilevel group parenting intervention designed to reduce problem behaviors in middle school-aged youth (Andrews & Dishion, 1995). The advisory board selected six sessions—family management, skills of encouragement, limit setting and supervision, problem solving, improved family relationships, and communication patterns—and adapted the sessions for cultural contemporary relevance and individual or group implementation.

One modification made by the board was to acknowledge parent stress in urban environments as a part of the sessions. This included: (1) discussion of parent stress and methods of parental stress management; (2) addition of a “parent survival kit” including small gifts acknowledging the challenges of parenting; and (3) discussion of specific family stresses and referral to community resources (a compilation of local community resources was generated for these purposes). Additionally, in lieu of the videos included in ATP, photo novellas designed by the board were utilized to present the authentic voice of parents in the community.

A photo novella is a photo essay which brings to life issues of relevance to a community using photographs and short scripts to bring the story to life. Photo novellas are used to encourage the participation of community members in creating and delivering health messages (Wang & Burris, 1994). In this particular implementation of photo novella techniques, the parent advisory group participants developed a scenario regarding a curriculum concept (e.g., parental monitoring). Collaboratively with research staff, they wrote the story line. Photographs were taken demonstrating communication between parents and children. The process of developing the photo novella allowed the advisory board to directly influence the curriculum. Examples of pages in the resulting photo novella are shown in Figure 1.

The six intervention sessions were expected to be completed within six months. Parent participation was monitored weekly. Phone calls to schedule home sessions were made at varying times, including evenings and weekends, in accordance with best practices for working with low-income parents in urban environments (Barton, Drake, Perez, St. Louis, & George, 2004; Mannan & Blackwell, 1992). If there was no response after six phone calls, the health educator would drive to the address on record to attempt to schedule in person. After eight contacts with no response, a letter would be mailed to the home. Participants were categorized as difficult to reach if they were not able to be scheduled for an appointment after ten contacts. Once a visit was scheduled, a

reminder phone call was made the day before the session. Parents were able to reschedule visits to best fit their schedule.



Figure 1. Photo Novella Sample Pages

Group sessions were scheduled when groups of 20 participants were randomized into Group C. Parents were contacted to determine what time and location were best to hold the sessions. Sessions were scheduled for various times throughout the day and evening and held in multiple community sites near the majority of participants' homes or workplaces. At least two concurrent groups with the capacity for up to 10 participants were offered at a time to accommodate varied schedules. A flier with the details of the locations and times of group sessions was mailed. The health educator called each parent the day before each session as a reminder. Transportation vouchers, meals, and child-care were offered (Baker, 1997; Van Velsor & Orozco, 2007) at each group session. Parents were called by the health educator and invited to attend the next session regardless of participation in the previous session. For all group sessions, absence from one session did not preclude participation in subsequent sessions. Financial incentives were not provided for home or group session attendance. The same health educator provided all home and group sessions so as to maintain rapport for those in the combined home and group intervention. She was an older African American woman from a background similar

to participants. As a result, she had a close understanding of the community which enabled her to better facilitate and deliver the intervention sessions.

Procedures

Baseline assessments included both a dyadic interview of parent and child and survey questionnaires to assess parent–child communication about violence which have been described previously (Lindstrom Johnson, Finigan, Bradshaw, Haynie, & Cheng, 2011, 2012). Follow-up assessments were comprised only of the survey questionnaires with the inclusion of closed and open-ended questions about program satisfaction. Health educators who were not involved in intervention delivery conducted both the baseline and follow-up assessments.

Measures

Enrollment and Attendance

Participants were enrolled at baseline survey administration. Health educators documented attendance at program sessions, number of contacts with nonattending parents, reasons for nonattendance, and follow-up coaching phone calls with attending parents. Participants were coded as yes regardless of which session (1–6) they attended first in any intervention modality—home or group. Follow-up survey completion rates were also monitored.

Satisfaction

Enrolled participants were asked to indicate how satisfied they were with the intervention sessions on a four-point scale (very satisfied to not at all satisfied). Similarly, the participants rated the extent to which the health educator understood their concerns and was sensitive to their feelings on a five-point scale. These participants were also asked open-ended questions about their reasons for participation and preference for home visits versus group sessions.

Analysis

Session participation was calculated as the number of intervention sessions attended (range = 0–6 sessions). Follow-up completion rates were compared across treatment modes (Group A—home only, Group B—home and group, Group C—group only) for differences in the proportion using a Marascuilo procedure to correct for Type I error. Because of the small number of participants completing sessions in Group C, rates of completion were also examined comparing Group A to the combined completion rate of Groups B and C. Satisfaction rates with enrolled participants based on the treatment group assigned were similarly examined. Open-ended questions were coded for general trends.

Results

Study Participants

The majority of the parents were single, non-Hispanic, African American mothers. No significant differences were found among groups regarding demographics, educational attainment, or income. The participants reside in predominately African American communities on the east side of Baltimore City characterized by racial and socioeconomic hyperconcentration. Specifically for this sample, the median income ranged from \$10,000 to \$14,999 per year which is below the established poverty threshold of \$20,650 for an average family of four for the study year (see <http://aspe.hhs.gov/poverty/figures-fed-reg.cfm>). Thirty-one percent of participants had a high school diploma or GED; 28% had less than a high school education. Table 1 presents the sample characteristics by intervention group. There were no significant differences in demographic characteristics across the groups.

Session Participation

For those randomized to receive six home sessions (Group A – $N = 47$), 25 (53%) participated in at least one session. Of those who began home sessions, 76% completed all sessions. For parents randomized to receive two home sessions followed by four group sessions (Group B – $N = 49$), 20 (41%) participated in at least one home session (18 of 20 participated in both); of those, only five (10%) participated in at least one group session, and three of the five completed all sessions. For those who were to receive group sessions only (Group C – $N = 48$), 4 (8%) participated in at least one group session, and one completed all six sessions. Figure 2 shows enrollment and session participation rates by group. From health educator records, reasons given for not initiating sessions included: difficult to reach (41%; 34%; 48% for Groups A, B, and C, respectively), and work/caregiver obligations (41%; 31%; 48%). Reasons given for not completing sessions included: difficult to reach (33%; 18%; 0%), and work/caregiver obligations (67%; 82%; 100%). A few parents refused participation in the intervention due to lack of monetary incentive (2%). In addition, there were many parents who were unable to be contacted for the intervention due to disconnected phones and household moves (6%; 24%; 54% for Groups A, B, and C, respectively).

The qualitative data provide a more detailed understanding of whether or not a parent participated. Three themes emerged: “Schedule Conflicts,” “Caregiving,” and “Not Needed.” Another major theme which emerged among those randomized to the home visitation group only is “Interested in Group Sessions.”

Table 1. Sample Characteristics by Group [*n* (%)]*

	Group A Home Visits	Group B Home/ Group	Group C Group Sessions
	(<i>N</i> = 47)	(<i>N</i> = 49)	(<i>N</i> = 48)
Relationship to Child			
Mother	36 (78.3)	37 (75.5)	32 (66.7)
Father	1 (2.2)	2 (4.1)	6 (12.5)
Other	9 (19.6)	10 (20.4)	10 (20.8)
Race			
African American	46 (97.9)	47 (95.9)	48 (100)
Other	1 (2.1)	2 (4.1)	0 (0)
Mean Age (years)	40.6	40.6	40.1
Education			
< High School	13 (28.9)	10 (21.3)	17 (35.4)
High School/GED	14 (31.1)	17 (36.2)	13 (27.1)
> High School	18 (40.0)	20 (42.6)	18 (37.5)
Annual Household Income			
< \$15,000	24 (54.5)	21(45.7)	26 (55.3)
\$15,000 - <\$25,000	9 (20.5)	8(17.4)	12 (25.5)
\$25,000 - < \$35,000	7 (15.9)	9(19.6)	7 (14.9)
> \$35,000	4 (9.3)	8(16.3)	2 (4.6)

*There were no significant differences in characteristics across the three groups.

Schedule Conflicts

The majority of parents had numerous work, school, and other scheduling conflicts. One mother randomized to group sessions stated, “We were in the process of moving, and I work full time, so this didn’t fit our schedule.” Another mother assigned to groups said, “My work schedule did not permit me to attend.” One father in the home visit group noted he “just did not have the time.”

Caregiving

There were several parents randomized to the group sessions who would have preferred to be placed in the home visit group due to caregiving issues. One mother stated that the reason she did not enroll in sessions was because “I was taking care of my mother at the time, and I couldn’t leave her.” Many others mentioned babies or younger children that they did not want to bring out.

Not Needed

A few parents were not interested in enrolling in any types of sessions because they weren't having issues with their child at the time. One mother stated, "It didn't matter because we aren't having problems at this minute." Another said, "Well, my child isn't a problem child."

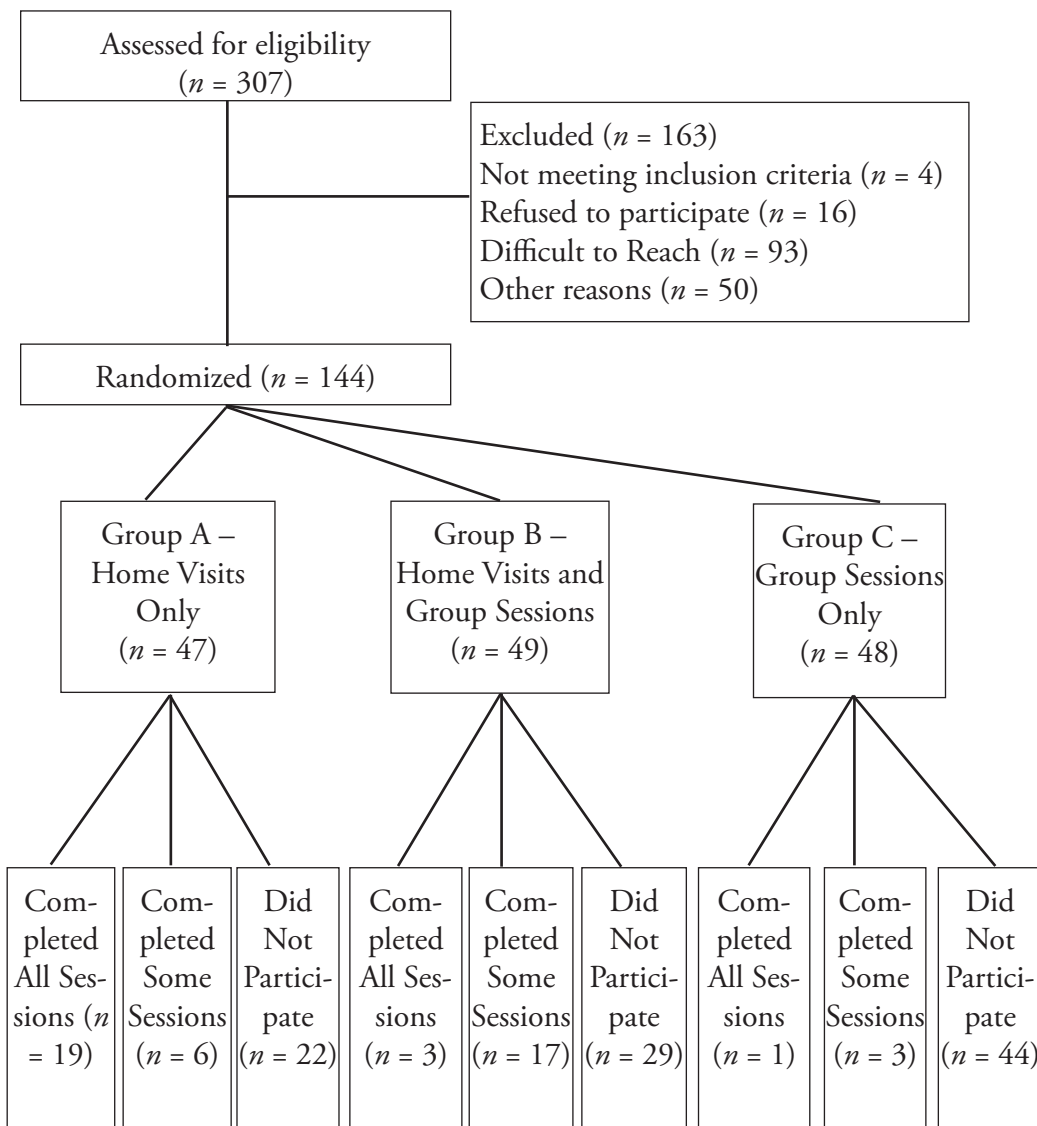


Figure 2. Enrollment and Session Participation

Interested in Group Sessions

Although the majority of the parents randomized to the home visit group were glad that they were randomized to this group because it worked with their schedules and was convenient, there were several parents who mentioned that they would be interested in participating in group sessions or a combination of group and home sessions. There were two main reasons given for this: to hear the opinions of other parents, and to get out of the house. An example of the first reason was, “Sometimes others’ opinions sometimes help. It would have been good to get some other parents’ opinions and hear their issues.” For the second reason, examples include: “It would have been fun. You never know who you would meet;” and “Group sessions are better. You get to be around others.”

Follow-Up Completion Rates

Groups differed in rates of participation in the follow-up survey. Table 2 presents a comparison of session attendance and follow-up assessment completion. All participants were invited to complete the follow-up assessment regardless of session attendance. For Group A, 40% of participants completed all 6 sessions; 94% of participants completed the follow-up assessment. For Group B, 6% completed all 6 sessions; 84% completed the follow-up assessment. For Group C, 2% completed all 6 sessions; 71% completed the follow-up assessment. Participation and follow-up rates were found to differ between Group A and Group C ($p = 0.000$, with Marascuilo procedure). Participation and follow-up rates between Group A and combined Groups B and C were still found to be statistically significant ($p = 0.0005$).

Table 2. Session Attendance and Follow-Up Assessment Completion

	% Completed			
	0 Sessions	1–5 Session(s)	6 Sessions	6-month Follow-Up*
Group A: 6 Home Sessions ($n = 47$)	47	13	40	94
Group B: 2 Home/4 Group Sessions ($n = 49$)	59	35	6	84
Group C: 6 Group Sessions ($n = 48$)	92	6	2	71

*Participants were invited to participate in follow-up assessments regardless of participation in the intervention.

Participants' Satisfaction

Overall rates of satisfaction for enrolled participants varied across the three groups. Participants in Groups A (home visits only) and C (group sessions only) reported that they were very satisfied with the sessions (92% and 100%, respectively). Among Group B participants (home visits followed by group sessions), 81% reported that they were very satisfied with the home visits, and 53% reported that they were very satisfied with the group sessions. Participants in all three groups strongly agreed that the health educator understood their needs and was sensitive to their feelings.

All enrolled participants were asked to speak about how helpful they found the sessions regarding communicating with their child about violence. Two related themes emerged: the sessions helped them to get ideas and information about how to communicate with their child and to build a better relationship. One mother in Group A felt that the sessions helped her to “see the right way to talk to your child and how to listen to their side. It helped my child to open up more.” A mother in Group B was happy to learn and discuss the “different situations children and parents can come upon. It was good to learn the different organizations made available to us.” A mother in Group C said, “It opened the conversations about school and the bully. It helped my son better understand his peers.” In addition, many of the parents found that being able to speak to the health educator was helpful. Specifically, one Group A parent said, “talking to the session facilitator helped to relieve stress.”

Discussion

Only 34% of those who consented to participate in this prevention intervention actually enrolled in sessions. This is in line with the other studies in which about 30% of families invited to participate in prevention projects for behavior problems actually enroll (Heinrichs et al., 2005; Spoth & Redmond, 2000, 2002). The majority of these studies have been with families of preschoolers and early elementary school children. This similarity is particularly notable in that the current study focused on families of early adolescents, with whom it might be expected that participation may be even lower than among parents with younger children.

Session participation (enrollment and completion of sessions) was highest for those in the home visit group compared to the other groups. These findings corroborate research that indicates that families from lower socioeconomic backgrounds may benefit more from individualized as opposed to group intervention formats as well as findings that suggest that home-based formats, in

particular, are optimal for families who may otherwise face a variety of obstacles to receiving services in the community (Lundahl et al., 2006). The qualitative responses of parents support this interpretation as well, with obstacles such as time and family commitments being the majority of reasons provided for why they did not participate. For those in the group sessions, a meal was provided, transportation was offered, and for those who needed it, child care was available. Sessions were provided in community places identified by participants as accessible to their homes or workplaces. Even with this level of active assistance, parents still struggled with competing demands from work schedules as well as those which may have arisen from social or school activities.

Home visits provide the opportunity for parents to develop a longitudinal relationship with another adult. For those who received home visits only, the majority completed all sessions. Group A follow-up assessment completion was also highest, suggesting strength in the relationships developed with the home visitor. Parents' responses about the helpfulness of speaking with the health educator provide support for the adequacy of this interpretation.

Overall, the participants who received home visits reported higher levels of satisfaction with the sessions and with their health educator. The home-based format may have allowed for more rapport to develop which resulted in home session participants feeling better understood and better able to confide in the health educator. However, building rapport during home sessions did not have a significant impact on attendance at group sessions for Group B. Satisfaction with the group sessions was also notably diminished among this group which had previously experienced the home visits. In addition, home visits resulted in a larger proportion of completion of the follow-up assessment which suggests that there was some effect of the individual attention on the likelihood of completing assessments.

Participation in all three groups was higher for the follow-up assessments than for the intervention sessions. Participating in the sessions required more commitment than completing the assessments. Further, monetary incentives were offered for the assessments, but not for the sessions. Either or both of these reasons could explain differences in participation. However, only two percent of parents specifically stated that the lack of monetary incentive was the reason they did not participate in the intervention. This highlights the challenge of translating efficacious practices to routine practice settings to produce effective results.

Results from another study's qualitative interviews indicate that residents feel emotionally isolated from one another in that they reported that they did not really know and sometimes did not feel comfortable around members of their community (Murray et al., 2014). Given these feelings of isolation, in

conjunction with responses from the current study of parents who were interested in group sessions for the interaction with other adults, it would seem that parenting interventions in a group format could provide a much needed social support network for parents. However, despite great efforts to initiate parent groups, enrollment and attendance was extremely poor even among those who had experienced home visits and thus presumably had built some rapport with the health educator. Future research might investigate the use of a safe intermediary, such as a church or a trusted community organization, to discern if that increases levels of comfort and facilitates participation in groups. In addition, perhaps the feelings of comfort, familiarity, and individualized attention that parents may experience during home visits outweigh the benefits of increased peer support that may be developed and experienced in group formats. As some parents in the home visit group expressed interest in attending group sessions, it is possible that groups are appealing but not feasible for urban parents of early adolescents.

Study Limitations

Our sample included parents of early adolescents in an urban community. It is unclear how our findings generalize to other populations of parents of early adolescents. Nonetheless, it is a clear strength of this study that it investigates prevention intervention modalities and expansion of enrollment research in a population considered difficult to reach.

Conclusion

Interventions targeting parents of young children have shown effectiveness, but research is lacking about best practices for engaging parents of early adolescents. Early adolescence is a critical time for youth to develop and establish healthy behaviors and avoid risky situations. Recruitment and participation are potential barriers to the success of a parenting program. Effective and efficient ways to engage and collaborate with parents to strengthen parenting practices and to promote healthy development of early adolescents are needed. This study examined the feasibility of three methods of engaging parents in positive parenting activities. Home visits were found to be the most viable option for engagement, yet they may not be the best choice for all parents. As discussed in the extant literature, implementation strategies which maximize schedule flexibility and minimize time demands for prospective parent participants should be used to increase enrollment and participation (Spoth & Redmond, 2002). The use of pretest measures which screen for types of scheduling issues, high levels of caregiving burden, and need for social support could be used to assign parents to appropriate intervention modalities in future interventions.

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