

July 2007

An Assessment of Parent Involvement Strategies in Programs Serving Adolescents

Task Order 15 – Contract No. 233-02-0090

Final Report

**Summary Analysis of Literature Review, Assessment Methods, and
Assessment Results**

Prepared for

Barbara Cohen and Susan Moskosky
Department of Health and Human Services
Office of Population Affairs
The Tower Building at Tower Oaks
1101 Wootton Parkway, Suite 700
Rockville, MD 20852

Prepared by

Olivia Silber Ashley
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

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Executive Summary

Emerging empirical research has shown that parent involvement is associated with later adolescent sexual initiation; lower rates of adolescent premarital sexual activity, sexually transmitted infections (STIs), pregnancy, and childbearing; reduced numbers of adolescent sexual partners; and increased use by adolescents of condoms and other contraceptives. Findings from a wide range of studies highlight multiple dimensions of parent involvement associated with positive adolescent reproductive health behaviors, including parent-child communication about sex, contraception, pregnancy, and/or HIV risk; parental monitoring of adolescents' behavior; and parent involvement in adolescents' activities. Research also documents the important role that parents play in the lives of pregnant or parenting adolescents and their children. However, barriers to involving parents in intervention programs include low rates of parent participation, especially among parents of at-risk children; the challenging social contexts in which many parents live, such as poverty, communities with high crime rates, areas of high substance use, inadequate employment opportunities, and insufficient support systems; perceived barriers to communication; and low self-efficacy among parents.

The purpose of this project was to examine outreach and intervention strategies used by Title X Family Planning and Title XX Adolescent Family Life (AFL) programs to involve parents and families, with a focus on strategies to achieve improved communication between parents and adolescents aged 19 or younger about sexuality. A goal was to identify promising practices (or adaptation and application of evidence-based strategies) among Title X and Title XX programs for possible implementation across additional program settings. In addition, we set out to identify barriers to implementing promising practices, feasibility issues or needs identified by programs, approaches tried that have not worked well, and lessons learned.

This report first presents findings from a literature review of evidenced-based parent involvement strategies and an assessment of parent involvement strategies in Title X and Title XX programs. We identified 26 studies of the effectiveness of parent involvement strategies: 14 randomized controlled trials and 12 nonrandomized studies. Our findings from the literature review include the following:

- The evidence base for the benefit of parent involvement programs is limited.
- Of the 14 randomized controlled trials reviewed, 9 measured adolescent behavioral outcomes, such as contraceptive behavior, sexual behavior, risky sexual behavior, or pregnancy.
- Of these nine studies, four concluded that the program affected adolescent behavioral outcomes, one found short-term impacts but no long-term impacts, and four concluded that the program did not affect adolescent behavioral outcomes.
- Participation is a big problem with parent involvement programs.

Seven parent involvement strategies were identified: home-based videos, parent-only workshops or training sessions with a companion adolescent component, joint parent-adolescent attendance at workshops or training, homework assignments, parent-only training with no adolescent component, grassroots community organizing, and combinations of multiple approaches. A total of 11 of the 14 randomized controlled trials showed positive results, including parent-child communication, knowledge, skills, and parental monitoring. Some evaluators suggested that the lack of strong differences between study groups on some targeted outcomes may be a result of the limited parent participation in the study or in the program and/or programmatic flaws, including failure to fully implement parent involvement components as intended. Across the 26 populations analyzed, 21 studies reported improved outcomes, including parent or adolescent knowledge, attitudes, or communication or adolescent intentions or behaviors regarding sexual activity or reproductive health. Outcomes among pregnant and parenting adolescents and their parents included reduced likelihood of experiencing a repeat pregnancy, higher self-esteem, improved parent understanding of adolescents and acceptance of the pregnancy and baby, and improved communication and family relationships.

The review of evidence-based programs suggests that programs tend to be successful in drawing greater parent participation by using home-based strategies for involvement, such as sending skills-based videos to the homes of program participants for them to watch with their parents, although no rigorous study has shown impact on adolescent behavioral outcomes. Evaluations of programs using homework assignments completed by parents and their adolescents found them to be more effective in achieving participation among parents, particularly in school-based programs operating during school hours. Some researchers suggested that programs may be more successful in gaining parent participation if they implement incentives, such as child care or transportation, and incorporate smaller groups (e.g., 15 to 30 people). Other evaluators found that the most effective technique in recruiting parents was personal telephone calls from classroom teachers.

Both the Title X Family Planning and Title XX AFL programs emphasize the importance of family involvement in family planning, prevention, and care for adolescents. This study is the first comprehensive examination of the range and implementation of parent involvement strategies employed by these programs.

Our assessment examined parent involvement strategies, strategies for encouraging parent participation, barriers to involving parents, outcomes, and lessons learned. Our findings from this assessment include the following:

- Title X programs employed strategies such as counseling adolescents about talking with their parents, parent workshops, printed materials on parent-child communication, agency tours and open houses, and training and assisting staff in working with parents and documenting this effort.
- Title XX prevention and care programs employed a variety of parent involvement strategies, including parent meetings, whole-family activities, home visits involving adolescents and parents together, and providing gifts and food to increase parent participation in activities.

- Title X programs were unique in offering counseling to adolescents and focusing on staff training and paperwork assistance and monitoring, Title XX prevention programs were more likely to deliver evidence-based curricula with parent involvement components than other programs, and Title XX care programs linked parents with other needed services and attended to empowering parents.
- Programs identified multiple reasons why parents do not participate in program activities, including limited availability, logistical barriers, and psychosocial issues. Additional barriers to parent involvement include staff-related or administrative barriers among Title X programs, adolescent opposition to parent involvement, and complex dynamics and cultural barriers that discourage parent involvement among Title XX care programs. Title X and Title XX care staff discussed perceptions about confidentiality as a barrier to parent involvement, but there was much disagreement among staff (and within sites) about whether and how confidentiality hinders parent involvement.
- Little evidence is available to demonstrate impacts of parent involvement programs on parent or adolescent outcomes. Two Title XX prevention programs have demonstrated positive impacts of whole-family meetings and at-home parent-only group meetings on parent-child communication, parents' comfort with parent-child communication, and adolescents' perceived risk from sexual activity.
- Lessons learned from unsuccessful attempts to involve parents include the need to obtain Title X staff buy-in for involving parents; the importance of presenting opportunities for parents to interact, providing food and incentives for parent participation, and partnering with schools among Title XX prevention programs; and specific steps for interacting with parents among Title XX care programs.

Overall, we identified mixed evidence for effectiveness of parent involvement programs in improving reproductive health among adolescents. In particular, there is a paucity of research on parent involvement for pregnant and parenting adolescents. Low parent participation was noted in studies of Title X and Title XX programs. Although Title X and Title XX programs employ a variety of creative strategies to involve parents, additional evaluation is needed.

Practitioners need to further address barriers to parent involvement, particularly psychosocial barriers, relationship dynamics, and cultural issues. Staff training and technical assistance may be needed to address these. In the absence of evidence-based parent involvement strategies, programs should employ theoretically based parent recruitment, involvement, and retention strategies. Because the empirical research base is limited, rigorous evaluation of such strategies is needed. Individual-level data about parent involvement should be collected for analysis of parent-child paired data to examine the relationship between parent involvement and adolescent outcomes. It may be beneficial for recommended measures and methodologies to be developed and tailored by program type, for use by Title X, Title XX prevention, and Title XX care programs. Studies with enhanced methodology (e.g., biological outcomes) and clearly specified parent involvement strategies with quality control for training and implementation are needed. In addition, family involvement studies, including fathers, mothers, parent substitutes, older siblings, and grandparents, may also benefit the field.

This report is organized into seven chapters:

- Chapter 1 reviews evidence of the associations between parent involvement and adolescent sexual risk behavior.
- Chapter 2 reviews previous research on the effectiveness of strategies designed to enhance parent involvement in programs serving adolescents.
- Chapter 3 describes Office of Population Affairs (OPA) programs, the site selection strategy, the assessment sample, and data collection methods.
- Chapter 4 describes parent involvement strategies in Title X and Title XX programs.
- Chapter 5 summarizes barriers to involving parents in program activities.
- Chapter 6 presents additional lessons learned about parent involvement.
- Chapter 7 summarizes the chief findings of this report in comparison with other relevant studies, describes strengths and limitations of the current study, presents recommendations for promising practice models and future assessments, reviews lessons learned from more developed disciplines, and discusses policy and future research implications for improving adolescent health services.

Why Parents Matter: A Brief Review of the Research

Jennifer Manlove, Lina Guzman, Olivia Silber Ashley, and Sarah Cottingham

Parents are a primary source of socialization and influence on many aspects of adolescent psychological and social functioning and behavior (Ashley et al., 2004; Bauman, Carver, & Gleiter, 2001; Johnson & Pandina, 1991; Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Steinberg, Lamborn, Dornbusch, & Darling, 1992). Although many other factors associated with adolescents' risk behaviors have been identified (Jaccard, Dodge, & Dittus, 2002), there is emerging interest in understanding the impact of parents and family on adolescents' adoption and maintenance of health-compromising and protective behaviors (Jessor, Turbin, & Costa, 1998). A large body of empirical research and theory has shown that the nature and extent of parents' involvement in their children's lives are strongly related to adolescent risk behaviors (Ajzen & Fishbein, 1973; Hindelang, Dwyer, & Leeming, 2001; Nelson, Patience, & MacDonald, 1999; Pearce, Jones, Schwab-Stone, & Ruchkin, 2003; Resnick et al., 1997). Parent involvement has been shown to be uniquely associated with a decrease in adolescent problem behaviors, even among adolescents exposed to community-level risk factors (Pearce et al., 2003). Although many studies of parent involvement have utilized cross-sectional designs, which are limited in their ability to establish causality, the literature suggests that parent involvement is beneficial for adolescents.

Parents may influence their children's behavior many ways. Throughout the socialization process, parents transmit their own standards of conduct, both directly through their parenting practices and indirectly through their own observable behavior. Social learning theory (Bandura, 1977) emphasizes the importance of modeling for the acquisition and maintenance of behavior. Child socialization researchers have further suggested that a key way in which parents influence their children's well-being is by steering them toward membership in prosocial peer groups (Parke & Ladd, 1992). Parent involvement therefore reduces problem behaviors by limiting the number of friends engaged in such behaviors (Simons-Morton, Chen, Abroms, & Haynie, 2004). Parent involvement can also counteract negative peer influences on

1.1 Parent Involvement and Adolescent Sexual or Contraceptive Use Behaviors

Adolescents have been found to be at particularly high risk for many negative consequences related to sexual risk behavior (U.S. Department of Health and Human Services [DHHS], 1997; DHHS,

2000). Empirical research has shown that parent involvement is strongly associated with adolescent sexual behaviors (Manlove, Terry-Humen, Franzetta, & Moore, 2004; Repetti, Taylor, & Seeman, 2002). Specifically, parent involvement has been shown to delay sexual initiation; decrease rates of premarital sexual activity, sexually transmitted infections (STIs), pregnancy, and childbearing; reduce the number of sexual partners; and increase use of condoms and other contraceptives (Kotchick, Shaffer, & Forehand, 2001; Tinsley, Lees, & Sumartojo, 2004). Findings from a wide range of cross-sectional and longitudinal studies highlight several dimensions of parent involvement associated with positive adolescent reproductive health behaviors, including parent-child communication about sex, contraception, pregnancy, and/or HIV risk; parental monitoring of adolescents' behavior; and other parenting behaviors.¹

1.2 Parent-Child Communication

Numerous studies have found that parent-child communication about reproductive health issues, such as sex, contraception, and HIV and pregnancy risk, is associated with delayed sexual initiation, reduced sexual activity, improved use of condoms and/or other contraceptives, increased communication between adolescents and their sex partners, a lower risk of pregnancy, and increased self-efficacy to negotiate safer sex (DiClemente et al., 2001; Dutra, Miller, & Forehand, 1999; Guzman et al., 2003; Holtzman & Robinson, 1995; Hutchinson, Jemmott, Braverman, & Fong, 2003; Jaccard et al., 2002; Manlove, Terry, Gitelson, Papillo, & Russell, 2000; Miller, Forehand, & Kotchick, 1999; Miller, Levin, Whitaker, & Xu, 1998). This association has been found among many adolescent subgroups, including multiple racial/ethnic groups, low-income populations, and males and females (Miller, Benson, & Galbraith, 2001; Romer et al., 1999). Serious parent-child discussions about sex and condoms can be especially important for adolescents in communicating with sexual partners about sexual risk and condom use (Whitaker, Miller, May, & Levin, 1999) and in preventing adolescents from conforming to more permissive peer norms about sexual risk-taking (Whitaker & Miller, 2000). Adolescents who talked with their parents about sex were more likely to believe that parents, rather than peers, provide the most useful information about sex (Whitaker & Miller, 2000). Recent studies have found that the relative timing of parent-child communication and sexual initiation influence whether communication has a positive or negative association with risky sexual behaviors. Whereas parent-child communication after sexual initiation was associated with reduced condom use (Miller et al., 1998), parent-child communication before sexual initiation was associated with a later timing of first sex, fewer sexual partners, and increased use of condoms and other contraceptives (Clawson & Reese-Weber, 2003; Miller et al., 1998).

The association between parent-child communication and adolescent sexual and contraceptive use behaviors may depend on parent values, attitudes, and responsiveness. Several studies have found that adolescents whose parents clearly express their values and beliefs, including those who communicate strong disapproval of sexual activity or unprotected sex, are more likely to avoid risky sexual behaviors (Jaccard, Dittus, & Gordon, 1996; Romo, Lefkowitz, & Sigman, 2002). One study found that the association between parent-child communication and increased condom use was significant only if

¹ Because many of the studies discussed in this section are based on analyses of cross-sectional data, where parenting and adolescent outcomes are measured at the same time, concluding that parent involvement caused the observed outcomes is not possible. Instead, associations between parent involvement and desired outcomes are described. Section 2 of this review profiles experimental studies, which provide the only appropriate research approach for determining causality.

parents were responsive, open, and knowledgeable in their discussions about sex, contraception, and HIV/STI risks (Whitaker et al., 1999). Positive parent-child communication in combination with a strong parent-child relationship and more traditional parent values may provide the most protective outcomes for adolescents (Jaccard et al., 1996; Miller, 1998).

1.3 Parental Monitoring/Awareness

Parental monitoring includes parent knowledge about where and with whom their adolescents are, their activities when they are not at home or in school, and their friends and their friends' parents, as well as supervision of dating and activities (Borawski, Levers-Landis, Lovegreen, & Trapl, 2003; DiClemente et al., 2001; Manlove et al., 2004; Xiaoming, Stanton, & Feigelman, 2000). Higher levels of parental monitoring are associated with fewer risky sexual behaviors among adolescents, mainly by limiting opportunities for sexual activity (DiClemente et al., 2001; Dishion & McMahon, 1998). Several studies have shown that parents who monitor their adolescents' behavior can help delay initiation of sexual activity (Manlove et al., 2004; Miller, 1998; Romer et al., 1999; Smith, 1997). Increased parental monitoring has also been associated with fewer sexual partners (DiClemente et al., 2001; Miller, 1998; Miller et al., 1999; Pearce et al., 2003; Rodgers, 1999), increased condom or other contraceptive use (Borawski et al., 2003; Miller et al., 1999; Rodgers, 1999; Xiaoming et al., 2000), lower risk of pregnancy (Crosby et al., 2002), and a lower likelihood of testing positive for an STI (Crosby, DiClemente, Wingood, Lang, & Harrington, 2003; DiClemente, Crosby, & Wingood, 2002a; DiClemente et al., 2001). Parental monitoring shows consistent protective effects among many adolescent subgroups, including both males and females; white, black, or Hispanic adolescents; both younger and older adolescents; and adolescents in economically disadvantaged communities (Kotchick et al., 2001; Miller et al., 2001; Romer et al., 1999). However, excessive or inappropriate parental control can be associated with increased problem behaviors among adolescents (Miller, 1998; Rodgers, 1999). In addition, polling data indicate that a substantial percentage of parents of sexually experienced adolescents do not know that their children have had sexual intercourse (Kaiser Family Foundation, 2002).

1.4 Other Parenting Behaviors

Similar associations have been found between other parenting behaviors and adolescents' sexual risk behaviors. Turner, Irwin, Tschann, and Millstein (1993) found that parental autonomy support, which included avoiding overprotection and encouraging expression of opinions, was inversely related to initiation of sexual intercourse during early adolescence. Several studies indicate that strong parent-child relationships are associated with later adolescent sexual initiation, lower likelihood of pregnancy, and increased contraceptive use (Dittus & Jaccard, 2000; Jaccard et al., 1996) among males and females and among multiple racial and ethnic groups (Bearman & Bruckner, 1999; Miller et al., 1997; Resnick et al., 1997; Scaramella, Conger, Simons, & Whitbeck, 1998; Smith, 1997). Dimensions of parent-child relationships include adolescent perceptions of parental caring (Bearman & Bruckner, 1999), adolescent satisfaction with their relationship with their parent (including satisfaction with general communication, affection and emotional support, discipline, conflict resolution, respect, and shared time and interests) (Dittus & Jaccard, 2000; Jaccard et al., 1996), parent-child attachment (Smith, 1997), and parent-child connectedness (such as closeness, caring, satisfaction, and being loved [Dittus & Jaccard, 2000; Jaccard et al., 1996; Miller et al., 1997; Resnick et al., 1997]). While most studies of relationship quality focus on

mother-child relationships, one study has also found that the link between father-son closeness and the number of adolescent sexual partners was similar to the link found between mothers and sons in this regard (Feldman & Brown, 1993). Some studies have found that adolescents with weaker relationships with their parents are more likely to use alcohol or other drugs, associate with sexually active friends, and have more sexually permissive attitudes, all of which are associated with riskier adolescent sexual behaviors (Miller et al., 2001). A combination of close, supportive environments and encouraged independence is associated with successful transitions from adolescence to adulthood (Noller, 1995).

1.5 Parent Involvement with Pregnant and/or Parenting Adolescents

In addition to the influence of parents on adolescent sexual risk behaviors, research documents the important role that parents can play in the lives of pregnant or parenting adolescents and their children.² There is a significant relation between the amount and quality of the social support a pregnant or parenting adolescent receives and her health, her general life circumstances, and the health and well-being of her child (Clemmons, 2001; Logsdon, Birkimer, Ratterman, Cahill, & Cahill, 2002). These relations are observed regardless of the source of the social support. However, social support for the pregnant or parenting adolescent comes primarily from her parent(s) (McCullough & Scherman, 1991) and from the baby's father (Koniak-Griffin & Turner-Pluta, 2001).

Parents provide a wide range of assistance and resources to adolescent mothers, including economic and emotional support, child care, and a place to live (Caldwell & Antonucci, 1997; Gordon, Chase-Lansdale, Matjasko, & Brooks-Gunn, 1997; Jayakody, Chatters, & Taylor, 1993; Kalil & Danziger, 2000; Minkler, 1999; Spencer, Kalil, Larson, Spieker, & Gilchrist, 2002). In particular, coresidency facilitates the provision of these other forms of support, such as economic support (Bunting & McAuley, 2004). Furthermore, parents continue to act as primary parents for their adolescents while potentially compensating for a lack of adolescent parenting skills or attention given to the adolescents' children (Dallas, 2004).

Researchers and practitioners have viewed the support provided by mothers of adolescent parents as a crucial force in improving the life circumstances of these adolescents and their children. In general, family support has been demonstrated to be essential for successful long-term outcomes among adolescent mothers and their children (Apfel & Seitz, 1991). Some studies suggest that parent involvement in grandchild rearing reduces the parental burden of adolescent mothers (Spencer et al., 2002; Unger & Cooley, 1992) and that adolescent mothers who receive child care assistance, advice, and support from their mothers exhibit more positive and less restrictive or punitive parenting styles (SmithBattle, 1996). Living with their own mothers has been linked to better school outcomes and reductions in the likelihood of repeat pregnancies for adolescent mothers (Solomon & Liefeld, 1998). Parent involvement has also been found to be associated with improved outcomes for the children of adolescent parents, in particular for those children whose adolescent parents lack the maturity or experience to care for them adequately on their own (Apfel & Seitz, 1991; Caldwell, Antonucci, Jackson, Osofsky, & Wolford, 1995). Existing research suggests that parent involvement may be most beneficial

² However, most studies have been based on small or localized samples or have focused exclusively on minority and low-income groups.

for very young adolescent mothers (Chase-Lansdale, Brooks-Gunn, & Zamsky, 1994; Wakschlag, Chase-Lansdale, & Brooks-Gunn, 1996). Family support may also facilitate the continued paternal involvement of adolescent fathers (Bunting & McAuley, 2004).

However, adolescents whose parents possess fewer resources or skills may benefit less from parent involvement (Wakschlag et al., 1996). Indeed, researchers have found that in some cases parents' parenting styles and behavior may not be superior to those of adolescent mothers (Chase-Lansdale et al., 1994; Wakschlag et al., 1996). Recent studies have also identified potential negative effects of parent involvement on adolescent mothers' emotional and psychological well-being and parental role and identity (Minkler, 1999; Solomon & Marx, 1995). For example, several studies have found that childrearing conflicts between adolescents and their mothers are associated with adolescents' parental stress (Caldwell & Antonucci, 1997; Spencer et al., 2002) and poorer psychological functioning and social adjustment (Davis & Rhodes, 1994). Although causality may run in multiple directions, other studies have found that when adolescent mothers and their own mothers live together, adolescent mothers showed less competent and more problematic parenting behavior (Chase-Lansdale et al., 1994; Wakschlag et al., 1996).

Effectiveness of Parent Involvement Strategies

Jennifer Manlove, Lina Guzman, Olivia Silber Ashley, Zakia Redd, and Sarah Cottingham

Reviews of effective reproductive health programs for adolescents have not specifically highlighted parent involvement as a key factor that may affect program effectiveness (Robin et al., 2004). This chapter presents the first examination of the effectiveness of strategies designed to promote parent involvement in programs serving adolescents.

Evidence was gathered through a systematic literature search. Publications from 1985 to January 2005 were identified through a search of peer-reviewed published literature using multiple electronic databases (e.g., Medline, Web of Science, Psychlit, Psychology & Behavioral Sciences Collection, Sociological Collection, Social Science Abstract, and PsycINFO) and existing lists of relevant pregnancy prevention programs compiled by Child Trends (Manlove et al., 2002), the National Campaign to Prevent Teen Pregnancy (Kirby, 2001), Sociometric's Program Archive on Sexuality, Health, and Adolescence (PASHA), and the Sexuality Information and Education Council of the United States (SIECUS) (Kirby, 2002; Sexuality Information and Education Council of the United States, 2002). To be included in this review, studies must have explicitly defined the target population as adolescents in the United States or Canada, included a parent involvement component, and presented outcome measures to evaluate program effectiveness. The outcome measures included adolescent intentions or behaviors regarding sexual activity or reproductive health and parent or adolescent knowledge, attitudes, or communication. Study characteristics were examined, including study design, sample size, participant characteristics, nature of interventions, and outcomes.

We identified a total of 26 studies: 14 randomized controlled trials and 12 nonrandomized studies.³ Optimally, health interventions are evaluated through a rigorous randomized controlled trial (or series of trials), the standard for establishing efficacy (Bauman, 1980; Bauman, Viadro, & Tsui, 1994; Campbell & Stanley, 1963; Sackett, Haynes, Guyatt, & Tugwell, 1991). The 14 randomized trials differed in interventions, methodologies, and parent involvement strategies, while the 12 nonrandomized studies employed quasi-experimental or pre-experimental study designs. Of the 14 randomized, controlled trials reviewed here, the Managing Pressure Before Marriage study (Blake, Simkin, Ledsky, Perkins, & Calabrese, 2001) and the Youth AIDS Prevention Project study (Weeks et al., 1997) came closest to the optimal study design for offering insights into the effectiveness of parent involvement strategies. The Managing Pressure Before Marriage study randomly assigned adolescents to receive a middle-school abstinence-only curriculum or to receive the curriculum plus homework assignments for parents and children and compared them immediately after the intervention. In the Youth AIDS Prevention Project, adolescents were randomly assigned to one of three groups—a comprehensive school-based AIDS

³ Randomized experimental evaluations of abstinence education programs in several states are underway (Devaney, Johnson, Maynard, & Trenholm, 2002), but these evaluation results are not yet available.

education curriculum plus parent involvement components, curriculum only, or control and were compared repeatedly over 2 years.

Across the 26 populations analyzed, 22 studies reported improved outcomes for adolescents and/or parents. A total of 11 of the 14 randomized controlled trials (Exhibit 1) and 11 of the 12 nonrandomized studies showed positive results with respect to parent-adolescent communication, knowledge, skills, parental monitoring, and in fewer cases, sexual initiation, unprotected sex, and pregnancy rates among adolescents.

Overall, it is not clear whether programs evaluated with randomized experimental designs affected adolescent behavioral outcomes. It is striking that only nine randomized experimental studies in this important area have measured adolescent behavioral outcomes. It is even more striking that almost as many randomized experimental studies found no such effects as found these effects. Four studies found that parent involvement programs reduced adolescent rates of sexual initiation; reduced adolescent frequency of intercourse without a condom and the number of sexual partners not using a condom; increased adolescent use of multiple methods of protecting against pregnancy and STIs; reduced adolescent pregnancy rates; and positively affected adolescent birth and delaying sex among girls (Allen, Philliber, Herrling, & Kuperminc, 1997; Coyle et al., 2001; Philliber, Kaye, Herrling, & West, 2002; Weed, 2004). These programs employed youth development models, parent workshops, and home-based videos. Outcomes were measured at 1- to 3-year follow-up. A fifth randomized experimental study decreased adolescent likelihood of being sexually experienced and engaging in unprotected sex at 6 months following program completion, but impacts were no longer present or significant at 12-month follow-up (Wu et al., 2003). Evaluators of the four randomized experimental studies that did not report positive impacts suggested that the lack of effectiveness of parent involvement strategies may be a result of limited parent participation in the studies and/or programmatic flaws, including failure to fully implement parent involvement components as intended (Kirby, Korpi, Barth, & Cagampang, 1997; Moberg & Piper, 1998; Oliver, Leeming, & Dwyer, 1998; Weeks et al., 1997).

As part of this review, three parent involvement approaches were examined: parent-adolescent programs, parent-only programs, and grassroots community organizing programs. We focus primarily on programs that have reported adolescent behavioral outcomes when evaluated with randomized experimental designs. In addition, parent involvement in one program for pregnant or parenting adolescents was examined.

Exhibit 1. Randomized Studies of the Effectiveness of Parent Involvement Strategies in Programs Serving Adolescents

Program Name	N	Population	Parent Involvement Strategy	Interventions	Control Condition	Outcomes
Teen Outreach Program (TOP) (Allen et al., 1997)	25 sites	Middle and high school students aged 11 to 19 from mixed socioeconomic backgrounds	Parent workshops	Youth development program, including “family night out” gatherings, parent workshops addressing adolescent sexuality, child care and dinner incentives for parent participation	No intervention	At end of school year: Positive results regarding pregnancy rates, reduced course failure and school suspension
Safer Choices (Coyle et al., 2001)	20 school sites	School sites in Texas and California	Parent workshops and homework assignments	Comprehensive school-based sexual education program with parent education newsletter, homework activities for parents and students to complete together, parent orientation and other activities and events, parent membership on a health promotion council	Standard knowledge-based HIV prevention programming	At 2-year follow-up: Reduced frequency of intercourse without a condom and number of sexual partners not using a condom; increased use of multiple methods of protecting against pregnancy, HIV, and STIs
Children’s Aid Society Carrera Model (Philliber et al., 2002)	484 individuals	Low-income, mostly minority adolescents	Parent workshops or training sessions	Long-term youth development program, including a family life and sex education program, extensive parent orientation session, staff members working with participant families, incentives such as compensation for tuition	Standard youth development program	At 3-year follow-up: Positive impacts on preventing adolescent pregnancy and birth, using dual methods of contraception, delaying sex among girls; very few impacts among boys, negative impact on dual method use

(continued)

Exhibit 1. Randomized Studies of the Effectiveness of Parent Involvement Strategies in Programs Serving Adolescents (continued)

Program Name	N	Population	Parent Involvement Strategy	Interventions	Control Condition	Outcomes
Choosing the Best WAY, PATH, and LIFE (Weed, 2004)	938 individuals	7th-, 8th-, and 9th-graders in health and physical education classes in seven schools in Pike and Spaulding Counties in GA	Parent training sessions and homework assignments	Abstinence education lessons with brief video vignettes, illustrated student manual, exercises with “hands-on” activities, homework interview questions to ask parents, 1-hour parent education trainings, mailed parent book	Did not receive program	At 1-year follow-up: Reduced rates of sexual initiation
Project Informed Parents and Children Together (ImPACT) (Wu et al., 2003)	817 individuals	12- to 16-year-old black adolescents from 35 low-income communities	Home-based videos	One-session videotape and discussion between adolescents and their parents, combined with Focus on Kids (an HIV/AIDS education program)	Focus on Kids alone	At 6-month follow-up: Increased parental monitoring, controlling for differences at baseline; decreased likelihood of being sexually experienced and engaging in unprotected sex. By the 12-month follow-up, impacts were no longer present or significant, and adolescents in the program group reported higher levels of problems with communicating with their parents
Facts and Feelings (Miller et al., 1993)	548 families	Predominantly white, Mormon 7th and 8th graders from two-parent families in semi-rural or urban school districts in northern Utah	Home-based videos	Either (1) six 15- to 20-minute videotapes covering a sexual education curriculum with mailed newsletters or (2) videotaped curriculum without mailed newsletters; Abstinence-based HIV/AIDS and sex education program	No videotaped training	At 1-year follow-up: Increased frequency of parent-child communication on sexual topics; no differences regarding sexual intentions and behaviors

(continued)

Exhibit 1. Randomized Studies of the Effectiveness of Parent Involvement Strategies in Programs Serving Adolescents (continued)

Program Name	N	Population	Parent Involvement Strategy	Interventions	Control Condition	Outcomes
Family/Media AIDS Prevention Project (Winett et al., 1992; 1993)	2 Evaluations: 45 families and 69 families	12- to 14- year-old boys and girls in Roanoke, VA	Home-based videos	Either (1) 2-hour, four-video program covering HIV/AIDS prevention, STI education, and adolescent assertiveness and family problem- solving strategies; or (2) video with information but no skills training	No video	At 6-month follow-up: Increased knowledge and skills for video and skills group (Winett et al., 1992) At 4-month follow-up: Increased HIV- related knowledge with both versions of the video, but increased knowledge of communication skills and behavioral demonstrations of family problem solving were only documented in families who received the skills-training version (Winett et al., 1993)
Postponing Sexual Involvement (PSI)/ Education Now and Babies Later (ENABL) (Kirby et al., 1997)	10,600 individuals	7th and 8th graders in several California counties	Parent training sessions	Statewide media campaign, school- and community- based activities to promote abstinence, five 45- to 60- minute curriculum sessions covering sexuality and skills training, one 1 ½- to 2-hour session for parents on the curriculum, parent nights, PTA meetings to discuss ENABL	No intervention	At 17-month follow-up: No impacts on attitudes and beliefs about sex, assertiveness skills, or sexual behaviors

(continued)

Exhibit 1. Randomized Studies of the Effectiveness of Parent Involvement Strategies in Programs Serving Adolescents (continued)

Program Name	N	Population	Parent Involvement Strategy	Interventions	Control Condition	Outcomes
Reaching Adolescents and Parents (RAP) (Anderson et al., 1999)	251 individuals	Racially diverse adolescents aged 9 to 14 in Los Angeles from a range of socioeconomic backgrounds	Joint attendance	School-based program including eight sex education sessions (one including parents and adolescents and one for parents only)	Delayed intervention	At 12-month follow-up: Increased parent-child communication about sexuality
Managing Pressures before Marriage (MPM) (Blake et al., 2001)	351 individuals	Middle-school students from a predominantly white middle-class suburb near Rochester, NY	Homework assignments	Abstinence-only curriculum plus homework assignments for parents and children	Curriculum only	Upon program completion: Increased adolescent self-efficacy to avoid high-risk behaviors and in reinforcing their decision to postpone sexual intercourse, increased communication with parents, no differences in adolescent comfort in talking to parents about sex
Youth AIDS Prevention Project (YAPP) (Weeks et al., 1997)	2,392 individuals	High-risk 7th- to 9th-graders, in 15 school districts in the Chicago metropolitan area; 56% African American, 23% white, 17% Hispanic	Homework assignments	Comprehensive school-based AIDS education curriculum over 10 lessons and five additional “booster” classes 1 year later plus parent-child homework assignments, parent meetings, parent information booklets, parent-organized networks and activities	Either (1) YAPP curriculum only or (2) standard AIDS curriculum	At 2-year follow-up: No difference in adolescent comfort in discussing sex and drugs with their parents, knowledge of AIDS and effectiveness of contraceptives, or adolescents’ alcohol use or sexual activity between curriculum only and parent involvement groups

(continued)

Exhibit 1. Randomized Studies of the Effectiveness of Parent Involvement Strategies in Programs Serving Adolescents (continued)

Program Name	N	Population	Parent Involvement Strategy	Interventions	Control Condition	Outcomes
Healthy for Life Project (Moberg & Piper, 1998)	21 middle schools	6th, 7th, and 8th grader at middle schools in small Wisconsin cities and towns	Parent workshops and homework assignments	Comprehensive sex education and substance abuse prevention program with parent orientation sessions, home mailings, and homework in which adolescents interview their parents about dating and sexual behaviors; baseball cap and t-shirt incentives	Standard sexual education programming	At 4-year follow-up: No reduction in sexual risk behaviors
Los Angeles communication program (Lefkowitz, Sigma, & Au, 2000)	40 families	Mothers of 11- to 15-year-olds in the Los Angeles area	Parent-only approach	Two parent training sessions on parent-child communication, including audio tapes, role-playing exercises, homework assignments	Delayed receipt of program	Upon program completion: Improved conversational style, content, adolescent comfort level, parent knowledge about AIDS

2.1 Parent-Adolescent Programs

Studies that evaluated the effectiveness of parent-adolescent programs provided home-based videos, included parent workshops or training, conducted sessions for parents and adolescents together, and/or assigned homework. Findings concerning these types of parent involvement strategies are discussed below.

2.1.1 Home-Based Videos

No rigorous study has shown impacts of home-based videos on adolescent behavioral outcomes. Two experimental studies evaluated adolescent behavioral outcomes from parent-adolescent programs that used home-based video training as their primary strategy for involving parents. The first program, Project Informed Parents and Children Together (ImPACT), provided an extension of Focus on Kids, an experimentally evaluated HIV/AIDS education program with positive impacts on condom use (Wu et al., 2003). ImPACT consists of a one-session videotape and discussion program between adolescents and their parents. A 6-month follow-up showed that compared with Focus on Kids alone, adolescents who participated in Focus on Kids + ImPACT reported higher levels of parental monitoring, controlling for differences in monitoring at baseline, and were less likely to be sexually experienced and to have engaged

in unprotected sex. By the 12-month follow-up, these impacts were no longer present or significant, and adolescents in the program group reported higher levels of problems with communicating with their parents (Wu et al., 2003). A second program, Facts and Feelings, provided abstinence-based sex education through either (1) six 15- to 20-minute videotapes covering a sexual education curriculum with mailed newsletters covering discussion points or (2) the videotaped sex education curriculum without the mailed newsletters. Both treatments led to increases in the frequency of parent-child communication on sexual topics, though these effects subsided after the families no longer had access to the videos. No differences were found between the treatment and control groups regarding sexual intentions and behaviors (Miller et al., 1993). A third program, The Family Media AIDS Prevention Project, provided a 120-minute, four-video program covering the topics of HIV/AIDS prevention, STI education, and adolescent assertiveness and family problem-solving strategies (Winett et al., 1992). The program resulted in increased knowledge and skills by parents and adolescents (Winett et al., 1993).

2.1.2 Parent Workshops or Training Sessions

Many programs conduct workshops or training sessions for parents of adolescent participants. It is difficult to analyze the unique impact of parent workshops or training sessions on outcomes because in some studies, this strategy was combined with other program approaches, and the effectiveness of the parent involvement component was not separately evaluated (Kirby, 2002). Three randomized trials compared adolescents receiving programs using parent workshops or training sessions as their primary means of involving parents with adolescents not receiving such programs. First, Teen Outreach Program (TOP) is a youth development program with a service learning focus implemented through schools and communities throughout the country. It has two major components: small group classroom discussions about values, decision making, communication skills, parenting, and life options; and volunteer experiences and volunteer service in the school or community (Kirby, 2001). The TOP curriculum includes a parent component, including “family night out” gatherings and parent workshops that addressed child sexuality. TOP provided child care and dinner as incentives for parent participation. Two studies of the program, one quasi-experimental and one experimental, found reductions in pregnancy rates, course failure rates, and school suspension (Allen et al., 1997; Kirby, 2001; Philliber & Allen, 1992).

Second, the Children’s Aid Society Carrera Model is a long-term youth development after school and summer program (Philliber et al., 2002). The program has five essential parts: a work-related intervention, an educational component, self-expression through the arts, lifetime individual sports, and the family life and sex education (FLSE) program. Parents attend an extensive orientation session, and staff members work with participant families to aid in overcoming family-related barriers that potentially inhibit adolescents from participating in the program fully, such as caring for younger siblings or lack of transportation. Community organizers make about two contacts a month with adolescents or their families outside of program hours. The program discourages parents from pulling their children out of the program as a means of punishment and uses incentives, such as compensation for tuition, to encourage parents to stay involved in the program (Philliber, Kaye, & Herrling, 2001). The program prevented adolescent pregnancy and birth, increased use of dual methods of contraception, and delayed sex among girls but produced few impacts among male participants and negatively affected their dual method use (Philliber et al., 2002). Overall, educational attainment and job skills also improved (Philliber et al., 2001).

Third, the Postponing Sexual Involvement (PSI) curriculum used as part of the Education Now and Babies Later (ENABL) initiative employed a statewide media campaign and school- and community-based activities (such as assemblies and fairs) to promote messages encouraging young people to abstain from sex (Kirby et al., 1997). Students received five 45- to 60-minute PSI curriculum sessions covering sexuality and skills training, such as peer resistance and assertiveness skills, from trained professional or youth educators in a program or school setting. The program offered PSI for Parents, which usually provided one 1½- to 2-hour session for parents on the curriculum (Kirby et al., 1997). Other activities for parents included courses offering the PSI for Parents curriculum, parent nights, and PTA meetings to discuss ENABL. However, only 17 sites (representing only about 5% of parents and youth in the California study) of the ENABL initiative utilized PSI for Parents (Kirby et al., 1997). Further, only about 19% of adolescents in the ENABL study had parents who attended one or more parent events. Although the program did have a few favorable impacts at the 3-month follow-up on some attitudes and beliefs about sex for the group receiving youth-led training, these impacts were short-lived and had disappeared by the 17-month follow-up. The program had no impact on parent-child communication or adolescent assertiveness skills or sexual behaviors at either the 3- or 17-month follow-ups.

A fourth study involved a nonrandomized quasi-experiment of a school-based sex education program that used voluntary training workshops for parents and homework assignments as main strategies for involving parents (Oliver et al., 1998). Only 14 families (among 274 treatment condition adolescents) attended the parent workshops, and only a little more than half of the planned homework assignments were actually provided to students. The study found no significant differences in recency of parent-child communication about sex or the value of these discussions.

2.1.3 Joint Attendance Programs

Some studies that evaluated the effectiveness of parent involvement strategies examined opportunities for parents and adolescents to learn about and discuss sexuality issues together by requiring or encouraging joint attendance at multiple sexual education sessions. One study reported evaluation results using a randomized experimental design but did not measure adolescent behavioral outcomes. RAP is a school-based program that includes eight sex education sessions, two of which include parents (one parent and youth, one parent only), and focuses on activities designed to increase knowledge and improve decision-making skills. Overall, the researchers found a significant increase in parent-child communication about sexuality for participants, but the effect diminished by the 12-month follow-up survey (Anderson et al., 1999).

Results from three quasi-experimental studies provide preliminary evidence that joint attendance programs can be an effective way to improve parent-child communication and improve sexual intentions and behaviors among adolescents. First, the Family Guidance Center Parent-Child Program provides small-group classes separated by gender (mother/daughter groups and father/son groups) and by age of adolescent (9- to 12-year-olds and 13- to 17-year-olds), in community settings in rural counties of northwest Missouri (Kirby, 1984). A quasi-experimental evaluation of this program compared adolescent participants to adolescents in sites that did not receive the intervention. Adolescents and parents in the program reported improvements in the frequency of parent-child communication and greater comfort in communicating about sexuality compared with adolescents and parents who did not receive the

intervention (Kirby, 2002). Participation in the program was also associated with increases in adolescents' knowledge of reproductive health and with improvements in attitudes toward sexual risk-taking behaviors; however, older adolescents in the program showed no improvements in decision-making skills (Kirby, 2002).

The Parent-Adolescent Relationship Education (PARE) program educated parents and middle-school adolescents aged 12 to 14 in southeast Texas about STI and pregnancy prevention (Lederman & Mian, 2003). An evaluation study of the program combined an experimental design comparing students who received the interactive approach to students who received the didactic approach with a quasi-experimental design comparing students who received either intervention treatment with the remaining 634 students in the same schools, who received no treatment. The study found that the young adolescents in the interactive parent-child group sessions expressed stronger intentions to avoid sexual involvement than those in the parent-child group receiving didactic trainings or those in the comparison group of non-participants (Lederman, Chan, & Roberts-Gray, 2004). However, no statistically significant differences were found among the three groups in the extent to which adolescents reported they talked with their parents and their attitudes toward sexual risk-taking behaviors (Lederman et al., 2004).

Project Taking Charge uses an abstinence-based approach, administered for 6 weeks to adolescents enrolled in 7th-grade home economics classes (Jorgensen, Potts, & Camp, 1993). The parent involvement component included three evening sessions designed to help parents and adolescents communicate by using communication exercises, values exploration, and presentation of factual materials. The program was evaluated using a pre-test, post-test quasi-experimental group design in Wilmington, Delaware, and West Point, Mississippi. The comparison group was composed of students who had not been exposed to the curriculum. Participants showed increases in knowledge at post-test, but the program was not associated with increases in parent-child communication about sexual issues or values. At the 6-month follow-up, program participants were significantly less likely to have initiated sexual intercourse during the period following the intervention.

Two less rigorous evaluations of parent-adolescent joint attendance programs have also been conducted. The Family Communication Project was administered to 10- to 13-year-olds and their parents in four 2½-hour sessions, using lecture, group discussions, and video presentations (Benshoff & Alexander, 1993). The first session was a parent orientation to the program, and the following three sessions were designed for parents to attend with adolescents. An evaluation that compared adolescents and their parents before and after the program (using pre-tests and post-tests) showed increases in the frequency of parent-adolescent conversations and in comfort levels with conversations about sexual topics over the course of the program among parents and adolescents, as well as improvements in knowledge and attitudes about sexuality. The Growing Together curriculum has been used with girls aged 12 to 14 and has been adapted for younger age groups as well (Girls Incorporated National Resource Center, 2003). Growing Together sessions included didactic materials about relevant topics, as well as small group discussion, films, and experiential activities to facilitate parent-child communication. The program was evaluated in Dallas, Texas; Memphis, Tennessee; Omaha, Nebraska; and Wilmington, Delaware, using pre-test and post-test data. The study found that participants were less likely to report initiation of

sexual intercourse than non-participants. However, given the non-experimental design used in the evaluations of both programs, it is not clear whether improvements could be attributed to the programs.

2.1.4 Homework Assignments

This approach enables programs to reach out to a large number of parents through supplementary homework assignments and activities that facilitate parent-child interaction about sexuality. Moreover, the inclusion of homework assignments in programs serving adolescents may help to minimize the self-selection bias associated with other types of parent involvement, since only the most motivated of parents tend to participate in school-based events. One study randomly assigned adolescents either to an HIV/AIDS prevention curriculum plus parent interactive components, curriculum only, or control. The Youth AIDS Prevention Project (YAPP) included a comprehensive school-based AIDS education curriculum delivered over 10 lessons and five additional “booster” classes 1 year later (Levy et al., 1995; Weeks et al., 1997). The parent-interactive components included parent-child homework assignments, parent meetings, parent informational booklets, and parent-organized networks and activities. Parent participation in school meetings and parent networks was minimal, with an average of 10 to 15 parents among the 1,459 adolescents assigned to the parent interactive condition present at meetings; fewer than 30 parents contacted available health educators to receive additional information. Thus, interactive homework assignments constituted the main difference between the two treatment conditions; between 65% and 74% of the students completed interactive homework assignments with their parents (Blake et al., 2001; Levy et al., 1995; Sexuality Information and Education Council of the United States, 2002; Weeks et al., 1997). Adolescents’ rating of the importance of their parents’ feelings about whether or not to have sex increased at significantly higher rates over time among both treatment groups, but this was especially true for adolescents in the noninteractive group (Weeks et al., 1997). No differences in adolescents’ comfort in discussing sex and drugs with their parents, overall knowledge of AIDS and the effectiveness of contraceptives, or alcohol use or sexual activity were found between the two treatment groups (Weeks et al., 1997).

A number of other studies have evaluated the effectiveness of homework assignments. Managing Pressure Before Marriage is a middle-school abstinence-only program that employs a skills-based curriculum aimed at helping youth postpone sexual intercourse until marriage (Blake et al., 2001; Kirby, 2002). Students were randomly assigned to one of two treatment groups: curriculum only and curriculum-plus homework assignments for parents and children. The curriculum-plus homework program increased (1) adolescent self-efficacy to avoid high-risk behaviors and to reinforce their decision to postpone sexual intercourse and (2) communication with parents. However, adolescents in both treatment and control groups reported similar levels of comfort in talking to their parents about sex. Adolescents who completed more homework assignments reported decreased intentions to become sexually active, greater self-efficacy to refuse alcohol or sexual intercourse, and increased parent-child communication compared with adolescents who did not complete any homework assignments.

Nonrandomized studies have evaluated the effectiveness of homework assignments in combination with sex education curricula, role-playing exercises, or media outreach. Reducing the Risk is a high-school sex education curriculum consisting of 15 sessions, lasting approximately 45 minutes each (Kirby, Barth, Leland, & Fetro, 1991). The program includes role-playing exercises and assignments for

students to ask their parents about their views on abstinence and birth control. In general, results suggest that the program was effective in facilitating parent-child communication about abstinence and birth control. Overall, parent-child communication about pregnancy or STIs did not increase, although parent-child communication about pregnancy did increase among Latinos. Among adolescents who were virgins at the start of the study, the likelihood of sexual intercourse decreased in the program group significantly over the comparison group. The program was not associated with reduced sexual intercourse or increased use of birth control among sexually active adolescents.

Several other programs (such as Families in Touch: Understanding AIDS and Life's Walk) have included homework assignments as part of their sex education efforts. Although these programs were evaluated using small samples, without appropriate comparison groups, and over short periods of time (e.g., 1 month), they suggest that homework assignments may facilitate parent involvement and increase parent-child communication (Barnett & Hurst, 2003; Crawford et al., 1990).

2.1.5 Multiple Parent Involvement Strategies

Research has provided evidence that combining multiple strategies for involving parents in parent-adolescent programs is effective. Three randomized controlled trials addressed adolescent behavioral outcomes. One randomized study assessed Safer Choices, a comprehensive school-based sexual education program that included a parent education project newsletter covering program content, homework activities for parents and students to complete together, parent attendance at orientation and other activities or events, and parent membership on a health promotion council (Coyle et al., 2001). Results included reduced sexual risk-taking behaviors, frequency of intercourse without a condom, and number of sexual partners not using a condom, as well as increased use of multiple methods of protecting against pregnancy, HIV, and other STIs.

A second randomized study evaluated the Choosing the Best Way, Path, and Life abstinence education sequential curricula taught to 7th-, 8th-, and 9th-graders, respectively. Students received homework assignments requiring them to interview their parents; school sites held 1-hour training sessions for parents; and the program distributed "The Big Talk Book" to parents to reinforce the abstinence message and to provide 10 interactive sessions for parents to conduct with their adolescents (Weed, 2004). This approach reduced the initiation of sexual intercourse among adolescents and produced cumulative impacts when adolescents received all three curricula.

A third randomized study evaluated the effectiveness of the Healthy for Life Project, a comprehensive sex education and substance abuse prevention program involving 58 lessons over 12 weeks (including 16 class periods focused on sexuality issues), peer leadership, community involvement, parent orientation sessions, home mailings relevant to the program, and "homework" in which students were assigned to interview their parents about dating and sexual behaviors. However, the family component was not fully implemented as intended, with some sexuality messages omitted from parent and community components of the program, and the program did not demonstrate effectiveness in reducing sexual risk behaviors, such as condom use during intercourse (Moberg & Piper, 1998).

2.2 Involving Parents Only

Parent-only programs provide direct services and training to parents rather than to adolescents. Only programs that provide no direct services or curricula to adolescents are included in this category. Parent-only programs employ short-term training sessions that use videos, group discussions, role-playing, and homework assignments for parents to learn about sexuality and fertility issues and practice discussing these issues with their adolescents (King, Parisi, & O'Dwyer, 1993; Kirby, 2002; Lefkowitz et al., 2000). One small-scale randomized trial compared mothers receiving two training sessions to those assigned to receive the program at a later time (Lefkowitz et al., 2000). The first training session focused on communication skills, such as taking turns talking and listening and providing supportive responses to adolescents, while the second session focused on how to talk about dating and sex (Kirby, 2002). The study found improved conversational style, content, and adolescent comfort level in conversations, as well as mothers' knowledge about AIDS (Lefkowitz et al., 2000).

2.3 Grassroots Community Organizing

Programs incorporating community-based approaches seek to engage members of the community in analyzing the problem of adolescent pregnancy within the community and developing appropriate prevention strategies on a local level. Parents and other concerned adults are integral contributors to program success and often serve as the agents of change in these types of programs (Kirby, 2002).

One nonrandomized study among Latino (predominantly Puerto Rican) adolescents evaluated Poder Latino, an 18-month community-based program involving parents of neighborhood adolescents as peer educators for other adults in the community. It recruited effective parent leaders through community agencies and trained these parents to conduct home-based sessions, providing them with a small stipend to cover the expenses of hosting program events (Smith, McGraw, Crawford, Costa, & McKinlay, 1993). Additional outreach efforts included public service announcements, posters, a quarterly newsletter, and door-to-door and street corner canvassing to provide information on condom use and condoms (Manlove et al., 2001). Results showed that male adolescents were less likely to become sexually active, and female adolescents were less likely to report multiple sexual partners, but no difference was found between the intervention and comparison groups in reported frequency of sex.

2.4 Parent Involvement in Programs for Parenting and/or Pregnant Adolescents

We identified only one quasi-experimental evaluation of a program for pregnant and parenting adolescents that involved parents. The Teenage Mothers-Grandmothers (TAM-GM) Program was developed as an adjunct to an already existing Teenage Mothers Program in a large inner-city municipal hospital in the Bronx, New York (Royce & Balk, 1997). Eligible adolescents seen at the adolescent prenatal clinic were invited to ask their mothers or mother surrogates to participate in the TAM-GM Program. Most adolescents brought their mothers, while a small number brought their grandmothers or their boyfriends' mothers. The TAM-GM Program began with a series of structured, 1-hour sessions scheduled along with the adolescents' prenatal visits. At the first two visits, a social worker met only with the mother, offering her information about adolescence and communication and inviting the mother to express her feelings about the pregnancy. The adolescent joined the third session, where the social worker

acted as a catalyst for discussion about the pregnancy, both individuals' feelings, and how the baby's arrival would change their lives. During the fourth session, the social worker met with the mother alone to discuss the issues raised during the third session. During two additional sessions, coinciding with the infant's first and second well-baby visits, the social worker examined the new family situation and how significant family members were responding to the infant. The social worker then invited the adolescent and her mother to return for additional sessions as needed. Sixty-five adolescents completed questionnaires before participating in the program and again several years later, when adolescents and mothers were also asked open-ended questions. A comparison group of eligible adolescents whose mothers chose not to participate was identified, and statistical analyses revealed no demographic or self-esteem differences between the two groups at baseline. When a pregnant adolescent and her mother enrolled in this program, the adolescent was less likely to drop out of school following the birth of her baby. Adolescents whose mothers participated in the program were less likely to experience a repeat pregnancy and had significantly higher self-esteem after program completion. Overall, the mothers felt that the program helped them to understand their daughters better and thus accept the pregnancy and the baby. While mothers felt that the program helped their daughters become better mothers, several also said that it helped the entire family. Similarly, the adolescents reported that the program improved communication with their mothers, thus enhancing their relationship. Many of the adolescents and their mothers had not been speaking to one another prior to the program, although they were living together.

Because we only identified one quasi-experimental evaluation of a program for pregnant and parenting adolescents that had a parent involvement component, we also reviewed other evidence-based literature on programs for pregnant and parenting adolescents. Although these other programs did not have a parent involvement component, they offered important information for pregnant and parenting adolescent programs. For example, one program found that family members appeared to be a barrier to pregnant or parenting adolescents, negatively impacting participation or integration of new skills and practices taught by the program (Quint, Bos, & Polit, 1997; Zaslow & Eldred, 1998). Specifically, some adolescents' relatives or partners had problems with drug or alcohol abuse that interfered with the adolescents' ability to participate fully or continue in the program.

2.5 Summary

Only nine randomized experimental studies have measured parent involvement program effects on adolescent behavioral outcomes (e.g., contraceptive behavior, sexual behavior, risky sexual behavior, pregnancy), and findings were mixed. The models that showed long-term effectiveness in changing adolescent behavioral outcomes were two youth development models (Teen Outreach Program and Children's Aid Society Carrera Model), the Safer Choices comprehensive sexual education program, and the Choosing the Best WAY, PATH, and LIFE abstinence education program. We identified only one quasi-experimental evaluation of a program for pregnant and parenting adolescents that involved parents. The Teenage Mothers-Grandmothers (TAM-GM) Program showed promising results regarding reductions in repeat pregnancy, increased self-esteem, and possible improvements in family relationships and communication.

Assessment Methods and Activities

Kellie M. Loomis, Megan Williams, and Olivia Silber Ashley

Both the Title X Family Planning and Title XX Adolescent Family Life programs emphasize the importance of family involvement in providing services to adolescents. This chapter describes Title X family planning, Title XX prevention, and Title XX care programs; the site selection strategy for assessment; the study sample; and assessment methods.

3.1 Office of Population Affairs (OPA) Programs

This study examined programs funded under two different statutes, Title X family planning programs and Title XX Adolescent Family Life (AFL) programs (including Title XX prevention programs and Title XX care programs). This section describes the two statutes and the types of programs funded by each.

3.1.1 Title X Family Planning Programs

Title X is the only federal program dedicated solely to providing family planning and reproductive health care services (Office of Population Affairs, 2004b). A broad range of acceptable and effective family planning methods and services (including natural family planning methods, infertility services, and services for adolescents) are offered through Title X programs on a voluntary and confidential basis. In addition to providing family planning services, Title X clinics offer preventive health services such as education and counseling on a range of topics; breast and pelvic exams; cervical and breast cancer screening; STI and HIV prevention education, testing, and referral; and pregnancy diagnosis and counseling. The Title X program also supports training for family planning clinic personnel through general training programs and information dissemination and community-based education and outreach activities.

Services are delivered through a network of more than 4,400 community-based clinics that include State and local health departments, hospitals, university health centers, Planned Parenthood affiliates, independent clinics, and public and non-profit agencies (Office of Population Affairs, 2005). The program provides family planning and related preventive health care services to approximately 5 million persons each year (Office of Population Affairs, 2005); 29% are adolescents aged 19 or younger (The Alan Guttmacher Institute, 2004).

Requirements and Program Guidelines. The Family Planning Program, authorized in 1970 under Title X of the Public Health Service Act and administered by the Office of Family Planning (OFP) within the Office of Population Affairs (OPA), was designed to provide access to contraceptive supplies and information to all who want and need them with priority given to low-income and uninsured persons. Grants are provided to public and private nonprofit agencies to assist in the establishment and operation of family planning projects. Any public or nonprofit private entity in a State may apply for a grant under

Title X. Projects funded through Title X should consist of the educational, comprehensive medical, and social services necessary to aid individuals to determine freely the number and spacing of their children. Funds may be used for related service provision as well as education and training, research for service delivery improvement, and information and education, within regulatory guidelines.

Persons from low-income families (family income at or below 100% of the federal poverty level) may not be charged for services. Low-income families also include members of families whose annual family incomes exceed the poverty level, but who are unable to pay for family planning services for good reasons, as determined by the project director. This also includes unemancipated minors who wish to receive services on a confidential basis and are considered on the basis of their own resources.

All personal information obtained by staff in the course of family planning service provision must be held in confidence. Information must not be disclosed without the individual's documented consent, except as may be necessary to provide services to the patient or as required by law, with appropriate safeguards for confidentiality. Information must only be disclosed in summary, statistical, or other form which does not identify particular individuals (Public Health Service Act, 2000). Parent consent must not be required to provide family planning services to minors, nor can projects notify parents before or after the receipt of family planning services by a minor (Office of Population Affairs, 2001). Adolescents must be assured that counseling sessions are confidential, and if follow-up is necessary, that every attempt will be made to preserve the privacy of the individual. Section 219 of the Fiscal Year 1999 Omnibus Appropriations bill (P.L. 105-277) states that Title X providers must comply with State laws, particularly those which require notification or reporting of child abuse, child molestation, sexual abuse, rape, or incest (Fiscal Year 1999 Omnibus Appropriations Bill, 1999). This language has been reiterated as part of annual Title X appropriation language each year since 1999.

The Title X statute states that "to the extent practicable, entities which receive grants or contracts under this subsection shall encourage family participation in projects" (Title X: Population Research and Voluntary Family Planning Programs, 1970). Family participation must be encouraged within the context of providing family planning services to the adolescent, and Title X programs must certify in writing that they have complied with this requirement (Departments of Labor, Health and Human Services, and Education Appropriations Act, 1998; Kring, 1998). Each grantee must certify in writing that it encourages family participation in the decision of minors to seek family planning services, and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities (Departments of Labor, Health and Human Services, and Education Appropriations Act, 1998).

3.1.2 Title XX Adolescent Family Life (AFL) Programs

The Adolescent Family Life (AFL) Demonstration and Research program, created in 1981 as Title XX of the Public Health Service Act, supports both demonstration and research grants (Office of Population Affairs, 2004a). The program supports two basic types of demonstration projects: prevention demonstration projects to develop, test, and use curricula that provide sexuality education designed to encourage adolescents to postpone sexual activity until marriage; and care demonstration projects to develop interventions with pregnant and parenting adolescents, their infants, male partners, and family members in an effort to ameliorate the effects of too-early childbearing for adolescent parents, their

babies, and their families. The AFL program also funds grants to support research on the causes and consequences of adolescent premarital sexual relations, pregnancy, and parenting.

Statutory Requirements. The Title XX statute states that the Federal Government should promote the involvement of parents with their adolescents aged 18 or younger, and should emphasize the provision of support by other family members. The first purpose of Title XX of the Public Health Service Act of 1981 is to find effective means within the context of the family of reaching adolescents before they become sexually active in order to maximize guidance and support available to adolescents from parents and other family members. The second purpose is to promote self discipline and other prudent approaches to the problem of adolescent premarital sexual relations, including adolescent pregnancy. In addition, families of adolescents are assisted with understanding and resolving the societal causes which are associated with adolescent pregnancy, such as perceived lack of educational opportunity or peer norms regarding sexual behavior. The Title XX statute states that educational services relating to family life and problems associated with adolescent premarital sexual relations provided by grantees include the development of material to support the role of parents as the provider of sex education, assistance to parents to educate adolescents and preadolescents concerning self-discipline and responsibility in human sexuality, counseling for the immediate and extended family members, and outreach services to families of adolescents to discourage sexual relations among unemancipated minors.

The Title XX statute also states that grantees will notify the parents or guardians of any unemancipated minor requesting services and will obtain permission from the parents or guardians before providing the requested services. However, grantees will not notify or request permission of the parents or guardians without the consent of an unemancipated minor if the minor is solely requesting pregnancy testing or testing or treatment for venereal disease; if the minor is the victim of incest involving a parent; if an adult sibling of the minor or an adult aunt, uncle, or grandparent who is related to the minor by blood certifies to the grantee that notification of the parents or guardians would result in physical injury to the minor; or if a pregnant unemancipated minor's parents or guardians are attempting to compel the minor to have an abortion. Grantees should periodically notify the Secretary of the exact number of instances in which a grantee does not notify the parents or guardians of a pregnant unemancipated minor.

Title XX prevention programs aim to reduce adolescent pregnancy by providing abstinence education. Title XX care programs aim to lessen the negative effects of adolescent childbearing by developing appropriate interventions with pregnant and parenting adolescents and their families.

3.2 Research Questions

The purpose of this study was to address the research questions presented in Exhibit 2. These research questions address strategies for involving parents, barriers to implementing these strategies, lessons learned, and implementation of strategies in other settings.

Exhibit 2. Research Questions**Strategies**

- What strategies are used in the Title X service setting to comply with the parent involvement mandate? What strategies (e.g., outreach) have Title X-funded programs used to enhance parent involvement?
- What strategies are used in Title XX prevention and Title XX care programs to comply with the parent involvement mandate?
- How do these strategies differ by program type?

Barriers

- What are the barriers faced by programs in implementing their parent involvement strategies?
- How do perceptions of barriers (e.g., perception of confidentiality as a barrier) prevent different program types from implementing parent involvement strategies?

Lessons Learned

- What parent involvement strategies have worked?
- In what situations/settings have these strategies not worked?
- What lessons have been learned from Title X and Title XX programs from unsuccessful attempts to involve parents?

3.3 Site Selection

Office of Population Affairs (OPA) staff identified 12 Title X programs with known parent involvement activities to highlight in this report.⁴ Information about the programs came from descriptions of parent involvement activities provided by OPA and program staff, and information about two programs was presented at a 2004 poster session (Planning Healthy Families National Title X Grantee Meeting). OPA staff also identified 45 Title XX programs with known parent involvement activities. Information about the programs came from descriptions of parent involvement activities provided in Title XX grant applications. For some programs, evaluation and annual reports were also available. From the 57 programs identified by OPA, we selected a set of 15 programs for qualitative data collection. This section describes our site selection strategy for choosing these 15 programs.

Our goal was to select programs in a way that maximized diversity with respect to program and population characteristics and parent involvement experiences. To identify candidate programs, we considered the following characteristics:

- **Program type.** Our goal was to select five programs from each program type (Title X, Title XX prevention, and Title XX care).
- **Geographic region.** To avoid clustering of sites in a single region and disproportionately burdening regional consultant staff with respect to Title X programs, we classified programs using the 10 Department of Health and Human Services (DHHS) regions.

⁴ It is important to note that Title X programs are funded in the DHHS regions, and providers are not required to report specific information about program activities directly to OPA, although this information may be included in progress reports of grant applications, which are housed in the regions. Many program activities are conducted by subrecipients of grantees, and information may be in grantee files but not reported to OPA. Because of these complexities, parent involvement activities in Title X programs may far exceed what is described here.

- **Agency type.** To ensure diversity across types of programs, we classified programs according to the type of agency receiving Title X or Title XX funding.
- **Approach.** We identified the parent involvement approach(es) used by each program.
- **Parent engagement strategy.** We identified programs that noted innovative strategies to recruit or engage parents and prioritized selecting these programs when possible.
- **Outcomes.** Data collection about parent involvement strategies would be enhanced if programs had evaluated outcomes of their strategies. We therefore prioritized programs that reported evaluations of parent outcomes, adolescent outcomes, or parent attendance at program activities.
- **Lessons learned.** In order to capture the insights identified by program staff, we prioritized programs that reported lessons learned.
- **County type.** To avoid selecting programs operating within only one or two county types, we classified Title XX programs as rural or urban. (This information was not available to us for Title X programs.)
- **Population race/ethnicity.** To ensure diversity across different populations, we classified Title XX programs according to the racial/ethnic groups they served. (This information was not available to us for Title X programs.)
- **Program size.** We classified Title XX programs as serving fewer than 100 clients, 100 to 500 clients, or more than 500 clients. (This information was not available to us for Title X programs.)

Because there were fewer Title X programs to choose from than other program types, we prioritized selecting Title X programs first. Among the 12 Title X programs we reviewed, we first selected the two programs that reported parent attendance outcomes and lessons learned (Family Planning Council in Philadelphia and Family Planning of Clallam County in Washington State). Of the two health departments we considered, we selected the one that also reported an innovative parent engagement strategy and parent outcomes (Kentucky Department of Public Health). We selected one regional training center (JSI Research and Training Center in Boston). Finally, we selected the Planned Parenthood agency that used a joint attendance approach and reported parent outcomes (Planned Parenthood of the Inland Northwest in Washington State).

We next considered the Title XX prevention programs. Among the 21 Title XX prevention programs, we first selected the program using a parent-only approach (*Southern Nevada Area Health Education Center* in Las Vegas). Of the two faith-based organizations we reviewed, we selected the one with an innovative parent engagement strategy and positive parent and adolescent outcomes (*Roanoke Chapel Baptist Church* in North Carolina). Of the two programs reporting parent attendance, we selected the one that served adolescent males only, included home visits and an evidence-based curriculum (Choosing the BEST) in its multiple strategies, and reported a low number of parent participants and no changes in adolescent sexual behavior, despite a large number of high quality activities offered (*Fifth Ward Enrichment Program* in Houston). Of the three hospitals, we selected the one that included drama

productions and workshops on how to use and reinforce the play’s message in its joint attendance activities (*St. Luke’s Roosevelt Hospital* in New York), an approach that was previously evaluated and found to be effective, according to the program. Finally, of the four universities, we selected the one with an innovative parent engagement strategy that served both rural and urban populations (*Colorado State University*).

Last, we considered Title XX care programs. Among the 24 programs, we selected the one county government agency, which combines home visits with support groups, camps, and parent advisory boards; actively seeks to involve males; and reported low parent attendance (*Garrett County* in Maryland). We selected the one clinic, which reported lessons learned (*La Clinica de Raza’s Teen Clinic Program* in California). Of the two health departments we reviewed, we selected the one that served Region 7 (*Siouxland District Health Department* in Iowa), which had not been represented in our previous selections. We also selected the program located in Region 5, which had not been represented in our previous selections; this program provided school-based counseling and case management combined with home visits, joint attendance, parent support, and an adapted curriculum to serve the Hmong population (*Minneapolis Public Schools* in Minnesota). Finally, we selected the program that offered newsletters, used innovative parent engagement strategies, and served more than 500 clients (*Arlington Independent School District* in Texas). Exhibit 3 shows the distribution of the 15 selected sites across the United States.

Exhibit 3. Distribution of Selected Sites across the United States



3.4 Sample

After being contacted, the 15 programs agreed to participate in the study. Exhibit 4 presents information on program characteristics. Title X programs served almost exclusively female clients. Most clients were white or black, and most adolescents served by Title X programs were aged 15 to 19. The

Title XX prevention grantees served largely low-income and minority populations. Individual programs serve between 60 and 6,000 adolescents and between 60 and 1,650 parents, with the majority serving approximately 500 adolescents. All grantees listed goals related specifically to parent involvement. The common goals of these programs were to improve parents' knowledge about abstinence and to increase abstinence education resources available to parents and the larger community. Many programs also sought to increase the incidence and quality of parent-child communication about sexual topics and to improve parenting skills overall, including monitoring child behavior; managing parental stress and personal behavior; and modeling appropriate decision making, behavior, and communication. The target populations of the Title XX care programs varied across providers, although many programs focused on adolescent parents and their children from low-income or impoverished households. Adolescent mothers and their children were the primary client population for most programs, and many programs also targeted adolescent mothers' male partners, parents, younger siblings, and other family members. Overall, the size of the participant population varied greatly, with most programs serving between 75 and 250 adolescent mothers and their families.

3.5 Assessment

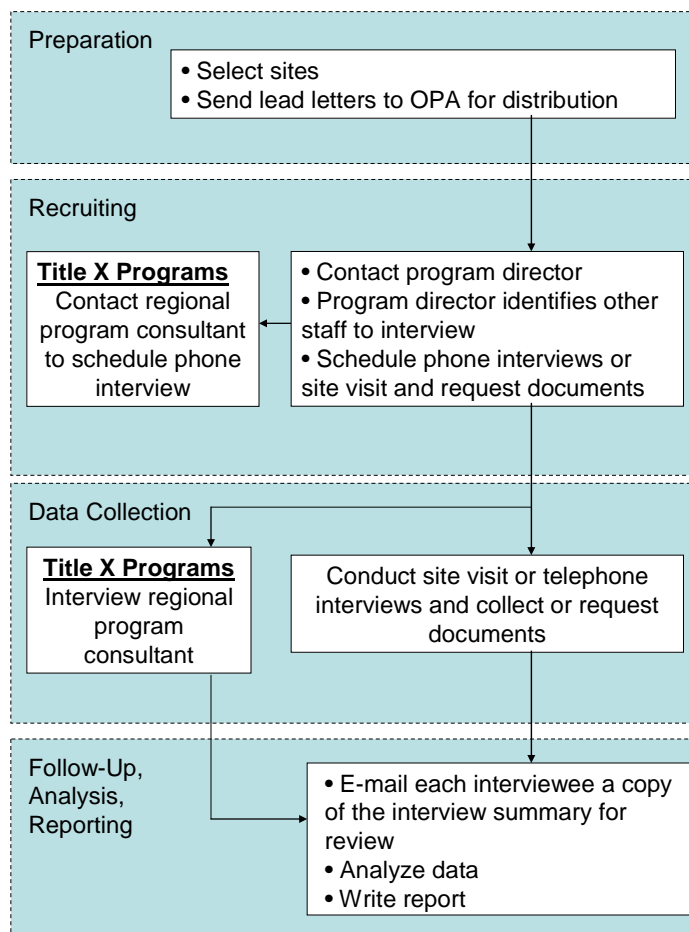
We collected data through site visits or telephone interviews with 15 programs. Data collection at each program included interviews with program directors and parent involvement staff, as well as interviews with regional program consultants serving Title X programs. To help us better understand these strategies, some program staff also requested a time for us to observe parent involvement activities (workshops, support groups, or home visits) during scheduled site visits. This section outlines our approach to planning, data collection, data management, and analysis, as shown in Exhibit 5. All procedures were approved by RTI's Institutional Review Board (IRB).

Initial contact was made with the Title X grantee director or Title XX program director of each of the selected programs. We used the OPA Web site and worked with the OPA project officers to identify the appropriate individual. This individual received a lead letter from OPA describing the study and requesting cooperation. For Title X programs, OPA notified regional program consultants via a memo, regional program consultants forwarded the lead letter to grantee directors, and if applicable, grantee directors forwarded the lead letter to the site. After lead letters were mailed, the RTI team contacted the grantee director or program director at each site and worked with this person (or his or her designee) to address any questions or concerns the site had about the visit. For Title X, we asked grantee directors to provide the RTI team contact information for clinic managers (if applicable). Regional program consultants were copied on communications with Title X site staff. We asked grantee directors/clinic managers or program directors to identify other staff members within the respective program who would be appropriate to interview for the study, make initial contact with these staff members, and provide us with contact information so we could follow up with interviewees. In addition, we requested that grantee directors/clinic managers or program directors advise whether a group interview would be beneficial, discuss whether telephone interviews were preferable, and assist with scheduling a 1-day site visit (including a time to observe a parent involvement activity if requested) or telephone interviews. Prior to conducting interviews, we reviewed program grant applications and program reports for each site and asked grantee directors/clinic managers or program directors to provide us with any additional documents

Exhibit 4. Selected Characteristics of Title X and Title XX Programs Participating in Site Visits and Telephone Interviews

Program Type	Title X					Title XX Prevention					Title XX Care				
	JSI Research and Training Center	Family Planning Council	Kentucky Department of Public Health	Family Planning of Clallam County	Planned Parenthood of the Inland Northwest	St. Luke's Roosevelt Hospital	Roanoke Chapel Baptist Church	Fifth Ward Enrichment Program	Colorado State University	Southern Nevada Area Health Education Center	Garrett County	Minneapolis Public Schools	Arlington Independent School District	Siouxland District Health Department	La Clinica de Raza's Teen Clinic Program
Program Name	1	3	4	10	10	2	4	6	8	9	3	5	6	7,8	9
DHHS Region	MA	PA	KY	WA	WA	NY	NC	TX	CO	NV	MD	MN	TX	IA	CA
State															
City	Boston	Philadelphia	Frankfort	Olympia	Spokane	New York	Roanoke Rapids	Houston	Cortez	Las Vegas	Oakland	Minneapolis	Arlington	Sioux City	Oakland
Agency Type	Regional Training Center	Community Organization	Health Department	Planned Parenthood	Planned Parenthood	Hospital	Faith-based Organization	Community Organization	University	Community Organization	County Government	School	School	Health Department	Clinic
Parent Involvement Approach(es)															
Counseling	x	x													
Counseling/Case Management												x			x
Educational Materials		x													
Events													x	x	
Home Visits															
Joint Attendance				x		x	x				x	x		x	
Multiple Strategies								x	x						
Newsletter													x		
Parent Only										x					
Parent Workshops		x	x	x											
Support Groups											x				
Other											x	x	x		
Client Gender															
Female		91%	90%	92%	99%	57%	—	0%	58%	51%	58%	89%	81%	63%	75%
Male		9%	1%	8%	1%	43%	—	100%	42%	49%	42%	11%	19%	38%	25%
Client Race/Ethnicity															
Black or African American		52%	11%	1%	2%	31%	mainly	80%	x	12%	1%	35%	mostly	8%	
White		32%	87%	95%	90%	26%			x	52%	99%			32%	
Hispanic/Latino		8%				40%		20%	x	24%		7%		37%	90%
Asian		2%			2%	3%				6%		32%		1%	
American Indian or Alaska Native				3%	2%				x	1%		8%		22%	
Native Hawaiian or Other Pacific Islander				2%	1%										
Other		3%										12%			
Unknown		3%	1%		4%										
Adolescent Client Age (Years)															
<14		7%	15%			100%		ages 9 to 19	ages 12 to 14	parents only	29%			30%	ages 12 to 19
14		4%													
14-15												13%	14%		
<15				5%	3%										
15		10%													
15-17			37%	48%	34%						13%			23%	
16		16%										25%	27%		
17		23%										43%	46%		
18		23%										4%	4%		
18+											59%			47%	
18-19			48%	47%	63%										
19		22%										6%	7%		
Program Size															
<100											x			x	
100-500						x		x	x	x		x			x
>500							x						x		
Community Type															
Rural							x		x		x			x	
Urban						x		x	x	x		x	x	x	x

Exhibit 5. Qualitative Assessment Approach



that described their parent involvement process that would extend our understanding of their programs beyond data in these reports. Documents included organizational charts, reporting forms recording numbers of services provided, educational materials, parent newsletters, and other information. Contact persons were encouraged to send such documents to the RTI team prior to the interviews. However, materials were also collected during and after interviews as they were identified. These documents supplemented our program report review and provided contextual information for analysis.

3.5.1 Site Visits and Telephone Interviews

All telephone interviews and site visits were conducted between June 6, 2005, and August 1, 2005. For site visits, our team spent 1 to 2 days at each site conducting interviews, observing parent involvement activities, and collecting documents. Site interviews took place in an office or conference room selected by the grantee director/clinic manager or program director. We conducted a total of 34 interviews involving 71 staff interviewees across the 15 programs. Each interview was tailored to the appropriate program type and staff role. A list of Title X and Title XX programs and staff participating in site visits and telephone interviews is included in Appendix A. Individual interviews lasted 60 minutes,

and interviews with two or more staff simultaneously lasted 90 minutes. The total number of individual interviews was determined by the program director at each site.

On-site and telephone interviews were semi-structured, collecting information to address the study's primary research questions surrounding strategies for involving parents, barriers to implementing these strategies, implementation of strategies in other settings, and lessons learned. Since the populations served and program settings varied, we developed a separate interview guide for each program type (Title X family planning, Title XX prevention, and Title XX care programs). In addition, we developed individual interview guides to capture position-specific knowledge about a site's parent involvement strategies. Development of interview guides was based on primary research topics and informed by literature and program reports and input from OPA and the staff advisory committee for this study. An example interview guide in Appendix B served as a starting point for discussion, and we incorporated ideas that occurred spontaneously. We pursued the same lines of inquiry with multiple respondents whenever possible, but an iterative process was used, in which topics and themes identified by programs visited early in the project were incorporated into the interview guides. Program staff were also asked questions designed to elicit information about measurement of the effectiveness of their efforts (and the quality of such measurement), outcome tracking procedures, methods of soliciting program feedback, and identified needs in the area of parent involvement.

Two-person teams conducted the site visits or telephone interviews, sharing responsibility for leading the interview activities, taking detailed notes, and setting up the interview room with necessary materials (tape recorder, name tags, refreshments for on-site group interviews). We sought verbal consent from all professional staff for their participation in the individual or group interviews. Detailed notes were taken on a laptop computer or by longhand during the interviews, and with participants' consent, interviews were audio taped as a backup. After the site visit or telephone interviews, we sent an e-mail message thanking each interviewee for his or her participation and attaching a copy of the interview summary for factual review. Interviewees were asked to indicate if there were any statements in the notes for which they preferred not to be cited by name. The data collection team also completed a structured debriefing form at the end of each 1-day site visit or after each telephone interview to integrate and augment notes taken during interviews and to elaborate on key observations and findings.

Parent involvement activities we observed involved parents, emancipated minors, and/or unemancipated minors; some activities involved minors without parents present. We treated emancipated minors as adults. Adolescent and parent observation participants received a lead letter from the program director describing the study and informing them of their rights and protections before our 1-day site visit. The letter also informed adolescents and parents that attending an observed activity was completely voluntary and would have no effect on any services the adolescents or parents received. At the beginning of observed activities, RTI staff waited outside the room while program staff read a general description of the study before asking all participants present for permission for RTI staff to observe. If all participants did not agree, we did not observe the parent involvement activity. For observations of unemancipated adolescents aged 17 or younger, we asked program staff to seek verbal parent consent and verbal adolescent assent prior to the activity. Program staff assigned an identification number to each adolescent participant. Verbal consent from parents and verbal assent from adolescents was documented by the

program staff on a consent form and submitted to RTI project staff before the observation. If RTI staff did not receive documentation of verbal consent/assent for all unemancipated adolescent participants, we did not observe the parent involvement activity. For general program social activities open to the public with a large number of attendees (for instance, an awards ceremony for program graduates), we asked the program director to send lead letters to adolescent and parent participants notifying them of the proposed observation and inviting participants to call the program director if they preferred that RTI staff not observe. For this type of activity, we omitted the verbal (documented) parent consent and adolescent assent process. The RTI project team completed an observation guide during scheduled parent involvement activities. Parents and adolescents participating in observed activities were not be cited by name, nor did we take notes about individual participants' information.

3.5.2 Data Management

All data were kept on a secure shared drive requiring security clearance to obtain access. Project staff signed confidentiality agreements detailing security procedures.

3.6 Analysis

The RTI team began the data analysis process as soon as the first site visit or telephone interviews were completed, and these initial results shaped the interview process at subsequent sites. We identified themes from the interviews that corresponded to the research questions, paying special attention to consistencies or discrepancies across respondents. Initial analysis was completed using electronic interview notes, which were organized into general themes. Within these themes, open-coding procedures were used later to further develop categories and identify patterns and contrasts among participant responses. After reading through the notes from each interview, we made a list of topics discussed. After data from the first three sites were coded this way, topics that emerged in at least two of the sites were chosen to become open codes. The RTI team compared initial site visit or telephone interview data to new site visit or telephone interview data as they became available, adding new codes using constant comparison as new topics emerged from interviews, and then summarized data on key topics. We also used participants' words and phrases during the analysis and writing process.

Parent Involvement Strategies

Olivia Silber Ashley

For the purpose of this study, we defined “parent” broadly to include parents or family members involved in adolescents’ lives. This definition reflected programs’ own broad approach toward both parent and family involvement. One Title XX prevention program director expressed this in the following way:

We’ve tried to incorporate the whole family. You don’t have to be the parent of the child to be involved; you could be the brother, uncle, or grandmother. As long as it is someone positive in the child’s life committed to working and supporting the child, someone who we can be in contact with along with the child and who will help the child wholeheartedly.

—Ernest McMillan, Chief Executive Officer, Fifth Ward Enrichment Program, Houston, Texas

Often, extraordinary circumstances necessitate involving trusted adults who can serve in a parenting role:

I have a parenting teen whose baby’s father is living in foster care, and the teen is living with the father at the foster care home. The teen’s father committed suicide a couple of months ago, and her mom is in an abusive relationship, so the teen actually feels safer with people she doesn’t know than with her family. In that case, I try to involve the foster mother as much as I can because she is just letting this girl be there. I let her know what I’m about and that I’m there to help. I try to keep everything healthy now that the teen has had the child.

—Jeanne Kumlin, Public Health Nurse, Minneapolis Public Schools, Minnesota

4.1 Strategies Used in the Title X Service Setting

Based on the analysis of the reading and codifying of interviews with Title X program staff, several themes were identified in the way in which program staff who were interviewed involve parents. Exhibit 6 presents these themes.

Exhibit 6. Themes Identified among Title X Program Staff

Adolescent-Centered	Parent-Centered	Staff-Centered
<ul style="list-style-type: none"> • Counseling 	<ul style="list-style-type: none"> • Interactive workshops for parents • Handouts and brochures on parent-child communication • Agency tours and open houses 	<ul style="list-style-type: none"> • Prompting staff to provide counseling • Staff training

4.1.1 Adolescent-Centered Strategies

Adolescent-centered strategies encourage adolescents to communicate with parents. The primary theme that emerged among Title X programs for interacting with adolescents directly was counseling. Several Title X programs reported counseling adolescents about talking with parents about reproductive health, their visit to the Title X program, decision making, contraception, or other issues:

The main strategy is the discussion of parental involvement during counseling sessions with adolescents, mostly during the initial visits. In counseling, there is the opportunity for the teen to involve their family in their reproductive health decisions.

—Cristino Rodriguez, Regional Program Consultant, speaking about the Kentucky Department of Public Health

At Family Planning of Clallam County in Washington State, a client advocate is assigned to counsel adolescent clients and encourage parent involvement:

The client advocate asks the adolescent client, “Does your family know that you are seeking family planning services?” If the answer is yes, the client advocate is very positive. If the answer is no, the client advocate asks, “What do you think their reaction would be?” We ask open-ended questions to assess this and suggest, “If you think your parents would be receptive, maybe we can help broach the subject with your parents.” We hear that adolescents are not afraid to talk with their parents; they just don’t know how to.

—Martina Kerr, Clinic Operations Manager, Family Planning of Clallam County, Washington State

The discussion about parent involvement occurs again when the adolescent sees the nurse practitioner. It is considered a group effort on the part of program staff so that if the client advocate misses the opportunity to provide counseling or if counseling does not appear in the client advocate’s notes, other staff double check with the adolescent.

4.1.2 Parent-Centered Strategies

Parent-centered strategies provide skills to parents to communicate with adolescents. Three types of parent-centered strategies were identified consistently among Title X programs: interactive workshops, printed materials on parent-child communication, and agency tours and open houses.

Workshops. Title X providers have offered workshops for parents to help them communicate with their adolescents about sexuality and reproductive issues. The Family Planning Council in Philadelphia offers sex education workshops for parents in community-based settings through the statewide Communicating Healthy Advice for Teens (CHAT) program to support parents’ efforts in educating adolescents aged 9 to 18 about healthy sexual development and decision making. CHAT provides workshops to address issues related to normal adolescent development as well as parent-child communication. The Council works with community agencies to identify groups of parents for the workshop. CHAT targeted community-based organizations with existing parenting groups to identify potential audiences for programming. A mass mailing describing the program and inviting organizations to participate targeted child welfare/foster parent agencies, charter schools, after school programs, and

Abstinence Education and Related Services (AERS) grantees. Twenty-two community-based organizations and school-based programs partnered with CHAT in 2004 to bring this workshop series to parents. The typical size of these workshops is 12 to 16 parents. A recent CHAT workshop was presented to 60 parents, but this level of attendance is difficult and not desirable; larger groups usually receive a presentation rather than an interactive workshop. In fact, interaction was mentioned as an important component of successful parent workshops by several Title X programs.

The name of the workshop can also be very important in terms of marketing:

The name I started out using for the parent workshop was Talking with Your Child about Sex, but we've found that the word "sex" makes parents nervous. But I still needed to communicate to parents what we'd be talking about in the workshop, so we changed the title to Beyond the Birds and the Bees—Talking with your Child about Relationships, Values, and the Facts of Life. Parents told me themselves that the word "sex" put people off. We came up with the softer Birds and Bees title to sound less blunt. We also let communities adapt the title if they want. It's different if I'm recruiting organizations to host the workshops—then I use the Talking with your Child about Sex title.

—Betsy Neale, Consultant and Trainer, Kentucky Department of Public Health

Frequently, incentives are offered to parents to encourage participation in workshops, including a light meal, on-site child care for parents with young children, and raffle prizes, such as gift certificates or parenting books. In Kentucky, the workshop is sometimes paired with a middle school dance. The workshop is offered on-site at the school in a separate room during the dance, and the children are told in advance that they will receive free admission to the dance if they bring a parent to the workshop. Children are also provided coupons to the concession stand at the dance. Collaboration with schools also involves teachers asking the children what incentives they would like to receive in exchange for bringing a parent into a workshop, so leniency on a certain homework assignment or getting to do something special at school are also offered as incentives. Flyers for the workshop were sent home by host agencies with school report cards.

Printed materials. Title X programs also developed and disseminated reading materials telling parents how to bring up discussions about reproductive health with their children. For example, the Family Planning Council in Philadelphia worked with a local graphic design company to develop and produce a magazine for parents on talking about sex and sexual health issues with adolescents. The *Parent Probe* magazine was designed to mimic a tabloid, using bold colors; attention-grabbing graphic design elements; photographs; catchy, amusing headlines; coupons; games; an advice column; and horoscopes. Articles include information about changing norms over time, male reproductive health issues, the ups and downs of mother-daughter communication about sex, Web sites for parents, and contact information for the Family Planning Council's Title X-funded family planning agencies. *Parent Probe* won the 2004 Distinguished Achievement for Excellence in Educational Publishing award from the national Association of Educational Publishers. *Parent Probe* is distributed free throughout the Family Planning Council's Title X service area, and thousands of copies have been given out through family planning agencies. Thousands of copies of *Parent Probe* from the Family Planning Council have been distributed to parents at Philadelphia Family Court. Copies of the magazine and order forms were also mailed to local politicians, youth-serving organizations, parent-teacher groups, and other social service

agencies. The Family Planning Council distributed copies of the magazine to adult commuters at large public transit hubs during National Sexuality Education Month in 2003. Parent Probe was also approved for distribution in the Philadelphia public schools and was made available to staff, faculty, and parents at the Title X-funded Health Resource Center schools. A mailing was done to all Philadelphia public schools, inviting the schools to order the magazine for use by their staff, faculty, and parent-teacher association. On its Web site, www.familyplanning.org, the Family Planning Council provides information for parents and also hosts links to other internet sites for parents and caregivers that provide information on enhancing communications with adolescents related to sexual health and healthy decision making.

The Kentucky Department of Public Health distributes handouts in conjunction with workshops. One handout is called *Tips for Parents from Teens* and was developed by adolescents from Kentucky. A resource list handout includes books and Web sites. Another handout provides guidance for parents about what to tell adolescents from different age groups, which was one of the main things parents wanted at the workshops. Handouts from OPA—Teen Talk 1, 2, and 3—are also distributed to provide information about contraception, STIs, and abstinence. Brochures for parents, titled “Sexual Pressure: A Survival Guide for Guys,” “Saying No If You’ve Had Sex Before,” and “Encouraging Abstinence,” are also distributed. A short book about parent-child communication, titled “Words Can Work,” includes topical information and vignettes plus professional advice on communication. Family Planning of Clallam County in Washington State distributes tip cards about talking to adolescents about sex, as well as a newsletter for parents.

Printed materials are also provided to inform parents about agency services. Because the Family Planning Council in Philadelphia has a Health Resource Center in 10 high schools that distributes free condoms, parents receive a letter at the beginning of the school year describing the program and giving them an opportunity to refuse permission for their adolescent to receive condoms. Sometimes, such materials serve a dual purpose—informing parents about services and promoting parent-child communication. For Family Planning Council schools that provide STI screening, parents receive a letter from the school principal at the beginning of the school year describing the STI program, its importance, and why it is in the school. The letter helps to educate parents and encourage talking with their adolescents about these issues, creating a teachable moment.

Agency tours and open houses. Title X programs sometimes offer information to parents in order to educate them about services offered to adolescents generally and agency policies about confidentiality and adolescent care. Parents may be offered a tour of the agency, and program staff explain that adolescents may request and receive services without parent knowledge; this proactive communication with parents can help to establish relationships with parents that are based on realistic expectations about agency practices and limitations on communication with parents or others about specific services provided to the adolescent. Program staff have also organized open houses attended by parents, although attendance numbers were not high.

4.1.3 Staff-Centered Strategies

All Title X programs interviewed mentioned staff-centered strategies to support staff in their efforts to counsel adolescents or work with parents. The two major themes were prompting staff to provide counseling and providing training for staff.

Prompting staff to provide counseling. Some sites have created prompts, checkboxes, or lists of counseling strategies in medical records to document counseling provided to adolescents (and provide data for monitoring this activity). The intake form may include a social history section that prompts the staff to introduce counseling about parent involvement. At Planned Parenthood of the Inland Northwest in Washington State, family involvement appears on all forms to be completed by anyone seeing a client.

A challenge the Family Planning Council in Philadelphia identified has been in developing documentation and tracking systems so that providers can have meaningful and non-repetitive discussions with adolescents at initial and subsequent visits. Documentation is now designed so that the provider can track the extent of family support over time with the adolescent and draw upon it as appropriate to the counseling and education the adolescent receives at subsequent visits to the clinic.

Staff training. Title X programs have centered efforts toward parent involvement on setting agency policies to comply with the family involvement mandate in both clinical and educational services, providing staff training around family involvement, and reviewing documentation by staff about counseling to monitor compliance. Planned Parenthood of the Inland Northwest in Washington State makes sure in orientation procedures that staff members understand that the agency mandates parent involvement. In-service training is provided as well. The Family Planning Council in Philadelphia developed model materials for family planning staff to use to guide conversations in the clinic and is currently producing a video to supplement current training materials. JSI Research and Training Center in Boston uses multiple levels of clinic staff, such as front desk staff, counselors, and clinical staff, to involve parents and families, with a focus on strategies to achieve improved communication between parents and adolescents about sexuality. Trainings have addressed involving parents in their adolescents' sexual decision-making process, skills for counseling adolescents and their parents, and legal issues. JSI also provides on-site technical assistance to involve parents, especially if grantees are involved with schools.

In addition to these broad themes mentioned by Title X programs, two especially innovative strategies are worth mentioning separately. First, Family Planning of Clallam County in Washington State uses talking circles in Native American communities. A talking stick is used to encourage parent involvement while building on cultural traditions of turn-taking and respect for the speaker. Second, one Title X program plans to use Safer Choices in its high school adolescent health program, an evidence-based curriculum with demonstrated adolescent behavioral outcomes (Coyle et al., 2001).

4.2 Strategies Used in Title XX Prevention and Care Programs

Data analysis revealed that Title XX prevention and care programs used parent involvement strategies grouped into the themes presented in Exhibit 7. Overall, programs focused on contacting parents without adolescents present, working with parents and adolescents jointly, and finding ways to encourage parents to participate in scheduled activities.

Exhibit 7. Themes Identified among Title XX Prevention and Care Program Staff

Parent-Centered	Joint	Engagement Strategies
<ul style="list-style-type: none"> • Meetings or groups 	<ul style="list-style-type: none"> • Whole-family activities • Home visits 	<ul style="list-style-type: none"> • Gifts • Food

4.2.1 Parent-Centered Strategies

Parent-centered strategies in Title XX prevention and care programs focus on providing skills to parents to communicate with adolescents and maintaining communication with parents while program staff work with adolescents. The primary parent-centered strategy identified across Title XX programs was parent meetings.

Several Title XX programs conducted meetings or support groups for parents to promote open discussion without adolescents present. The Southern Nevada Area Health Education Center (SNAHEC) is a parent-only prevention program with no accompanying adolescent component. It is a three-level program: Level 1 builds on the “Tupperware party” format by conducting meetings in parents’ homes; Level 2 incorporates the Substance Abuse and Mental Health Services Administration (SAMHSA) Model program Parenting Wisely to increase effective parenting skills; and Level 3 is an Asset Building Club (ABC) as a maintenance program for parents to understand how they can help their children:

The ABCs would meet on a monthly basis. We’d recruit a parent coordinator who would over time take responsibility for the club. We would have to have buy-in and get space from the host organization, be it a church, school, or community center, and there would be one contact who would be enthusiastic about logistics and willing to help with this. And then an outreach coordinator from SNAHEC would be responsible for other logistics, such as identifying speakers, helping to write small grants, etc. The parents choose the topics, and then I help them by bringing in the right people to talk about the topics. They were concerned about peer pressure, so I brought in someone to talk about peer pressure. The idea is that they bring up the risk, and then we go in and pull out the developmental assets that can be protective against those risks. The speaker tries to bring the assets into their presentation.

—Mary Rosenthal, Adolescent Family Life Program Manager, Southern Nevada Area Health Education Center, Las Vegas, Nevada

Program staff asked parents what they would like to discuss, and then staff tied those topics in with youth developmental assets. Staff used a Mexican bingo game as an introduction and familiarization with the assets. The meetings also incorporated scrapbooking activities.

Roanoke Chapel Baptist Church in North Carolina directs the Communities Learning and Investing in Pregnancy Prevention; Early Reaching Strategies (CLIPPERS) program that teaches a curriculum that promotes abstinence in the high schools. At least quarterly or every other month, the parents are brought together to learn what is going on and how their children are reacting to CLIPPERS. During the first meeting, statistical data about the county's high pregnancy rate were shared. The second meeting involved parents sharing what had happened and how they did not want their child to repeat the parent's mistakes. This created dialogue from which program staff and parents could springboard. Fifth Ward Enrichment Program in Houston also conducted parent meetings:

What I've tried is personally contacting parents and inviting them to the initial meeting that is an open house. I also sent out invitations to this open house. I had parents fill out a survey on what they needed from the program to help them. We also asked for suggestions for the next meeting and asked them to bring another parent to the next meeting.

—Gayle Manning, Parent Liaison, Fifth Ward Enrichment Program, Houston, Texas

Title XX care programs also employed monthly parent meetings and groups as a way to establish relationships with parents. The Healthy Families of Garrett County program in Maryland conducts parent groups weekly or twice a month:

Support groups are part of our lessons learned. We did focus groups with parents of adolescents. One of the things we learned was that the parents of adolescents felt very isolated. They didn't know who they were supposed to talk to about these issues—issues of not knowing what to do about their adolescent, issues of not necessarily wanting to raise their grandchildren. So we decided to apply in the grant for a support group just for parents of adolescents.

—Earleen Beckman, Program Director, Healthy Families of Garrett County, Maryland

Parent outreach meetings allow parents to talk about their feelings and what they are going through. Minneapolis Public Schools conducts an evening group that is open to parents. Program staff conduct sessions for the adolescent and baby to interact together, and parents are able to separate into their own group. If parents have questions, program staff let them know they are invited to come to this group. Alternatively, Arlington Independent School District in Texas set up a library group for parents. Initial individual meetings with parents can also be important:

My strategy is to make a phone call to the home to set up a meeting just to talk about the program.

—Jane Dixon, Family Support Worker, Siouxland Health Department, Sioux City, Iowa

4.2.2 Joint Parent-Adolescent Involvement Strategies

Joint parent-adolescent involvement strategies aim to work with adolescents and parents together. Across Title XX prevention and care programs, whole-family activities and home visits were mentioned by program staff.

Whole-family activities. Fifth Ward Enrichment Program in Houston, which serves adolescent males, has hosted social events, including trick or treating with children, Valentine's Day parties,

Christmas celebration programs, award ceremonies, end of school programs, and summer programs. Adolescents, parents, siblings, girlfriends/wives, and babies are included. We observed a summer program award ceremony and observed a play performed by adolescents, a video produced by adolescents and shown to parents, reading of adolescents' writing by a professional celebrity football player with local ties, and awarding of a donated scholarship for the best essay. Parents, adolescents, siblings, girlfriends/spouses, and infants attended the program. A hearty meal was served, and local television coverage was provided because of the professional football player's appearance at the award ceremony. Colorado State University also includes whole families:

Because it's a family program, we take all the family members so they don't have to worry about child care for anyone. We take infants as well. So the key strategy is it's an educational program that goes on for any family member older than age 2, and we have a high-quality children's educational program that matches the adults'. Under age 2, it is still infant stimulation and nurturing practices, not child care. It's usually mom, dad, stepmom, grandma, aunt, etc., who will attend a total of 20 hours of activities with their kids.

—Jan Miller-Heyl, Project Director, Dare to Be You, Colorado State University

Whole-family activities are also used by Title XX care programs. Arlington Independent School District in Texas hosts a holiday celebration dinner for students and families, with good turnout. Over 300 people attend, including Santa Claus. Adolescents are typically asked not to bring their babies to school, so this is one of the only opportunities for them to do this. All of the adolescents' parents were invited. The program also hosts a high school senior year recognition, and parents come to that. The Healthy Families of Garrett County program in Maryland delivers a curriculum called Parents as Teachers (PAT). Most of the PAT activities are for the whole family. Staff work with the whole family, especially if the adolescent is living at home. Camping trips are also scheduled that parents, adolescents, and adolescents' children can attend. Pizza and play activities allow adolescents, their children, and their parents to attend fun activities together. These intergenerational family activities were developed because program staff experienced difficulty getting parents together for support groups without the rest of the family. Turnout for the whole-family activities, in contrast, has been very good:

We've had the nurturing camp, too. This was a week-long camp at a 4-H center. The idea behind it was that we wanted to give our teen parents and their families a chance to come together and not worry about daily life chores. We wanted to give them a chance to relax and participate together in activities. We started with a Dare to Be You learning program to give teens skills for interacting with their child. There was massage and other activities at the camp. The camp has been well attended. We had a great-grandmother who came once and several parents of adolescents. We've gotten lots of good feedback. At the camp, one of the activities was shield-making. The shield was made to represent things that were important to the family—important memories, etc. They related the shield to their family and what their family stands for. It was an empowering process. Then they got to take it home with them as a symbol of what their family stood for. We had a lunch by the river, and they developed a lot of relationships. Parents of adolescents went on those as well, along with the teens.

—Karen Keefer, Enhanced Teen Services Coordinator/Family Support Worker, Healthy Families of Garrett County, Maryland

Siouxland Health Department uses whole-family meetings to discuss important decisions and mediate family conflicts:

I have two different families who have issues with wanting their daughters to go to school. They have family meetings with the mom, dad, sibling, and teen mom. I was there, and they had discussions. They were more toned down because I was there. They save up some of the things they want to discuss until I'm there. The teen mom feels somehow supported; it isn't just her parents jumping on her. We've had almost whole-family meetings in places. These were initiated by the teen mom. It helps to keep down on the yelling and screaming. For example, one time a teen was going to out of state to a large city with another teen, and her parents didn't want her to go. We had a discussion about it, and I think it helped to have someone else to point out the dangers involved.

—Tami Pfaffle, Family Support Worker, Crittenton Center, Sioux City, Iowa

Home visits. Many programs provide services, assessments, and referrals through home visits to adolescents. Many programs use home visits to assess pregnant and parenting adolescents' level of family support and adjust program services accordingly. For example, FWEP conducts home visits as an initial step in providing services:

When kids are first enrolled in the program, we conduct home visits. Our main point of contact is that initial home visit. If the child has problems with school, we sit down with the adolescent to discuss the consequences of the behavior and update parents on what we are doing.

—Brian Purnell, Lead Manager of School Projects, Fifth Ward Enrichment Program, Houston, Texas

School project managers try to frequently conduct home visits to touch base with parents.

Home visits are very common among Title XX care programs, and flexible scheduling of visits was mentioned by several programs. The Healthy Families of Garrett County program staff in Maryland conduct evening and weekend home visits to make sure that families can be involved. Staff try to involve parents if they are present during home visits. Staff have observed that adolescents look to their parents for support and answers, especially because parents provide child care while the adolescent is at school. The Siouxland Health Department in Iowa also involves parents in home visits. Staff have had to be flexible and go to home visits at 5 or 6 p.m. to discuss the program with parents.

Minneapolis Public Schools also includes parents in home visits, using assorted techniques to promote healthy pregnancy and improve the relationship between adolescent and parent:

When I do home visits, I always try to include a parent or caregiver in the visit. It can be difficult because the teen doesn't always have a good relationship with the parent. Sometimes mom can cause friction telling me things that the teen may not want me to know. But the goal for me is to make sure there is a healthy pregnancy. Strategies I use include the Nursing Child Satellite Assessment Training (NCSAT), promoting maternal health during pregnancy. Sometimes we can bring the parent into that by asking, "When you were pregnant, do you remember this?" and developing a healthy relationship by comparing pregnancies. I'll just ask mom a question that may seem unrelated to why I'm

here, but it helps develop an open relation between the mother and me. Sometimes I relate to the teen and mom through talking with them and asking, "It must be hard seeing your child go through this," or, "It must be hard for your mom to see you go through this."

—Jeanne Kumlin, Public Health Nurse, Minneapolis Public Schools, Minnesota

4.2.3 Engagement Strategies

Title XX programs reported providing incentives for parents to attend activities, especially gifts and food.

Gifts. When using the Tupperware party approach, Southern Nevada Area Health Education Center staff in Las Vegas provide a gift to the host parent when they arrive as a thank you and give gifts to the parent attendees because staff recognize how hard it is for them to make the time to attend. Fifth Ward Enrichment Program in Houston also provides gifts to bring parents to functions, including scholarships for adolescents and raffles for DVD players. St. Luke's Roosevelt Hospital in New York provides a theatrical performance involving professional actors trained as health educators. The program provides presents and t-shirts as incentives for attendance. Colorado State University offers a financial incentive that places value on having parents involved in learning how to do all the things the staff are teaching them to do with their adolescents. Up to two adult family members (anyone who spends a high percentage of their time monitoring the adolescent) can receive \$200 for completing 10 of 11 program sessions. The program has experienced a lot of success filling up the class with this recruitment strategy. Arlington Independent School District in Texas provides scholarships and other gifts at its holiday celebration.

Food. Title XX programs agree that feeding parents is a must to encourage attendance at activities. As one staff person said,

Food brings parents to functions. You have to give something to get parents involved.

—Billy Reese, Juvenile Mentoring Coordinator, Fifth Ward Enrichment Program, Houston, Texas

The Southern Nevada Area Health Education Center in Las Vegas provides refreshments at Tupperware party-type parent meetings. Roanoke Chapel Baptist Church in North Carolina holds its annual start-up meeting at a restaurant. St. Luke's Roosevelt Hospital in New York serves food at theatrical performances. Healthy Families of Garrett County in Maryland includes food in the title of its Pizza and Play activity. Siouxland Health Department in Iowa provides a big picnic. Arlington Independent School District provides food at its holiday celebration.

In addition to these broad themes mentioned by Title XX programs, three especially innovative strategies are worth mentioning separately. First, Roanoke Chapel Baptist Church in North Carolina and Fifth Ward Enrichment Program in Houston provide university tours for parents. In North Carolina, the strategy is to let parents know that their child can be a part of what parents observe. Some of the parents had never visited a college campus prior to the tour. This approach builds on etiological literature that educational aspirations are protective against adolescent sex risk behavior, and an important first step

toward developing such aspirations among adolescents may be exposing parents to possibility. Second, St. Luke’s Roosevelt Hospital’s theatrical performance approach provides 5 weeks of performances to children in school and then a parent program in the evenings. The children are excited and talk to their parents about the show, which is fun and not solely didactic. Live scenarios are enacted, and parents can ask the actors questions. Role plays engage parents and are reported by parents to be their favorite thing about the program. Third, Colorado State University’s Dare to Be You Program assesses risk factors among families as part of the selection and enrollment process. The program allows no more than 15% of the participants to have very high levels of risk factors and makes a conscious effort to ensure that at least 10% of the participants are people that the community regards as fairly highly functional parents. This approach destigmatizes the program.

4.3 Differences by Program Type

Each program type used distinctive approaches (Exhibit 8). Title X programs were unique in offering counseling to adolescents without involving parents of these adolescents directly. A tremendous focus on staff training and paperwork assistance and monitoring was also unique to the Title X service setting.

Exhibit 8. Differences by Program Type

Title X	Title XX Prevention	Title XX Care
<ul style="list-style-type: none"> • Offer counseling to adolescents without directly involving parents • Focus on <ul style="list-style-type: none"> – Staff training – Paperwork assistance – Monitoring 	<ul style="list-style-type: none"> • More likely to deliver evidence-based curricula with parent involvement components • Choosing the Best • Dare to Be You • Parenting Wisely 	<ul style="list-style-type: none"> • Provide parents with links to other needed services • Empower parents and clarify their role in relation to staff

In contrast, Title XX prevention programs were more likely than other programs to deliver evidence-based curricula with parent involvement components, including Choosing the Best (Weed, 2004), Dare to Be You (Miller-Heyl, MacPhee, & Fritz, 1998), and Parenting Wisely (Kacir & Gordon, 1997). Of these, Choosing the Best has demonstrated adolescent behavioral outcomes regarding reproductive health. Fifth Ward Enrichment Program staff in Houston use this abstinence education curriculum, picking 2 days per week to deliver the program over 8 weeks. The program occasionally requires adolescents to talk to their parents about questions on worksheets as part of a homework assignment.

Title XX care programs mentioned two strategies that did not surface at all during interviews with other programs. First, program staff provide parents with links to other services they need:

We let the parents of adolescents know what resources are available in the community that they can use for themselves or for their teens, like for health care or other services. We try to help them get the services they need. When they can’t afford it, we ask

Enhanced Teen Services to pay for driver's education classes, for example, and other services to help the child be more self-sufficient. We link them to services.

—Kathy Powell, Parent Educator and Family Support Worker. Healthy Families of Garrett County, Maryland

Usually, the cases where I've formed a relationship of my own with the parent have been when the teen comes in and reports about a family problem that is going on. If I feel I can be of service to help with the family problem, then I feel I should form a relationship with the parent and start working a little more one-on-one with the parent, and that's how that comes about. For instance, there have been immigration situations where the family is petitioning the court to increase immigration status. I've drafted letters of support, helped families get in touch with lawyers, either talking to parents on the phone or in person to help put things into writing or to help them fill out the forms.

—Stephanie Pepitone, Case Manager, La Clinica de Raza's Teen Clinic Program, California

If the family needs food or shelter, La Clinica de Raza staff will try to provide referrals to provide this.

Second, a very important theme voiced by Title XX care programs involved empowering parents and clarifying their role in relation to the staff:

My main strategy is to make sure that I let the mom know that I'm aware of how important her role is, that I am not replacing her or overruling her. I am trying to contribute to what she is doing.

—Tami Pfaffle, Family Support Worker, Crittenton Center, Sioux City, Iowa

Barriers to Involving Parents

Olivia Silber Ashley

Program staff identified many barriers to involving parents in programs serving adolescents. Overall, themes varied by program type (Exhibit 9).

Exhibit 9. Themes Identified among Program Staff

Title X	Title XX Prevention	Title XX Care
<ul style="list-style-type: none"> • Parents do not participate • Adolescents resist • Staff objections • Funding limitations • Staff shortages • Community resistance 	<ul style="list-style-type: none"> • Multitude of reasons why parents do not participate 	<ul style="list-style-type: none"> • Multitude of reasons why parents do not participate • Adolescents resist • Family dysfunction • Poor parent-adolescent relations • Physical separation of family members • Program staff contradict parents • Jeopardizes adolescent-provider relationship • Cultural barriers

5.1 Reasons Parents Do Not Participate

As in the evidence-based literature, OPA programs reported that parents frequently do not participate in activities:

Recruitment and getting parents to come is the biggest problem.

—Joy Hoskins, Supervisor of Women’s Health, Kentucky Department of Health

Recruiting can be a barrier. People will say they’ll show up at a class, and then they don’t show up.

—Karla Narcisse, Outreach Coordinator, Southern Nevada Area Health Education Center

All three programs identified parents’ not participating in program activities as a barrier to involving parents; this theme was the predominant response among Title XX prevention programs, and no other barriers were identified among these programs with any consistency.

Some programs noted that lack of parent participation is not unique to reproductive health programs, citing lack of parent participation at Parent-Teacher Association (PTA) or Parent-Teacher Organization (PTO) meetings or school band concerts.

Barriers to Involving Parents

Title XX programs were very specific and detailed about why this occurs, identifying many reasons parents do not participate (Exhibit 10). First and foremost, parents’ time is limited, particularly among the low-income, high-risk populations served by Title XX programs. Single parenthood, economic hardship, and work obligations were frequently cited by Title XX staff as barriers:

Some work multiple jobs; they get worn down. If they just got off work, it’s hard for them to have time to go home, prepare dinner, etc. I’ve had parents say, “I was just too tired to come.”

—Frank Richardson, School Project Manager, Fifth Ward Enrichment Program, Houston

Exhibit 10. Reasons Parents Do Not Participate

Limited Availability	Logistics	Psychosocial Issues
<ul style="list-style-type: none"> • Single parent • Working several jobs • Multiple children • Attending school while working • Poverty • Both parents work 	<ul style="list-style-type: none"> • Transportation • Location • Child care • Schedule • Grandparent is primary caretaker and lacks mobility • Concerns about being reported to authorities 	<ul style="list-style-type: none"> • Lack of trust in outsiders • Apathy • Mental illness • Has given up on child • Community disenfranchisement • Parents are overwhelmed • Parents believe they cannot influence their child • Stigma

Second, logistical barriers prevent parents from attending, even if they have time. Transportation was mentioned numerous times by Title XX staff:

Sometimes in this community, people have to travel long distances to get to classes. This is a poor community. They may not be able to afford gas or may not even have vehicles.

—Susan Blaire, Research Coordinator, Parent Trainer, and Case Manager, Colorado State University

Program service location, particularly if services are delivered at the school, can be a barrier. Many parents do not view the school as a neutral location and may harbor hostility against the school. Some of this conflict may have begun when the parent attended the school as an adolescent, and those early experiences with the school were not positive. Many parents experience additional conflicts with the school surrounding their adolescent’s behavior or pregnancy:

There is a stigma of parents always coming into the school for whatever reason. There is a feeling that if the parents are being called into the school, it is always for something negative.

—Kirstin Johnson-Nixon, Teen Parent Liaison, Minneapolis Public Schools, Minnesota

Finding child care can also be a problem for parents:

If their child is sick, there's a drop in attendance. A lot of them bring their young children with them because they don't have anyone to leave their children with. Sometimes we can do the class with the children there.

—Karla Banda, Adolescent Family Life Bilingual Program Coordinator, Southern Nevada Area Health Education Center

Scheduled times for parent involvement activities may also conflict with parents' schedules:

Parents work all types of shifts. So if we were to implement in the evening for parents who work in the morning and in the morning for parents who work in the evening, we might get a different variety of parents.

—Catherine Moody, Program Director, Roanoke Chapel Baptist Church, North Carolina

Title XX program staff also mentioned that extended family members may serve as parents to adolescents and that these family members may have health or mobility problems that prevent them from participating in program activities:

A lot of parents are grandparents or great-grandparents raising adolescents. Many of these grandparents or great-grandparents are not mobile enough to attend meetings.

—Billy Reese, Juvenile Mentoring Coordinator, Fifth Ward Enrichment Program, Houston

In addition, Title XX program staff cited concerns among parents about the possibility of being reported to law enforcement, child protective services, or immigration authorities as a barrier to parent involvement in program activities. Overall, staff were very focused on addressing the above logistical barriers to parent involvement.

However, many Title XX program staff cited important psychosocial issues that kept parents away, including lack of trust in staff who did not grow up in the community, parent apathy about adolescent well-being, parent mental illness, parents' having given up on adolescents because of adolescents' age or past problem behavior, community disenfranchisement that prevents parents from feeling that they are important or part of a larger social structure, parents' feelings of being overwhelmed by their responsibilities and attempts to help their adolescent, parents' belief that they cannot influence their adolescent's behavior, and perceptions of stigma associated with program activities (such as feeling that the program is designed for problem families or bad parents). Unlike the logistical barriers, psychosocial barriers were not formally addressed by Title XX program staff.

5.2 Adolescent Resistance to Parent Involvement

Both Title X and Title XX care programs noted that adolescents sometimes oppose parent involvement:

Barriers to Involving Parents

Adolescents who come to Title X clinics are assured confidentiality, so a lot of adolescents may be resistant to having parents get involved when they come for counseling, but it is part of the protocol to encourage adolescents to involve their parents.

—Kathy Stratford, Acting Regional Program Consultant, Region 1 Office of Family Planning

Some teens request that their parents not be involved.

—Judy Yellowbank, Family Support Worker, Native Family Resource Center, Sioux City, Iowa

Staff observe that parent involvement may inhibit open communication between adolescents and providers, which may prevent providers from providing appropriate care:

One girl I was working with wasn't being honest with me in front of her parents. She later moved out and told me she hadn't been honest before.

—Maria Friend, Registered Nurse, Healthy Families of Garrett County, Maryland

Some staff feel that involving the parent in the clinic visit may only address parent involvement in that moment but may ignore a larger goal of increasing parent involvement in the adolescent's life:

Sometimes, kids will be reluctant to describe the reality of their life if the mother is in the room. I am not convinced that what you want is a parent coming to the clinic with the child. What you want is for the parent to have the skills to talk to the child in the privacy of their home and not just in the clinic. It is important for family involvement to be an ongoing process and does not just mean the parent bringing the child to the clinic.

—Dorothy Mann, Executive Director, Family Planning Council, Philadelphia, Pennsylvania

Other staff worry that involving parents despite adolescents' resistance may be perceived as coercion, and staff are very concerned about avoiding this perception.

Adolescents may resist because of conflict with their parents, particularly among pregnant or parenting adolescents:

The most frequent time when I'm trying to involve a parent is when I do a session with a teen parent, and she'll keep talking to me about, "Me and my mom have conflicts about this. I can't talk to her about this." When it comes up so frequently, and I see it's such a big stressor for my client, the teen patient, I ask whether it would be helpful to bring the parent in and then have the three of us do a session. No teen parent has ever said yes. They either say that they don't want to or, "My mom would never do that. I'd never ask her. She'd never want to come in." That's how it usually goes: I open the door, and the teen says no.

—Stephanie Pepitone, Case Manager, La Clinica de la Raza's Teen Clinic Program, Los Angeles, California

If the adolescent's relationship with the parent is not good, that is another barrier. The adolescent may not want the parent there. The adolescent may be embarrassed.

—Electra Kitchin, Pregnancy, Education, and Parenting Program Counselor, Arlington Independent School District, Texas

5.3 Staff-Related or Administrative Barriers among Title X Programs

Title X staff identified several staff-related or administrative barriers that impede parent involvement. Staff objections were frequently cited as a barrier. The family involvement mandate raised some staff objections when it was initiated, and Title X staff feel that some of this resistance was simply a function of the newness of the mandate, rather than its content. In addition, some Title X staff feel that grantees did not initially make it clear to providers why it was important to involve families. Over time, this barrier has lessened as staff have learned more about the goals of the mandate.

Some Title X programs identified resource and funding limitations as a barrier to conducting the number of parent workshops needed and in doing this in all locations where they are needed. Title X programs also experience staffing shortages that prevent them from implementing parent involvement strategies. Related to this issue is the fact that Title X staff receive limited training on how to involve parents:

The only big problem they really have is a problem with staffing. I know at times when we've offered to have a staff member of the clinic come to a specific training, they haven't been able to send the staff member because they don't have anybody else they can put in that place, or they have to pay that provider to leave, and they can't pay for two providers at the same time. I'm pretty sure they don't have much depth if someone is sick or leaves. I think staffing, time, and money are always the issues for them. They are always asking for help for more funding for staffing.

—Janet Wildeboor, Regional Program Consultant

Staff shortages also limit the ability of Title X programs to encourage parent involvement training because staff often need to attend a different training:

Parent involvement is one piece of the training needs, but grantees have other training needs and have to prioritize trainings.

—Susan Grantham, Director of Region 1 Family Planning Training Center, JSI Research and Training Center, Boston, Massachusetts

5.4 Community Resistance

Title X programs also identify community resistance as a barrier to parent involvement. Staff report that misinformation and myths about the agency abound in the community, such as that the program encourages sex. Success in involving parents may depend on the level of acceptance of the Title X program in the community.

On the other hand, communities may push for parent involvement that conflicts with other agency and legal mandates, and this may also interfere with implementing parent involvement strategies:

The county boards of health have presented barriers. In some counties, the boards are very adamant that parents be involved, even in spite of the law protecting confidentiality. Most of the time, the county boards of health are more in favor of parental involvement than confidentiality. That is the main problem we've faced over the years. It's against the law to force the parental involvement issue on the client or the parent. Every year in the

state legislature, there are one or two states that are trying to pass legislation that would mandate parent involvement.

—Cristino Rodriguez, Regional Program Consultant

5.5 Problem Dynamics Cited by Title XX Care Programs

Title XX care programs identified many complex dynamics that discourage parent involvement. Staff noted a multitude of problems within families that hinder parent involvement. Family dysfunction, including substance abuse and domestic violence, was especially noted as a barrier:

We have faced dysfunctional families: alcohol and domestic violence. Eighty percent of teens in our program come from dysfunctional families. As a result, parent and family involvement is neither possible nor advisable much of the time.

—Tina Simeon, Project Director, La Clinica de la Raza's Teen Clinic Program, Los Angeles

Even when family dysfunction is not severe in terms of violence or substance abuse, the psychological damage to adolescents that parents may inflict can be a barrier to parent involvement.

As noted in the literature, deterioration of the parent-adolescent relationship may occur after the adolescent pregnancy becomes known. In many cases, the parent-adolescent conflict becomes so severe that parents ask the girl to move out of the house. This conflict between adolescents and parents presents a unique barrier to parent involvement in Title XX care programs.

In addition, physical separation of family members impedes parent involvement. Physical separation may occur for many reasons, including immigrant parents' remaining in or returning to another country while the adolescent lives with other family members, or other reasons:

Some parents just aren't around, for example, if the teen's mom is in prison. And once the teen has the baby, and if she is still with the father, there is a rush to get their own place.

—Judy Yellowbank, Family Support Worker, Native Family Resource Center, Sioux City, Iowa

Having access to the parent is a barrier in implementing parent involvement strategies if the parent is not living with the teen. A lot of our teens get married, and once they do, they just include their partners in activities, rather than their parents.

—Karen Keefer, Enhanced Teen Services Coordinator/Family Support Worker, Healthy Families of Garrett County, Maryland

In addition to conflicts among family members, the nature of the role of program staff as health educators and interventionists can create conflict between program staff and parents:

Sometimes the parent has a lot of misinformation, and it's hard to convince them to do it differently. Correcting that can make us at odds with the parent.

—Becky Friend, Lactation Consultant, Parent Educator, and Family Support Worker, Healthy Families of Garrett County, Maryland

This conflict with staff may be rooted in fear that parents experience:

Fear keeps parents from participating. Fear of sharing power in the family, having to think about the family system in a different way, incorporating new information about their parenting style, being confronted in any way that they might be a part of their teen's problems or that they are the reason for their teen's problems.

—Stephanie Pepitone, Case Manager, La Clinica de la Raza's Teen Clinic Program, Los Angeles

Staff also expressed concerns about potentially harming their own relationship with the adolescent by involving parents. Staff invest much time and effort to gain adolescents' trust and create relationships with them; introducing the parent into conversations and activities can create the risk of damage to the staff-adolescent relationship. And some staff feel strongly that adolescents need a separate place from the family where their parents are not involved, to feel safe to discuss their lives and reflect on how to change situations in their life. These staff perceive that adolescents do not want to contaminate the environment they have created together with the program staff by introducing the parents. So staff try to balance cultivating relationship with the parent while maintaining relationship with the adolescent and meeting the adolescent's needs and preferences for separation from parents.

5.6 Cultural Barriers

In addition, Title XX care staff noted cultural barriers to parent involvement. Staff advised that taking a cultural approach and understanding Latino families' beliefs and values are key. Two programs that reported Hispanic adolescents as the largest population served also noted that although the relationship between the adolescent female and her mother deteriorates when the pregnancy becomes known in all racial/ethnic groups, the baby's father may be more involved in Hispanic families. One program that serves 90% Hispanic adolescents reported that more often than not, the adolescent female lives with the baby's father's family. In many cases, the baby's father may be significantly older than the adolescent female, and the illegal nature of this sexual relationship may create fears among families of becoming involved in program services. In addition, some parents do not live in the United States. Parents who do live in the United States may work two or three different jobs that they combine to try to make the family financially viable. Also, undocumented or illegal alien individuals are afraid of being turned in, and this interferes with parent involvement. Staff also note that lack of education is a problem among Latino families:

We've worked with a lot more Hispanic families this year. The Hispanic mothers have been pretty willing to have us work with their kids. The Latino families in this community are not very educated themselves. Hispanic women usually have about a 6th grade education. And Guatemalan and El Salvadoran are even less; it is more like 2nd or 3rd grade. When we talk about barriers to getting kids to school, it also is getting across the value of what an education here can do for you. Communication with the schools is not easy.

—Mona Scaletta, Maternal and Child Health Services Coordinator, Siouxland Health Department, Iowa

Staff noted language barriers as well. For example, families who do not speak English experience problems completing paperwork and obtaining Social Security cards, birth certificates, and license plates.

These families require assistance in identifying whom to contact and what to ask. Staff also noted difficulty in simply assessing current services Hispanic families receive and that Hispanic families have problems understanding the bills they incur. These families do not understand the process of how billing and collections work; when they call a collections department, there is no interpreter to assist them with communication.

One program served white, Hispanic, and American Indian populations. Program staff noted that American Indian parents are more likely to discontinue participation than white or Hispanic parents. While family support workers reported that the proportion of white or Hispanic adolescents accompanied by a parent when they receive services (including home visits) ranges from 25% to 80%, the family support worker serving American Indian adolescents reported that about 10% of the parents accompany the adolescents she works with then they receive services.

Each individual organization has its own retention rate. Crittenton Center and Native Family Resource Center have lower rates than we do. Parent involvement in the Native family system is fairly non-existent. They may have some other significant adult woman than the teen's mother. It might be just another support person in the community.

—Mona Scaletta, Maternal and Child Health Services Coordinator, Siouxland Health Department, Iowa

The family support worker serving American Indian adolescents noted that half of her cases had no parent involvement, either because both parents worked or because the parent was incarcerated and the adolescent supported herself on Family Investment Program, which is like Aid to Dependent Children. This worker also described American Indian adolescents reporting their parents for drug abuse and being involved in drug use themselves. She noted that entire families—including both of the adolescents' parents—rely on her for everything, including helping with issues of homelessness, resource transportation, taking other siblings for pregnancy tests, and providing clothes. Overall, American Indian families and adolescents appeared to be the neediest and most dysfunctional; yet, parent involvement for these adolescents was lower than among other racial/ethnic groups.

Programs serving an immigrant population acknowledge that they need more information about the immigrant culture regarding the role of parents, and that research is not always available on this issue:

We would need to learn more about Hmong culture regarding whether parents or in-laws would be more helpful. We don't know enough. That's a barrier. We need more research to help us.

—Barbara Kyle, Teen Parent Coordinator, Minneapolis Public Schools, Minnesota

Program staff advised that they have to examine the cultural aspects of each situation. For example, adolescent abuse victims are sometimes in a cultural marriage situation, where the union is recognized by community members, but is not a legal marriage in the United States, and staff realized that there was much they did not know about this. In this situation, the Teen Parent Liaison was able to work with the mental health counselor to learn that cultural marriages are recognized by the immigrant community but not by the state. In such marriages, the authority roles and decision-making power shift to the baby's father and his family, and this can be problematic if the baby's father is a young adolescent

male with little reasoning ability or knowledge about the issues being discussed. Staff observed that the level of parent involvement may vary with the cultural, marital, and/or family dynamic.

5.7 Confidentiality

We asked Title X program staff about whether confidentiality is perceived as a barrier to parent involvement, and we identified more disagreement than agreement on this issue among program staff; in all Title X programs, staff within the same program who were interviewed separately disagreed about how confidentiality guidelines and parent involvement mandates relate to each other, although staff within the same program who were interviewed together did not disagree with each other. In addition, although Title XX care program staff were not asked about this issue, they identified confidentiality as a perceived barrier to parent involvement. Exhibit 11 presents issues raised in support of and in opposition of the role of confidentiality as a perceived barrier to involving parents. Among both Title X and Title XX care program staff, respondents agreed that confidentiality guidelines do not prevent them from complying with the parent involvement mandate. However, many staff feel that confidentiality restrictions affect the quality of their implementation of parent involvement activities.

Exhibit 11. Perceptions about Confidentiality as a Barrier

Barrier	Not a Barrier
<ul style="list-style-type: none"> • Would not notify parents without adolescent consent • When parent calls, cannot give information • Encourage adolescents to involve parents, but adolescents resist getting parents involved • Do not know for sure whether it is really okay with adolescent for parent to be present • Adolescents may not open up or disclose in parent’s presence 	<ul style="list-style-type: none"> • Protect clients and get the message out that the program helps adolescents and parents • Encourage adolescents to involve parents, but it is the adolescent’s decision • Safeguard for adolescents who are not safe at home

Staff who perceived confidentiality as a barrier to parent involvement reported that although staff may want to discuss adolescents’ activities and needs with parents, confidentiality guidelines prevent this type of parent involvement:

We wouldn’t break confidentiality unless the teen says she wouldn’t mind our notifying the parent. To some degree, confidentiality is a barrier.

—Janet Wildeboor, Regional Program Consultant

The biggest thing is confidentiality. You don’t want to hurt the relationship between the teen and the provider. By law it’s an issue.

— Jeanne Kumlin, Public Health Nurse, Minneapolis Public Schools, Minnesota

Title X staff also observe that while confidentiality guidelines require that staff ask for adolescent consent to allow parent involvement in examinations or discussions, it is not always clear that adolescents

are consenting freely when they allow this, and sometimes adolescents may not disclose important health information in front of parents, hindering providers' ability to provide the best care:

You don't know how to approach this because the kid says one thing when the parents are in the exam room. Mom may be inclined to speak for the kid, and we do not know for sure if it is really okay with the kid for the parent to be present. Sometimes you need to remove the child from the parent and ask the child if it is really okay for the parent to be present, but this can create a problem with confidentiality because the kid may not open up and say what needs to be said since the parent is present. It is a real delicate balance between Title X and confidentiality.

—Donna Garner, Co-Regional Program Consultant

On the other hand, some Title X staff report that they are always trying to make sure the adolescent client's privacy is protected but also to get the message out that their role is to serve both adolescents and parents. Confidentiality is not viewed as a barrier to parent involvement among these staff but instead as a choice for adolescents to make and an important safeguard for adolescents with potentially abusive parents:

We provide clinic services on a confidential basis, and we have procedures for that. We indicate adolescents as a "no home contact" if appropriate. We do encourage them to involve their parents, but that's the adolescent's decision.

—Joy Hoskins, Supervisor of Women's Health, Kentucky Department of Public Health

I think confidentiality might be a safeguard for seeing adolescents who aren't safe at home and for encouraging them to talk to another trusted adult if they can't see a parent.

—C.J. Gribble, Chief Executive Office and President, Planned Parenthood of the Inland Northwest, Washington State

Additional Lessons Learned

Olivia Silber Ashley

This chapter summarizes the evidence about effectiveness of parent involvement strategies on parent participation, parent outcomes, and adolescent outcomes among Title X and Title XX programs. In addition, the chapter presents case studies of Title X, Title XX prevention, and Title XX care programs that have been unsuccessful in involving parents. The chapter concludes with a discussion of lessons learned from these programs have been unsuccessful in involving parents.

6.1 What Has Worked

Overall, little evidence is available about effectiveness of parent involvement programs in Title X and Title XX programs. Exhibit 12 summarizes all findings reported by program staff during telephone interviews and site visits. Almost all programs reported information about parent participation related to specific parent involvement strategies.

Exhibit 12. What Has Worked

Parent Involvement Strategy	Parent Participation	Parent Outcomes	Adolescent Outcomes
Whole-family meetings	70% to 95%	Increased parent-child communication	Increased perceived risk
At-home parent meetings	✓	Increased comfort with parent-child communication	Anecdotal evidence
Parent-only group meetings	30% to 75%	No evidence	No evidence
Home visits	10% to 50%	No evidence	No evidence
Gifts	✓	No evidence	No evidence
Food	✓	No evidence	No evidence

Title XX prevention programs that conduct parent-only group meetings estimated that between 30% and 75% of parents who sign their kids up for the program attend meetings. These programs report a 15% to 20% dropout rate among parents across four meetings. Among Title XX prevention and care programs, the percentages of parents participating in home visits conducted by program staff ranged from 10% to 50%. Other programs reported that parent participation was high when they provided at-home parent meetings, gifts, or food, but these programs did not report specifics about percentages of parents participating in program activities.

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One thing that is important to keep in mind when comparing Title X and Title XX programs' reports of parent involvement is the difference in measurement and in denominators used to calculate percentages of parents involved in program activities. Title X programs frequently focused on percentages of parents who attend educational meetings as a proportion of all adolescents who receive services at Title X clinics. Most Title XX prevention programs also reported percentages of parents who attend parent-focused activities as a proportion of all adolescents who receive services from the program. However, Colorado State University's Dare to Be You program requires parent participation for adolescents to be involved in their whole-family meeting approach:

We don't take kids without their parents. They don't graduate unless they attend everything, and our graduation rate is about 95%, and sometimes we help them make up a class if they missed one.

—Jan Miller-Heyl, Colorado State University

Southern Nevada Area Health Education Center's program addresses parents only, so there is no larger base of adolescents served by the program from which to calculate the proportion of parents participating. Title XX care programs frequently measure parent participation as the proportion of parents at home during or participating in home visits conducted with adolescents served by the program.

In addition to differences in calculation of parent participation rates, possible explanations for the variability in parent participation include variance within sites; different workers within the same site (often in different interviews) reported different participation rates among parents. Also, program staff within the same program may have different caseloads, and the diverse populations served may exhibit different participation rates. In addition, program staff estimated parent participation rates and were not asked to provide records, so there may be some inaccuracy in the reporting of these estimates. However, parent participation may not be routinely recorded, so inconsistent recordkeeping may be another factor that contributed to the variability in parent participation reported.

Theoretically based recruitment and retention strategies seemed to yield the strongest parent participation. For example, Colorado State University's Dare to Be You program's recruitment strategy to ensure that program composition is balanced in terms of risk factors and community status seems to contribute to the program's high level of participation and retention among parents. The Southern Nevada Area Health Education Tupperware party approach is based on a strategy used by another program in heart disease prevention and uses social marketing constructs to assess why the strategy works.

Planning and controlled program implementation were also characteristics of programs exhibiting the strongest parent participation. Both the Dare to Be You program and the Parenting Wisely program incorporate evidence-based model SAMHSA program curricula, and implementation of these curricula are carefully supervised and monitored. Dare to Be You program staff are required to take the 20-hour Dare to Be You facilitation training and participate in additional training. A complex workshop log form records who attends, what is done each night, and the responses of the attendees each night. All instructors for the Southern Nevada Area Health Education Center receive 8 hours of training for Positive Choices Positive Futures and 16 hours of training for Parenting Wisely.

Only two Title XX prevention programs reported effectiveness outcomes beyond parent participation. First, Colorado State University's Dare to Be You program collects data from both parents and adolescents to evaluate the impact of whole-family meetings. Preliminary data show that the program has made a difference in parents in terms of how parents communicate with their adolescents. Preliminary data also show changes for adolescents in terms of perceptions of sexual risk taking; adolescents think there is more risk involved after the class than before the class. The randomized design of the evaluation enables attribution of such changes to the program.

Second, Southern Nevada Area Health Education Center's goals are to increase parent-child communication and parent-child connectedness. A secondary goal is to increase parent-to-parent communication and connectedness. Participants who only take Positive Choices Positive Futures, the Level 1 Tupperware party component, are compared with those who go on into the Level 3 Parenting Wisely SAMHSA model program and the Level 3 Asset Building Clubs maintenance component. The program evaluation has identified evidence of outcomes related to parent knowledge and attitude changes among participants who participate in Levels 2 and 3 compared with those who participate in Level 1 only. Although adolescents are not surveyed as part of the evaluation, program staff hear anecdotal stories about changes in adolescents' behaviors and attitudes:

One thing we hear very often is that parents say their children are changing because the parent's don't yell so much anymore. Or the children might communicate with the parents more about health issues like acne or sexual activity and then go get treatment for things.

—Karla Narcisse, Outreach Coordinator, Southern Nevada Area Health Education Center

Measurement of Title X program success in involving parents is largely conducted through review of charts for documentation of counseling adolescents. However, only presence or absence of counseling provided is recorded. One Title X program director speculated that tracking the number and percentage of adolescents who said that their parents are involved could be easily done but has not been done yet. Nevertheless, Title X programs report anecdotal evidence of improvements in parent involvement and parent-child communication:

Historically, I have personally noticed a difference in the level of involvement and comfort of both teens and parents over the years. They seem to be becoming more comfortable in discussing these issues. But I don't have hard data that show this.

—Cristino Rodriguez, Regional Program Consultant

Title XX program staff also report anecdotal evidence of successes:

We've had parents of adolescents say they've learned a lot about parenting. Some are very receptive.

—Kathy Powell, Parent Educator and Family Support Worker, Healthy Families of Garrett County, Maryland

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I think we are successful when I see the parent on my first visit and when I hear the mom say, "I'm sure glad someone is coming in to talk to my daughter because you are going to be objective. She sees me every day." I determine how successful our program's strategies are when we see some buy-in.

—Jane Dixon, Family Support Worker, Siouxland Health Department, Iowa

Although little information is available about how or whether parent involvement strategies have resulted in positive outcomes for adolescents, Title X providers offering parent workshops, joint attendance programs, or educational materials reported positive feedback from parents. Programs generally found that parents who participate are satisfied with program activities and report improvements in knowledge of issues related to abstinence and greater motivation to communicate with their children. At the beginning of Talking with Your Child about Sex workshops offered by the *Kentucky Department of Health*, parents typically report that they are not sure how to talk to their adolescents about sexual topics or what topics are appropriate to introduce, and many parents express discomfort about talking with their adolescent about sex. After the workshops, parents typically report higher levels of self-efficacy in talking with their adolescents about sexuality, increased knowledge about which topics to address for adolescents at different ages and developmental stages, and a high likelihood of trying to talk with their adolescents about sex during the next month. In addition, most of the agencies and organizations approached to host a Talking with Your Child about Sex workshop expressed that such parent training is needed in their communities. Puberty's Wild Ride from the *Family Planning Council* in Philadelphia, Pennsylvania, is well received by parents as a self-educational tool.

6.2 Situations and Settings Where Parent Involvement Strategies Have Not Worked

As part of our site selection, we deliberately selected programs that reported outcomes and lessons learned that reflected challenges experienced in implementing parent involvement strategies. This section describes one program of each program type that was not successful in involving parents. Information about each program is presented as a case study in order to present contextual information that may be helpful in interpreting outcomes.

6.2.1 Title X Program

A Title X program in a semi-rural area in the Northwest reported failing to capture enough interested parents to keep an educational program running. This program serves 5,000 adolescents annually. Approximately 94% of adolescents are Caucasian, and 78% are at or below 50% of the federal poverty level. This program marketed *Our Whole Lives* heavily. *Our Whole Lives* is a non-religious, values-based curriculum developed by the United Church of Christ and Unitarian Church for parents and adolescents to attend together (Unitarian Universalist Association, 2002). *Our Whole Lives* is a series of sexuality education curricula for five age groups: kindergarten to grade 1, grades 4 to 6, grades 7 to 9, grades 10 to 12, and adults. The curriculum helps participants make informed and responsible decisions about their sexual health and behavior. It equips participants with accurate, age-appropriate information on human development, relationships, personal skills, sexual behavior, sexual health, and society and culture. Grounded in a holistic view of sexuality, *Our Whole Lives* helps participants to clarify their

values, build interpersonal skills, and understand the spiritual, emotional, and social aspects of sexuality. The Title X program presented several classes for parents and adolescents.

Despite heavy marketing, the Title X program was unable to capture enough interested parents to keep the educational program running. Child care is on the list of engagement strategies that the Title X program eventually intends to provide, but it has not been provided yet. In addition, the curriculum requires a male and female educator and the program's male educator went to work with the HIV/AIDS program. The program has not successfully recruited another male educator to talk with male participants in order to ensure they are comfortable enough to ask questions. The Title X program director expressed concerns that Our Whole Lives has not been evaluated. The program is instead searching for a program that can be marketed to parents as evidence-based to assure parents that exposed children will be more likely to delay sexual initiation until age 18, have fewer sexual partners, and engage in safe sexual practices. The Title X program has just found a middle school curriculum that meets those standards, but the program has not implemented it yet. Once the curriculum is in place, the program will be looking for grant funding to increase staffing and build a better department so that regional statistics on STIs and unintended pregnancies can be measured to determine whether the program is making an impact in the region. It is important to note that although the Our Whole Lives curriculum was not successfully implemented, this Title X program engaged in many other activities to involve parents, including orientation procedures for staff members, in-service staff training, house parties for parents, printed materials, creative scheduling and extended hours, partnering with faith-based organizations, and sexuality education with parents of very young children.

6.2.2 Title XX Prevention Program

A Title XX prevention program in an urban area in the Southwest did not get the response from parents that it wanted. This program serves 1,400 adolescent males annually. Approximately 80% of adolescents are African American, and 20% are Latino. The area served is one of the most economically depressed areas in the county, with the lowest median wage in the county. This program conducted parent meetings at schools but found that schools were not good places to meet because some parents avoid going there and schools can be perceived as responding negatively to some parents. The program tried to find places other than schools to meet with parents but still experienced poor parent participation and turnout. In the program's first years, the program had a clinical psychologist who met monthly with as many adolescents as possible. The program called these meetings parent workshops. On Saturdays, 25 or 30 parents would attend, mainly from one or two schools. The program would post flyers all over and emphasize that parents did not have to have a child in the program. The program was unique in recruiting any parents from the community to serve as role models and mentors for adolescents served by the program. The program provided lunches and dinners, babysitting, and transportation. Creative scheduling was employed to meet later or on weekends to accommodate parents who worked. Meetings were scheduled at buildings that were convenient to parents. The program would get the more active and involved parents to get other parents involved. However, parents did not appear to have time to go to these meetings. The program found that a small core of parents always came to meetings and experienced difficulty creating a parent governance of program activities with only the same two parents participating each year. The program leadership's perception is that parent involvement is not improving each year.

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Instead, the program has continued to explore, innovate, identify new initiatives, and test different approaches year after year.

The program observed that parents' interests wanes as children age. Among elementary-age children, parents loved to come out and visit their children at school for the cute programs children participated in. However, in middle and high school, when the program perceived that adolescents needed parents more than ever, parents became less involved. The program noted that the local Parent-Teacher Organizations (PTOs) and Parent-Teacher Associations (PTAs) have experienced the same problem.

Another problem was balancing a sensitive political climate involving conflict between schools and communities. Sometimes, when the program advocated for a child, the parent named the program as an ally in conflicts the parent was engaged in with the school. Many parents would not go to the school to communicate with the school about their child because they complained about how teachers talked to parents and instead would call the program staff to ask that they take on this responsibility. The program worked very hard to avoid taking on this antagonistic role and instead tried to advocate for both schools and parents. However, schools would question the program's motives in forming an enrichment program instead of simply joining with the PTA. So delivering program services outside of the school's infrastructure and working with parents became a very politicized endeavor, which inadvertently created polarization.

In addition to these environmental challenges, the program's parent liaison, whose primary role was outreach to parents, was only funded for a part-time position. This person transitioned into the parent liaison role from an educational consultant role whose primary focus was to find financial aid for adolescents who wanted to pursue post-secondary education through universities, military, or vocational education.

The program included a school-based delivery of the Sex Can Wait curriculum and an evidence-based curriculum, Choosing the Best. However, because of the youth development model approach utilized by this program, its holistic service delivery also included lay counseling; individual, group, and family counseling with mental health professionals; life skills information and education (such as personal hygiene, interpersonal communication skills, heritage and career awareness, and violence prevention); cultural and informational field trips; group and individual mentoring; referral to outreach seminars, counseling, and reproductive health education; entrepreneurial education (such as building skills in the areas of marketing, saving money, and financial literacy); community services; cultural awareness; parent awareness; home visitation; teacher conferences; and man-to-man rap assemblies regarding manhood development issues. As such, the program staff forged very strong bonds with adolescents they served. Paradoxically, program staff suspected that the more the parents knew about the program and trusted the program staff with their adolescent, the less involved parents became because they knew that the adolescent was receiving good supervision and being cared for.

6.2.3 Title XX Care Program

An urban program in the West has contact with parents in only 5% of adolescent cases, usually a one-time encounter lasting 15 to 30 minutes. This program serves 4,000 adolescents (including 1,300

pregnant and parenting adolescents) annually. Approximately 90% of adolescents are Latino and 75% are female. The poverty rate is quite high in the area where the clinic and the population served are located. Involving parents is not a routine part of what the program does. Program staff follow the adolescent's lead, which sometimes does not include parent involvement. Staff primarily focus on building relationship with the adolescent, which involves letting adolescents know they can say what they want without having to have a connection to their parents and providing another family or safe environment in addition to their home. There have been many instances when staff have invited parents to come in or have told adolescents that they can invite their parents in as part of the program, but this is not a routine strategy; it is based on the needs of the adolescent patients, their request, or staff suggestion.

Nevertheless, program staff are available to involve parents and do respond to parents' requests for involvement. The program has a therapist available to provide family therapy, but this has not been identified as a routine need. Usually, the cases where staff have formed a relationship with the parent has been when the adolescent reports a family problem. If the staff feel that they can be of service to help the parent and start working a little more one-on-one with the parent, then parent involvement comes about. Sometimes staff are approached by parents who say they know the program is serving the adolescent; the staff cannot by law confirm this. In these cases, staff usually meet with the parent, focus on how the situation is affecting the parent, and try to refer the parent to another therapist to get support to help with the difficult issues the parent is having with the adolescent. When staff have conducted home visits, parents were often present, so staff would talk with them briefly. The program offers case management to the family for whatever the family needs. Staff conduct an initial psychosocial assessment to determine what type of family support is available to the adolescent. From this assessment, staff try to provide support to the parents and/or family if needed. For example, staff may provide parent education on child and adolescent development. Very rarely, parents become involved in the adolescent's prenatal care.

Despite the minimal focus on parent involvement, staff say that the level of involvement feels appropriate; more often that not, the adolescent truly needs separation from the family to feel safe to discuss what is happening and to reflect on how to change situations in their life. Staff perceive that adolescents do not want to contaminate the environment created between adolescents and staff or that adolescents believe that their parent would never agree to talk with the staff.

Involving parents has sometimes resulted in negative experiences for adolescents. The program started teaching parenting classes for adolescents, and some parents started to attend at the invitation of the adolescents. The program offered a \$20 gift certificate incentive for parent attendance, but the results were very problematic. Parents became very critical of what they heard in the class and were very rude to the group facilitators and insulting to the other adolescents. Because of the parents' inappropriateness, program staff felt they had to ban any parents from attending future adolescent parenting classes.

Involving parents has also resulted in negative experiences for staff. Because staff frequently conduct home visits, staff may be directly exposed to parent rage or explicit or implicit threats of violence. Such confrontations have frightened staff and created potential safety concerns, generating emotional barriers to involving parents. Of course, when these occur in front of adolescent clients, adolescents are also embarrassed. Staff noted that many of the parents are the reasons that adolescents are in their situations to begin with—either because of sexual abuse within the family or by someone outside

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the family without appropriate parent protection or response or because of the parent’s domestic violence or substance abuse issues.

Other barriers to parent involvement for this program are similar to those reported by many programs. Some parents live in Mexico while the adolescent is living with other family members; some parents are resistant to the program because they are undocumented; some work at two to three jobs to try to make the family financially viable; and in some cases, once the family learns of the adolescent’s pregnancy, the adolescent is kicked out of the home and must live elsewhere, making deterioration of the parent-child relationship a barrier once the pregnancy is known.

6.3 Lessons Learned from Unsuccessful Attempts to Involve Parents

This section summarizes lessons learned across all programs from problems encountered in trying to involve parents. Exhibit 13 summarizes lessons learned by program type.

Exhibit 13. Lessons Learned from Unsuccessful Attempts to Involve Parents

Title X	Title XX Prevention	Title XX Care
<ul style="list-style-type: none"> • Reframe parent involvement policy to get staff buy-in • Perceived lack of success may be due to poor reporting by program staff 	<ul style="list-style-type: none"> • Interaction among parents is important • Incentives and food increase parent participation • Parent involvement is harder with older adolescents • Partner with schools in designing and implementing outreach 	<ul style="list-style-type: none"> • Helping parents helps the adolescent • Involve parents as soon as possible • Develop relationship with families and parents to increase their comfort in participating • Convey respect for parents • Avoid contradicting parents • Praise parents • Educate parents without criticism • Focus on parent needs • Center activities on the adolescent’s child • Involve parents separately from the adolescent

6.3.1 Title X Programs

Because some Title X staff have expressed concerns about parent involvement interfering with patient care and confidentiality, it was recommended that Title X clinic managers reframe the parent involvement mandate in a positive light in order to convince staff that it is worthwhile:

I would advise the clinic to get the buy-in of their clinical staff. Tell them how important family involvement is and that it is an OPA priority. Regular meetings with staff would be a way to reiterate the importance of family involvement.

—Donna Garner, Title X Regional Program Consultant

The Family Planning Council learned that the Family Planning Council of America performance measure pilot [involving chart review to see whether adolescents' families are aware that they are seeking reproductive health services and to see whether adolescents are receiving client-centered counseling encouraging family involvement] was very important. During this pilot, many agencies did very poorly. The Council interviewed these agencies about why they did so poorly. One of the things the Council realized was that agencies were viewing family involvement as an ideological issue rather than providing better care for the adolescents. The Council reworked their policy to demonstrate that there is research to explain that kids do better if they have supportive environments of adults. Once the Council did this, we got a lot more buy-in from the agencies. Once agencies realized that there was a good best practice and family involvement was a good thing to do for patients and their families, that changed the whole conversation. Once the Council was able to put family involvement into context, it got better.

—Dorothy Mann, Executive Director, Family Planning Council, Philadelphia

In addition to getting staff buy-in, perceived lack of success in promoting parent involvement may be due to poor reporting by staff. In these cases, parent involvement counseling is provided to adolescents but is not noted in the chart, which then incorrectly suggests to reviewers that parent involvement is not occurring:

Usually from attending the counseling session and reviewing the charts, you get a good idea of the practices. Sometimes you see that the provider does discuss parental involvement but fails to document it or to check the box.

—Cristino Rodriguez, Title X Regional Program Consultant

6.3.2 Title XX Prevention Programs

Title XX prevention program staff highlighted the importance of allowing parents the opportunity to hear about each others' experiences and how they have handled issues. Interactive sharing of knowledge and experiences builds parents' confidence and sense of social support:

The interaction is one of the key elements. Once parents find out they're not the only ones going through this, they're much more open to suggestions.

—Karla Banda, Adolescent Family Life Bilingual Program Coordinator, Southern Nevada Area Health Education Center

Many program staff noted that providing incentives and food increase parent attendance and participation:

The DVD giveaway did make a difference, based on attendance count.

—Gayle Manning, Parent Liaison, Fifth Ward Enrichment Program, Houston

The only way that you can sometimes get parents out is to feed them or take them out to a restaurant or something.

—Catherine Moody, Program Director, Roanoke Chapel Baptist Church, North Carolina

Additional Lessons Learned

Program staff also observed that parents are more likely to be involved in activities for their younger children, but parent involvement is harder for both program staff and parents to achieve with older adolescents:

The timing is right for our program, which serves fifth- and sixth-graders. By high school, parents have dropped out.

—Cydelle Berlin, Program Director, St. Luke’s Roosevelt Hospital STARLO Program, New York City

Many programs recommended partnering with schools in designing and implementing outreach to parents. For example, some program staff contact schools by telephone and speak to the Title I teachers in order to collaborate on involving parents. Program staff noted that schools often refer program staff to other schools, which helps to identify and form additional partnerships for increasing parent involvement.

6.3.3 Title XX Care Programs

Title XX care program staff noted that because the family is an interdependent system, all efforts to work with parents have a positive effect on other family members. Adolescents in particular benefit from parent involvement efforts because they depend on their parents for their day-to-day needs, because adolescents’ emotional well-being hinges upon parent functioning, and because parents are important models and facilitators of adolescents’ social development.

Social support is positive to the teen. By bolstering a parent, you may bolster the teen.

—Tina Simeon, Project Director, La Clinica de la Raza’s Teen Clinic Program, Los Angeles

The adolescent relies on their parent for so much, so when the parent is functioning in a healthy manner, the entire household is better. Some of the parents of the adolescents aren’t very healthy mentally, physically, or socially. We’ve had success in mental health, mostly depression care, with the teen and the parent.

—Mona Scaletta, Maternal and Child Health Services Coordinator, Siouxland Health Department, Iowa

Some program staff also advocated for involving parents as soon as possible, particularly surrounding the birth of the adolescent’s baby, since this is a time when parents need support the most and may be the most open to program staff involvement.

I think it’s necessary to get in right away with the crisis after the baby arrives. That is how it is on my end of town. It is usually very appreciated. I try to meet families at the hospital. They may not want school or other kids to know or to be involved. Just the nurse and me, the counselor. I find that the ripest time to get involved is immediately, to build rapport at the time.

—Cindy Finberg, Pregnancy, Education, and Parenting Program Counselor, Arlington Independent School District, Texas

Many program staff noted that developing relationships with families and parents increases their comfort in participating in program services. While parents may attend workshops, home visits, prenatal

care visits, or social functions, they may not always feel at ease because they do not know the people who attend with them. Making an effort to get to know parents personally and to bond with them can be important so that they see a familiar and friendly face and begin to feel comfortable with program activities and settings.

Program staff also felt strongly that conveying respect for parents and avoiding contradicting them, particularly in front of the adolescent, is key to acknowledging the parent's role in the family and to assuring parents that the program staff is trying to help the family rather than undermine the parent.

You don't negate anything parent say. You don't negate them unless it's about an issue that will be harmful to the child. They are the authority in that household, and you have to respect that.

—Kathy Powell, Parent Educator and Family Support Worker, Healthy Families of Garrett County, Maryland

Because parents of pregnant or parenting adolescents may be sensitive to criticism or feeling judged, even when others do not intend to convey these negative messages, many programs go out of their way to find ways to praise parents. This strategy parallels the approach that program staff use when working with adolescents directly, in trying to find ways to reinforce adolescents' positive choices, view of themselves as responsible and capable, and confidence in their ability to address problems and try new behaviors. Often, the program staff find ways to reinforce both the adolescent and the parent by complimenting parents for their role in the adolescent's progress.

I have learned that you need to be supportive and find everything parents are doing well and point it out. Often parents feel like they aren't a good parent because they have a teen who got pregnant. If you point out all the wonderful things they are doing and how great their family is, it makes parents feel good.

—Tami Pfaffle, Family Support Worker, Crittenton Center, Sioux City, Iowa

It is so important to give positive feedback to the parent. When the adolescent does something right, I tell the parent, "You must have done something right."

—Tori Sisk, Pregnancy-Related Services Coordinator, Arlington Independent School District, Texas

Along this line of thinking, program staff noted that teaching parents new information can be threatening, even though this is not the program staff's intent. However, some staff reported that they realized that they did harbor judgments about parents and benefited from examining those feelings and challenging them. Because all individuals may unconsciously project biases on others who operate differently, program staff advised that it is important to understand that all families are unique, and they have different ways of living and different traditions. Program staff openly acknowledged that families they work with might be very different from their own family. Learning to appreciate differences is instrumental to successfully involving parents. Staff also emphasized that showing parents that information staff are presenting is based on research depersonalizes the message that parents should consider new ways of thinking or behaving and makes acceptance easier for parents.

Additional Lessons Learned

Educate them without making them feel like bad parents. A lot of things have changed, like you are supposed to lay a baby on its back, not on its stomach. You have to show parents how things have changed.

—Kellie Collins, Family Support Worker, Lutheran Services in Iowa

The health information may be different than what parents were taught or what they used when their adolescents were young kids. Also, we have to make sure not to challenge parents and to let them know that we are not looking for or expecting anything from them, and we are not looking for things that are wrong.

—Rachel Ibarra, District Pregnancy, Education, and Parenting Program Nurse, Arlington Independent School District, Texas

You have to look at it in a generational context. How long has this been going on? Who is involved in the thinking within the household? Sometimes we come in with preconceived notions that this isn't right, and things shouldn't be happening this way. But in this household, if this has always been the way they are living—in a state of crisis—then sometimes we're not just tearing at the teen but the entire family and who they network with on a day-to-day basis. Sometimes when you're dealing with the parents of the teens, you're thinking, "This isn't right!" Many of the parents don't look much further than the immediate moment. I immediately think about getting the school-based clinic mental health counselor involved.

—John Jackson, Teenage Pregnancy Prevention Program Liaison, Minneapolis Public Schools, Minnesota

Centering activities on the adolescent's child, such as the baby's growth and development from week to week, can be a positive approach that parents enjoy and look forward to. In addition, staff provide opportunities for parents to focus on their own needs instead of concentrating solely on the adolescent or the baby.

You have to connect with parents where they are. For a lot of parents, when their adolescent becomes pregnant, it is a direct hit to the parent's psyche. If the parent was pregnant as an adolescent, it brings up memories. I have meetings with parents where I listen to the parent's issue instead of all the focus being on the adolescent and child. I get more involvement.

—Tori Sisk, Pregnancy-Related Services Coordinator, Arlington Independent School District, Texas

In some cases, staff involve parents separately from the adolescent, noting that a number of parents are unable to take care of themselves and may not be positive influences on the adolescent. In these cases, staff may not encourage parents' involvement with the adolescent without addressing parent dysfunction first, noting that sometimes it is better for the adolescent's well-being to get out of a bad situation and into a healthier environment and then consider appropriate ways to involve parents.

Discussion

Olivia Silber Ashley

The broader research literature clearly shows a link between multiple aspects of parent involvement and improved sexual and contraceptive outcomes among adolescents, including communication about sexual and contraceptive issues (including communication of parental values), parental awareness and monitoring of adolescent activities, parent-child bonding, and parental support for adolescent independence. It has been suggested that a combination of positive parent-child relationships, appropriate monitoring, and strong parental disapproval of risky sexual behaviors may be necessary to prevent adolescent pregnancy (Miller, 1998). However, this literature is based on observational studies of naturally occurring parent involvement. Of note, only nine randomized experimental studies have measured effects of programs targeting increased parent involvement on adolescent behavioral outcomes (e.g., contraceptive behavior, sexual behavior, risky sexual behavior, pregnancy), and findings were mixed. In particular, we noted a paucity of research on parent involvement programs for pregnant and parenting adolescents.

Among both the published literature and Title X and Title XX programs, low parent participation was noted. Several evidence-based programs, as well as Title X and Title XX prevention and care programs, reported problems with parent attendance and/or retention, especially among parents of at-risk children. More than half of Title XX prevention programs reported a lack of parent participation in spite of multiple efforts to engage parents. It seems that creating or increasing parent involvement where it does not naturally exist is not easily accomplished, and when accomplished, it may not result in the same positive outcomes for adolescents as naturally occurring parent involvement. It is possible that this may be due to other factors that impact parent involvement and adolescent outcomes, such as levels of social support outside the family, early development of children's psychological and social functioning, and levels of family stressors.

Nevertheless, Title X and Title XX programs employ a variety of creative strategies for involving parents. Our review of selected Title X program activities revealed that many programs engage in counseling for adolescents and training of staff to provide such counseling. In addition, workshops are offered to help parents communicate with their adolescents about sexuality and reproductive health issues. Some programs offer opportunities for parents and adolescents to attend together, sometimes stratified by adolescent age and gender. Parent education materials are also offered, such as magazines, booklets, and Web sites. Title X and XX programs employ multiple strategies to inform and involve parents in program activities. These include approaches that provide information materials, including newsletters and informational packets; special events and dinners; and parent advisory groups.

Despite the creative strategies employed by Title X and Title XX programs to involve parents, few evaluation efforts were undertaken to assess the effects of program strategies on parent involvement or of any resulting parent involvement on adolescent outcomes. It is clear that additional evaluation is

needed in the research literature, as well as among Title X and Title XX programs in order to identify best practices and evidence-based approaches.

7.1 Comparisons with Other Relevant Studies

Studies of parent involvement in Title X programs and other settings have found results similar to ours, particularly regarding low participation among parents in parent involvement programs. A 1986 study found that 10% to 14% of adolescents who made contraceptive visits were accompanied by a parent, typically the mother (Herceg-Baron, Furstenberg, Shea, & Harris, 1986). This study also identified barriers to parent involvement in a special service offered to promote greater involvement of the adolescent's family through special counseling sessions. Furthermore, during the 15 months following the initial clinic visit, there were no significant differences in regularity of contraceptive use and pregnancy rates between the adolescents who received the special service and those who received only the regular clinic services. These results mirror our findings of low parent participation in both the literature and in Title X and Title XX programs and of a lack of clear evidence that parent involvement programs produce better outcomes for adolescents. A recent review of adolescent reproductive health programs designed to promote parent-child communication about sexuality found that most programs did not reach substantial numbers of families; an exception was student homework assignments and media campaigns, though the impact of these upon each parent is probably very limited. Studies reviewed and discussions with educators implementing programs indicate that getting parents to participate outside their homes is a challenge (Kirby & Miller, 2002). Most parents are unwilling or unable to participate in programs, even one-night events, especially if they have to travel to a meeting or gathering. And parents who do participate are much more likely to be mothers than fathers, which is unfortunate, because fathers are especially unlikely to communicate about sexuality with their children (DiIorio, Kelley, & Hockenberry-Eaton, 1999).

Studies have found that a majority of adolescents who use family planning clinics report that a parent knows they are at the clinic (Jones, Purcell, Singh, & Finer, 2005; Jones, Singh, & Purcell, 2005), and adolescents who are younger, are black, or have made prior contraceptive visits have been found to be most likely, and adolescents with college-educated mothers or who live with two parents least likely, to indicate that a parent knew they were at the clinic (Harper, Callegari, Raine, Blum, & Darney, 2004; Jones et al., 2005; Jones et al., 2005). A recent study of adolescents receiving services at family planning clinics found that 50% to 80% of adolescents had talked to parents about sexual issues (Jones et al., 2005). These findings may suggest that counseling by Title X staff of adolescents to talk with their parents about reproductive health decisions is a reasonable approach, but that many adolescents are already doing so. However, it does appear that counseling may benefit from tailoring messages to reinforce parent involvement among adolescents who are younger, are black, or have made prior contraceptive visits and to initiate discussions about perceived barriers to parent involvement among adolescents with college-educated mothers or those who live with two parents. Prior research has found that the most common reasons adolescents do not tell parents they use family planning clinics are that adolescents do not want parents to know they are having sex and concern that parents will be disappointed if they found out adolescents are having sex (Jones et al., 2005).

A specific challenge for Title X programs is how best to address the issue of encouraging greater parent involvement while respecting adolescents' rights to confidential care (Office of Population Affairs, 2001). Although medical professionals recognize the importance of parent involvement in adolescents' decisions about sexual behavior (American Academy of Pediatrics, 2003), mandating this involvement may discourage adolescents' use of family planning services (Jones & Boonstra, 2004; Reddy, Fleming, & Swain, 2002; Society of Adolescent Medicine, 2004). In particular, mandated parent involvement for contraception likely would discourage few adolescents from engaging in sexual behavior but would result in decreased use of contraception when needed and increased risk of pregnancies and births (Jones & Boonstra, 2004; Reddy et al., 2002; Zavodny, 2004). Title X program staff were very cognizant of these considerations and expressed primary concern for adolescents' privacy and related concerns about the lack of research evidence that supports parent involvement in this setting as a positive influence for adolescents and that specifies strategies that should be employed. A number of clinics have adopted practice and policies to promote parent involvement (Finer & Darroch, 2001), and researchers have previously noted that family planning clinics encourage adolescents to voluntarily talk to their parents, typically without compromising adolescent confidentiality (Innocent & Sugland, 2004; Sugland, Leon, & Hudson, 2003).

Our finding that Title X and Title XX programs rarely evaluate the impact of their parent involvement strategies on parent or adolescent outcomes parallels findings from other studies. A recent review of programs designed to promote parent-child communication about sexuality (one aspect of parent involvement) found that only a small number of studies measured program impact on adolescent behavior, and none of the programs produced any significant positive effect on this type of outcome (Kirby & Miller, 2002). In addition to not affecting adolescent behavioral outcomes, only a few studies of parent involvement programs have provided evidence that the programs met any of the common short-term objectives for parents, such as parents' knowledge, clarity of values, skills, or comfort in talking with their adolescent about reproductive health (Kirby & Miller, 2002). It has been suggested that most programs probably did not focus sufficiently on parents to produce significant changes other than knowledge gain. Many programs have evidence that they did increase parent-child communication about sexuality, but this increase was typically measured only in the short term, and when it was measured in the long term, effects on parent-child communication often did not last. Studies have also provided very little evidence that programs improved other risk or protective factors associated with adolescent reproductive health behavior, such as adolescent beliefs, attitudes, self-efficacy, or intentions. Many studies have not measured these effects, and among the few that did, most results were not statistically significant.

7.2 Strengths and Limitations of the Assessment

The small pool of programs from which we collected qualitative data limits the representativeness of our findings. However, many of our findings resonate with those of programs and administrators outside of our sample. Because none of the programs we assessed evaluated parent involvement as an independent or dependent variable in an experimental study—the only appropriate research approach for determining causality—observations about facilitators and/or barriers to parent involvement or benefits of parent involvement are anecdotal in nature. It is risky to speculate on the basis of a small number of

programs whether (and which) parent involvement strategies are effective in producing desired ultimate outcomes.

In selecting programs for assessment, we aimed to include a variety of program characteristics, including geographic location and parent involvement approaches. However, because we were limited to five programs from each program type and used 10 selection criteria, some program characteristics were not represented in the final sample. For example, while we selected a mix of rural and urban programs, we selected no suburban programs. In addition, we selected no programs that use homework assignments that parents and children complete together as a parent involvement strategy. An example of such a program is *Switchboard of Miami* in Florida, a school-based Title XX prevention program implemented through 9th-grade social studies courses. Adolescents attending the program receive homework assignments to complete at home with parents.

We identified a great deal of variability in parent participation. Although program staff did not keep thorough records about attendance, programs employing similar parent involvement or engagement strategies reported very different levels of participation, and often within a program, differences were reported in levels of parent participation among subpopulations served, time periods, and staff. Even when parent participation was reported as high by program staff, it was unclear whether parent participants were representative of the target parent population. For example, parents attending program events might disproportionately include parents who were highly motivated or interested in the program.

Staff frequently disagreed with each other, particularly regarding the role of confidentiality in promoting or inhibiting parent involvement in Title X settings. Such inconsistencies among staff in their perceptions and framing of issues may warrant additional queries and analysis to further understand this complex issue.

Although all of the programs we assessed have sought to incorporate parents and other family members, few have an explicit parent involvement program component, and as such, indicators or measures of parent involvement are rarely collected or reported—a pattern that is echoed in the evidence-based research. Thus, observations by program staff about what has worked to involve parents are not based on systematically collected data or experimental studies. In addition, parent involvement strategies were incorporated into other program activities, and it was not possible to isolate the independent effects of parent involvement strategies on positive outcomes over and above the effects of other program efforts.

A major limitation of the assessment is that parents and adolescents were not interviewed. While program staff appeared to be honest and insightful in sharing their perceptions about barriers to parent involvement, results do not necessarily reflect parents' own perceptions. Similarly, adolescents may have insights over and above those provided by program staff, and this perspective was not captured. Because the parent-adolescent-provider relationship is complex, focus groups or individual interviews with parents and adolescents themselves could provide helpful supplementary information about the accuracy and completeness of program staff interview data.

The present study's focus on parents ignores a more encompassing socioecological approach to adolescent reproductive health. Although the current project focuses on parent influences,

reconceptualizing adolescent reproductive health behavior within an expanded socioecological framework may provide an opportunity to better confront challenges. An integrated strategy has been proposed that addresses adolescent reproductive health behavior by promoting a socioecological perspective in both basic research and intervention design (DiClemente, Salazar, Crosby, & Rosenthal, 2005). Many of the program staff we interviewed (and published studies we reviewed) implicitly conceptualized adolescent reproductive health behavior as an individual-level or interpersonal-level phenomenon. However, emerging evidence indicates that a spectrum of contextual factors and exposures interact with each other in promoting or preventing adolescents' sex risk behavior (DiClemente & Wingood, 2000). Although individual-level interventions can be effective at reducing sex risk behavior, they may not be sufficient to promote the adoption and maintenance of desired behaviors for prolonged periods. Adhering to desired behaviors may be particularly challenging in the face of peer pressure and/or media exposure that encourage risky behavior. Prevention and intervention efforts for adolescents will ideally involve activities in multiple social contexts. Emerging approaches have been described that may prove more effective in the promotion of reproductive health among adolescents (DiClemente, Crosby, & Wingood, 2002b).

7.3 Recommendations for Promising Practice Models

Our assessment of OPA-funded programs suggests that there are multiple approaches to improving parent involvement regarding adolescent reproductive health. Programs that have demonstrated success in involving parents have incorporated several important characteristics highlighted in this section.

First, theoretically based recruitment and retention strategies, such as those used by Colorado State University's Dare to Be You program and the Southern Nevada Area Health Education Tupperware party approach, seemed to yield the strongest parent participation. Second, convenience is an important consideration when involving parents. Evaluations of community-based or grassroots approaches for involving parents have shown that reaching parents where they are located (home, church, work, etc.) is effective in drawing participation (Sexuality Information and Education Council of the United States, 2002). To facilitate the participation of working family members, programs may also increase the availability of appointment slots and provide evening and weekend activities whenever possible. Programs that want to host special events or workshops requiring active participation should work with parents to schedule times that work best for families. Practitioners experienced in implementing these approaches emphasize the importance of having strong, innovative facilitators, using established community agencies to reach parents (church, workplace, etc.), or going to their homes, whichever is most desirable for parents (Sexuality Information and Education Council of the United States, 2002).

In addition, Title XX care programs are uniquely set up to involve parents through home visits for pregnant and parenting adolescents and their families. Adolescent mothers may benefit from the sharing of parental responsibilities and child care, and research suggests that parents may act as important barriers to or facilitators of service delivery and impede or encourage the adoption of skills, values, and experiences taught by programs; it behooves programs serving pregnant or parenting adolescents to gain trust and buy-in from the adolescents' parents. Programs may need to provide training and support for

parents, as well as for the adolescents. The individualized approaches described in the literature and by Title XX care programs seem ideal for these situations.

Participants in national, state, or local campaigns to increase parent-child communication about sexuality cite numerous factors necessary for parent involvement strategies to succeed, including collaboration with well-established, respected community agencies that lend legitimacy to program efforts; development of culturally appropriate materials presented by staff who are representative of the population served; and incentives (Sexuality Information and Education Council of the United States, 2002). Programs seeking to implement a community-based strategy should heed warnings about lengthy participant involvement and a need to be flexible (Douglas, 1998).

Programs should also consider including approaches that emphasize parental expertise and voice. For example, parent focus groups could help program planners assess what types of information parents want and need, what types of relationships with staff they are seeking, what their concerns and fears are, and how parents can best be empowered to become effective sexuality educators of their children.

Recruiting and training parent leaders to reach out to other parents is a related strategy that may result in increased parent involvement. The Tupperware party approach mentioned by one Title XX prevention program is a promising strategy for both recruiting parents to reach out to other parents and involving parents in their own communities. Pairing the Tupperware party approach with identified parent leaders may be even more effective in increasing parent involvement. Such a model would identify parent leaders in small communities (the smaller the community, the more potent this model would be) and train these leaders to assist in recruiting parents and in delivering or leading parent groups while hosting parent get-togethers at their homes. A train-the-trainer strategy could be used to multiply intervention dissemination and effects. This model utilizes a diffusion of innovation approach (Oldenburg, Hardcastle, & Kok, 1997), which could be cost-effective and access many more parents and families than traditional workshop approaches.

Transferring lessons learned in one setting to another may yield more options for promising practices. Title X, Title XX prevention, and Title XX care programs are encouraged to learn from each other's approaches and successes. For example, it is possible that evidence-based strategies intended to involve parents in programs for pregnant and/or parenting adolescents (e.g., Roye & Balk, 1997) may be useful for Title X staff in some situations, if such strategies can be adapted appropriately.

Some programs have sought to increase father attendance by incorporating male facilitators, partnering with father involvement groups, and recruiting through sports and recreation facilities or other community venues frequented by males. Research findings also suggest that for sessions including both parents and adolescents, small groups and same-sex parent-child dyads tend to work best.

Programs need to continue to pay attention to important relationship factors that may increase or decrease involvement and retention, including staff-parent relationship and rapport; program longevity; staff turnover; program reputation and community-level trust; cultural sensitivity of program content and staff who are working with parents; and attention to how class, status, and power differentials between professional staff and low-income parents may be handled.

7.4 Possible Lessons from More Developed Disciplines

Because there is limited evidence in the research base and among OPA-funded programs about effective strategies to involve parents in reproductive health programs serving adolescents, it is possible that lessons could be learned from effective strategies to involve parents in other types of programs targeting other adolescent risk behaviors. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2007) in the Department of Health and Human Services (DHHS) maintains an online National Registry of Evidence-Based Programs and Practices (NREPP) of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers. The purpose of this registry is to assist the public in identifying approaches to preventing and treating mental and/or substance use disorders that have been scientifically tested and that can be readily disseminated to the field. The registry includes several programs with parent involvement strategies that may provide useful approaches for OPA-funded programs.

One evidence-based program listed in the NREPP that employed effective parent involvement strategies is the Family Matters program (Bauman, Foshee, Ennett, Hicks, & Pemberton, 2001). Family Matters is a family-directed program to prevent adolescents aged 12 to 14 from using tobacco and alcohol. The program encourages communication among family members and focuses on general family characteristics (e.g., supervision and communication skills) and substance-specific characteristics (e.g., family rules for tobacco and alcohol use and media/peer influences). The program involves successive mailings of four booklets to families and telephone discussions between the parent and health educators. Two weeks after family members read a booklet and carry out activities intended to reinforce its content, a health educator contacts a parent by telephone. A new booklet is mailed when the health educator determines that the prior booklet has been completed.

The Family Matters program assumes that in order to become adequately engaged in the program, parents need to believe that (1) negative consequences could occur if their adolescent engaged in the targeted risk behavior, (2) their adolescent is vulnerable to the risk behavior, and (3) they can influence their adolescent's risk behavior (Bauman et al., 2001). Each of these assumptions derives from principles of behavioral theories, including value expectancy theory (Feather, 1982), the Health Belief Model (Strecher & Rosenstock, 1997), and self-efficacy (Strecher, DeVellis, Becker, & Rosenstock, 1986), as well as formative research findings and empirical research observations (Friedman, Glickman, & Morrissey, 1988). The program further assumes that for some families, the program may need to establish or enhance these parent beliefs. Thus, the primary goal of the first Family Matters booklet is to describe the program to parents and motivate them to participate. Adolescent participation is not included in this first booklet. In addition to reading questions and answers about the three topics mentioned above, three activities are included to actively engage parents together in considering the topics. In Activity 1, parents decide whether various statements about the targeted risk behavior are true. Activity 2 has them identify negative consequences that might occur to the adolescent or other family members if the adolescent engaged in the risk behavior, and in Activity 3, parents identify habits and other attributes they each share with the adolescent to illustrate how parents can influence the adolescent. Subsequent booklets provide information and interactive activities for parents and adolescents to complete together. All materials provided to parents are available on the Web (Bauman, 2007).

Unique aspects of the Family Matters parent involvement strategies include reaching parents at home; employing a theoretical framework in developing engagement strategies; explicitly addressing parent engagement prior to expecting parents to address risk behavior with their adolescent; and providing short, interactive, fun, theoretically informed activities for parents to complete with their adolescent. Of particular importance is the program's focus on convenience for parents. During an initial formative research phase, nearly 50% of parents participating in a pilot test reported that they would not have completed the program had participation required leaving the home.

7.5 Policy Recommendations

These data are important because they suggest a direction for addressing barriers to parent involvement, including logistics, psychosocial considerations, relationship dynamics, and cultural issues. Improving staff training and providing technical assistance to address these issues will allow for the continued but appropriate involvement of the parent in the adolescent's life and decision making about reproductive health behavior and will enable parents to feel comfortable interacting with staff and adolescents in ways that they may have previously found to be difficult.

Support for more intensive interventions with follow-up activities over many months may be required to increase and maintain positive parent involvement outcomes. We found that while Title X and Title XX prevention programs have employed many of the types of parent involvement strategies reported in the literature, including parent workshops, joint attendance programs, homework assignments, youth development models, and various combinations of these, few programs mentioned evidence-based curricula as the basis for their approach, so it is unclear whether the curricula utilized have previously demonstrated any evidence of effectiveness. In fact, among the literature we reviewed, we identified few evidence-based curricula with demonstrated adolescent behavioral outcomes. Some of the conclusions in the literature must be tempered by the numerous limitations of reviewed studies. Sample sizes were frequently small, and parents who agreed to participate were different from those who did not, thus limiting generalizability beyond the sample. It was also noted that few of the programs evaluated in the literature were solidly based in theory or research, and many were knowledge-based rather than skill-based. Nevertheless, many programs we assessed have developed their own curricula tailored to the age and cultural experiences of adolescents in their target populations. It may be important for OPA to critically and systematically evaluate how Title X and Title XX program efforts do or do not resemble evidence-based approaches and to assess the feasibility of incorporating or adapting such approaches.

At the same time, the results suggest that encouragement and support may be needed for theoretically based parent involvement strategies in OPA-funded programs. Although promising parent involvement strategies, such as the Dare to Be You model and the at-home Tupperware party model, were identified through this study, program evaluation data were not available to identify specific program effects on parent involvement, parent outcomes, and adolescent outcomes. Although it is possible that some Title X-provided services may be less amenable to parent involvement, particularly if adolescents desire privacy and confidentiality from parents, it is also possible that the approach in delivering messages about parent involvement to adolescents could be improved. Support for patient-provider communication models that incorporate theoretical frameworks, such as addressing perceived benefits, benefits, and self-efficacy to involve parents (Strecher & Rosenstock, 1997) or tailoring messages based

on stages of behavioral change (Prochaska, Redding, & Evers, 1997), may be needed to encourage strengthening of parent involvement strategies in this setting. Consistent with this line of reasoning, support for rigorous evaluation of theoretically based parent recruitment, involvement, and retention strategies should be provided.

7.6 Future Research Implications

As parents with the greatest barriers to participation are probably often those with the greatest need, it is important that further research examine the effectiveness of strategies that engage parents by reducing barriers to participation. Many Title X and Title XX prevention and care programs list specific goals related to increasing parent involvement. Although several programs assess parent satisfaction, few measure whether their parent involvement strategies are associated with improved parent or adolescent outcomes. In addition, while many programs report parent attendance, it is not always clear which activities were successful in engaging parents. An ideal design for assessing the effectiveness of parent involvement strategies would be to randomly assign clients to receive one or more parent involvement strategies, to monitor whether and how the strategies are implemented, to measure parent attendance and changes in parent outcomes (such as parent-child communication) from both the parent and adolescent perspectives (to facilitate parent-child pair analyses), and to measure potential changes in adolescent reproductive health (and infant) outcomes. Studies with enhanced methodology (e.g., biological outcomes) and clearly specified parent involvement strategies with quality control for training and implementation are especially needed. Of note, relatively little information is available about the extent to which activities to promote parent-child communication have been adopted (Jones & Boonstra, 2004), and few evidence-based programs have measured whether parent involvement components are linked to specific adolescent outcomes. In addition family involvement studies, including fathers, mothers, parent substitutes, older siblings, grandparents, etc. may be needed, since many programs noted that they are already expanding beyond involving only biological parents as they work to support adolescents. These untapped areas of research represent an opportunity for OPA-funded programs to contribute to the knowledge base.

At the macro level, OPA may desire for grantees within each program type (Title X, Title XX prevention, and Title XX care) to employ a set of standard or core measures that could be used in a cross-cutting assessment of parent involvement, including improvements in parent knowledge, communication, and parenting skills as a result of parent involvement activities. In fact, Title XX prevention and care projects now have core evaluation instruments that serve such a purpose. However, an expanded set of measures of parent involvement tailored to meet the specific goals and contexts of each program type may be needed to facilitate more widespread assessment of effectiveness. It would also be helpful for programs to measure both parent and adolescent outcomes (for example, how much parents initiate conversations about reproductive health and how adolescent reproductive health behavior may change), to assess whether changes in parent involvement are associated with changes among adolescents. Some of the stronger existing models (with encouraging but non-experimental data about parent involvement) should be examined in a random assignment experimental study. The current project contributes to understanding of the implementation of a broad range of such strategies but cannot adequately assess effectiveness beyond considering the quality and results of evaluations that may have already occurred. Further research is particularly needed in the area of parent involvement and pregnant and/or parenting

adolescents, both to describe associations with parent involvement using a larger and more representative sample, and to evaluate programs that involve parents.

An emerging body of research on implementation evaluation suggests that intervention fit and implementation climate/context affect implementation fidelity. Recent research has estimated a large amount of resources wasted by organizations, due in large part to implementation failure (Klein & Knight, 2005). Furthermore, there is a growing body of evidence from various fields that suggests that program strategies often fail due to implementation issues (Nutt, 2004). Additional research might be needed to assess relationships between how parent involvement strategies fit into OPA-funded activities (including grantee motives for implementing parent involvement strategies and competing or complementary activities), implementation climate (including leadership support, goal clarity, dedicated resources, staff training and observation, reinforcement, and removal of barriers to implementation), and implementation fidelity (whether or not parent involvement strategies are implemented as intended). Particularly within Title X and Title XX care programs, staff noted conflicting views about the benefits and drawbacks of parent involvement in relation to parent functioning and adolescent confidentiality, so these settings may benefit from further investigation of what leads to successful implementation of planned parent involvement strategies. In addition, qualitative research involving adolescents and parents may shed light on their experiences with parent involvement strategies, which may be important to supplement what has been learned from program staff.

In addition to assessing outcomes of both parent involvement approaches and recruitment strategies, cost analysis and cost-effectiveness evaluations can be beneficial. Cost is an important consideration in policy decisions about expansion, continuation, adaptation, and improvement of program strategies. However, we did not identify cost analysis or cost-effectiveness evaluations of interventions in the literature. Because OPA programs are government funded, staff burden and competing priorities are important reasons to consider costs when assessing parent involvement strategies.

The current project presented a unique opportunity to examine strategies to reduce rates of sexual activity, pregnancy, and STIs among adolescents by increasing levels of parent involvement and improving parent-child communication. This study's combined literature review, program report review, and qualitative data collection yielded much useful information for programs serving adolescents but raised questions requiring further research. Our findings are an important first step toward understanding how best to involve parents within the context of government-funded adolescent services and improve desired outcomes.

References

- Ajzen, I., & Fishbein, M. (1973). Attitudinal and normative variables as predictors of specific behaviors. *Personality and Social Psychology, 27*, 41-57.
- Allen, J., Philliber, S., Herrling, S., & Kuperminc, G. (1997). Preventing teen pregnancy and academic failure: Experimental evaluation of a developmentally based approach. *Child Development, 68*, 729-742.
- American Academy of Pediatrics. (2003). Policy statement: Family-centered care and the pediatrician's role. *Pediatrics, 112*, 691-696.
- Anderson, N., Koniak-Griffin, C., Keenan, G., Uman, B., Duggal, B., & Casey, C. (1999). Evaluating the outcomes of parent-child family life education. *Scholarly Inquiry for Nursing Practice: An International Journal, 13*, 211-234.
- Apfel, N., & Seitz, V. (1991). Four models of adolescent mother-grandmother relationships in black inner-city families. *Family Relations, 40*, 421-429.
- Ashley, O. S., Herman-Stahl, M., Sanchez, R., Penne, M. A., Weitzenkamp, D., Bauman, K., Grau, E., Williams, J., Novak, S., & Williams, M. (2004). *Serious mental illness among parents: Implications for adolescent substance use*. The 132nd Annual Meeting of the American Public Health Association, Washington, DC.
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.
- Barnett, J. E., & Hurst, C. S. (2003). Abstinence education for rural youth: An evaluation of the Life's Walk program. *Journal of School Health, 73*, 264-268.
- Bauman, K. E. (1980). *Research methods for community health and welfare*. New York: Oxford University Press.
- Bauman, K. E. (2007). *Family Matters—Program materials*. Retrieved April 4, 2007, from http://familymatters.sph.unc.edu/Program_materials.htm
- Bauman, K. E., Carver, K., & Gleiter, K. (2001). Trends in parent and friend influence during adolescence: The case of adolescent cigarette smoking. *Addictive Behavior, 26*, 349-361.
- Bauman, K. E., Foshee, V. A., Ennett, S. T., Hicks, K., & Pemberton, M. (2001). Family Matters: A family-directed program designed to prevent adolescent tobacco and alcohol use. *Health Promotion Practice, 2*, 81-96.
- Bauman, K. E., Viadro, C. I., & Tsui, A. O. (1994). Use of true experimental designs for family planning program evaluation: Merits, problems, and solutions. *Family Planning Perspectives, 20*, 108-113.
- Bearman, P., & Bruckner, H. (1999). *Power in numbers: Peer effects on adolescent girls' sexual debut and pregnancy*. Washington, DC: The National Campaign to Prevent Teen Pregnancy.

References

- Benshoff, J. M., & Alexander, E. (1993). The Family Communication Project: Fostering parent-child communication about sexuality. *Elementary School Guidance and Counseling, 27*, 288-300.
- Biglan, A., Duncan, T. E., Ary, D. V., & Smolkowski, K. (1995). Peer and parental influences on adolescent tobacco use. *Journal of Behavioral Medicine, 18*, 315-330.
- Blake, S. M., Simkin, L., Ledsky, R., Perkins, C., & Calabrese, J. M. (2001). Effects of a parent-child communications intervention on young adolescents' risk for early onset of sexual intercourse. *Family Planning Perspectives, 33*, 52-61.
- Borawski, E. A., Levers-Landis, C. E., Lovegreen, L. D., & Trapl, E. S. (2003). Parental monitoring, negotiated unsupervised time, and parental trust: The role of perceived parenting practices in adolescent health risk behaviors. *Journal of Adolescent Health, 33*, 60-70.
- Bunting, L., & McAuley, C. (2004). Research Review: Teenage pregnancy and parenthood: The role of fathers. *Child and Family Social Work, 9*, 295-303.
- Caldwell, C., & Antonucci, T. (1997). Childbearing during adolescence: Mental health risks and opportunities. In J. Schulenberg, & J. Maggs (Eds.), *Health risks and developmental transitions during adolescence* (Vol. 18 pp. 220-245). New York: Cambridge University Press.
- Caldwell, C., Antonucci, T., Jackson, J., Osofsky, J., & Wolford, M. (1995). *The availability and use of social support in families with adolescent mothers*. Paper presented at the Society for Research in Child Development, Indianapolis, IN.
- Campbell, E. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research*. Boston: Houghton-Mifflin Company.
- Chase-Lansdale, P., Brooks-Gunn, J., & Zamsky, E. (1994). Young African-American multigenerational families in poverty: Quality of mothering and grandmothering. *Child Development, 65*, 373-393.
- Clawson, C. L., & Reese-Weber, M. (2003). The amount and timing of parent-adolescent sexual communication as predictors of late adolescent sexual risk-taking behaviors. *Journal of Sex Research, 40*, 256-266.
- Clemmons, D. (2001). The relationship between social support and adolescent mothers' interactions with their infants: A meta-analysis. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 30*, 410-420.
- Coyle, K., Basen-Engquist, K., Kirby, D., Parcel, G. S., Banspach, S., Collins, J., Baumler, E., Carvajal, S., & Harrist, R. (2001). Safer Choices: Reducing teen pregnancy, HIV, and STDs. *Public Health Reports, 116*, 82-93.
- Crawford, I., Jason, L., Riordan, N., Salina, D., Sawalski, L., & Ho, F. C. (1990). A multimedia-based approach to increasing communication and the level of AIDS knowledge within families. *Journal of Community Psychology, 18*, 361-373.
- Crosby, R., DiClemente, R. J., Wingood, G. M., Harrington, K., Davies, S., Hook, E. W. I., & Oh, M. K. (2002). Low parental monitoring predicts subsequent pregnancy among African-American adolescent females. *Journal of Pediatric and Adolescent Gynecology, 15*, 43-46.

- Crosby, R. A., DiClemente, R. J., Wingood, G. M., Lang, D., & Harrington, K. (2003). Infrequent parental monitoring predicts STD acquisition among low-income African American adolescent females. *Archives of Pediatrics & Adolescent Medicine*, *157*, 169-173.
- Dallas, C. (2004). Family matters: How mothers of adolescent parents experience adolescent pregnancy and parenting. *Public Health Nursing*, *21*, 347-353.
- Davis, C. S., & Rhodes, J. E. (1994). African American teenage mothers and their mothers: An analysis of supportive and problematic interactions. *Journal of Community Psychology*, *22*, 12-20.
- Departments of Labor, Health and Human Services, and Education Appropriations Act. (1998). P.L. 105-78, 212.
- Devaney, B., Johnson, A., Maynard, R., & Trenholm, C. (2002). *The evaluation of abstinence education programs funded under Title V Section 510: Interim report*. Princeton, NJ: Mathematica Policy Research, Inc.
- DiClemente, R., Wingood, G., Crosby, R., Cobb, B. K., Harrington, K., Davies, S., Oh, M. K., & Hook, E. W. I. (2001). Parent-adolescent communication and sexual risk behaviors among African American adolescent females. *The Journal of Pediatrics*, *139*, 407-412.
- DiClemente, R. J., Crosby, R., & Wingood, G. M. (2002a). Enhancing STD/HIV prevention among adolescents: The importance of parental monitoring. *Minerva Pediatrica*, *54*, 171-177.
- DiClemente, R. J., Crosby, R. A., & Wingood, G. M. (2002b). HIV prevention for adolescents: Identified gaps and emerging approaches. *Prospects*, *32*, 136-153.
- DiClemente, R. J., Salazar, L. F., Crosby, R. A., & Rosenthal, S. L. (2005). Prevention and control of sexually transmitted infections among adolescents: The importance of a socio-ecological perspective—a commentary. *Public Health*, *119*, 825-836.
- DiClemente, R. J., & Wingood, G. M. (2000). Expanding the scope of HIV prevention for adolescents: Beyond individual-level interventions. *Journal of Adolescent Health*, *26*, 377-378.
- DiClemente, R. J., Wingood, G. M., Crosby, R., Sionean, C., Cobb, B. K., Harrington, K., Davies, S., Hook, E. W. I., & Oh, M. K. (2001). Parental monitoring: Association with adolescents' risk behaviors. *Pediatrics*, *107*, 1363-1368.
- DiIorio, C., Kelley, M., & Hockenberry-Eaton, M. (1999). Communication about sexual issues: Mothers, fathers, and friends. *Journal of Adolescent Health*, *23*, 181-189.
- Dishion, T., & McMahon, R. (1998). Parental monitoring and the prevention of problem behavior: A conceptual and empirical reformulation. *Clinical Child and Family Psychology Review*, *1*, 61-75.
- Dittus, P., & Jaccard, J. (2000). Adolescents' perceptions of maternal disapproval of sex: Relationship to sexual outcomes. *Journal of Adolescent Health*, *26*, 268-278.
- Douglas, E. (1998). *Plain Talk: The Story of a Community-Based Strategy to Reduce Teen Pregnancy*. Baltimore, MD: Annie E. Casey Foundation.

References

- Dutra, R., Miller, K. S., & Forehand, R. (1999). The process and content of sexual communication with adolescents in two-parent families: Associations with sexual risk-taking behavior. *AIDS & Behavior, 3*, 59-66.
- Feather, N. T. (1982). *Expectations and actions: Expectancy-value models in psychology*. Hillsdale, NJ: Lawrence Erlbaum.
- Feldman, S., & Brown, N. (1993). Family influences on adolescent male sexuality: the mediational role of self-restraint. *Social Development, 2*, 15-21.
- Finer, L. B., & Darroch, J. E. F. J. J. (2001). U.S. agencies providing publicly funded contraceptive services in 1999. *Perspectives on Sexual and Reproductive Health, 34*, 15-24.
- Fiscal Year 1999 Omnibus Appropriations Bill. (1999). 219. P.L. 105-277.
- Friedman, A. S., Glickman, N. W., & Morrissey, M. R. (1988). What mothers know about their adolescents' alcohol/drug use and problems, and how mothers react to finding out about it. *Journal of Drug Education, 18*, 155-167.
- Girls Incorporated National Resource Center. (2003) *Program overview. Growing together: Building partnerships for youth*. Retrieved February 2, 2003, from <http://msg.calsnet.arizona.edu/fcs/index.cfm>
- Gordon, R. A., Chase-Lansdale, P., Matjasko, J., & Brooks-Gunn, J. (1997). Young mothers living with grandmothers and living apart: How neighborhood and household contexts relate to multigenerational coresidence in African American families. *Applied Developmental Science, 1*, 89-106.
- Guzman, B., Schlehofer-Sutton, M., Villanueva, C., Stritto, M., Casad, B., & Feria, A. (2003). Let's talk about sex: How comfortable discussions about sex impact teen sexual behavior. *Journal of Health Communication, 8*, 583-598.
- Harper, C., Callegari, R., Raine, T., Blum, M., & Darney, P. (2004). Adolescent clinic visits for contraception: Support from mothers, male partners and friends. *Perspectives on Sexual and Reproductive Health, 36*, 20-26.
- Herceg-Baron, R., Furstenberg, F. F. Jr., Shea, J., & Harris, K. M. (1986). Supporting teenagers' use of contraceptives: A comparison of clinic services. *Family Planning Perspectives, 18*, 61-66.
- Hindelang, R. L., Dwyer, W. O., & Leeming, F. C. (2001). Adolescent risk-taking behavior: A review of the role of parental involvement. *Current Problems in Pediatrics, 31*, 63-83.
- Holtzman, D., & Robinson, R. (1995). Parent and peer communication effects on AIDS-related behavior among U.S. high school students. *Family Planning Perspectives, 27*, 235-240.
- Hutchinson, S., Jemmott, J. B. I., Braverman, P., & Fong, G. T. (2003). The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. *Journal of Adolescent Health, 33*, 98-107.

- Innocent, M. A., & Sugland, B. W. (2004). *Connecting the dots: How practitioners engage parents, families, and youth around reproductive and sexual health*. Baltimore: Center for Applied Research and Technical Assistance.
- Jaccard, J., Dodge, T., & Dittus, P. (2002). Parent-adolescent communication about sex and birth control: A conceptual framework. *New Directions in Child and Adolescent Development*, 97, 9-41.
- Jaccard, J., Dittus, P. J., & Gordon, V. V. (1996). Maternal correlates of adolescent sexual and contraceptive behavior. *Family Planning Perspectives*, 28, 159-165.
- Jayakody, R., Chatters, L., & Taylor, R. (1993). Family support to single and married African American mothers: The provision of financial, emotional, and child care assistance. *Journal of Marriage & the Family*, 55, 261-276.
- Jessor, R., Turbin, M. S., & Costa, F. M. (1998). Protective factors in adolescent health. *Journal of Personality and Social Psychology*, 75, 788-800.
- Johnson, V., & Pandina, R. J. (1991). Effects of the family environment on adolescent substance use, delinquency, and coping styles. *American Journal of Drug and Alcohol Abuse*, 17, 71-88.
- Jones, R. K., & Boonstra, H. (2004). Confidential reproductive health services for minors: The potential impact of mandated parental involvement for contraception. *Perspectives on Sexual and Reproductive Health*, 36, 182-191.
- Jones, R. K., Purcell, A., Singh, S., & Finer, L. B. (2005). Adolescents' reports of parental knowledge of adolescents' use of sexual health services and their reactions to mandated parental notification for prescription contraception. *Journal of the American Medical Association*, 293, 340-348.
- Jones, R. K., Singh, S., & Purcell, A. (2005). Parent-child relations among minor females attending U.S. family planning clinics. *Perspectives on Sexual and Reproductive Health*, 37, 192-201.
- Jorgensen, S. R., Potts, V., & Camp, B. (1993). Project Taking Charge: Six-month follow-up of a pregnancy prevention program for early adolescents. *Family Relations*, 42, 401-406.
- Kacir, C., & Gordon, D. A. (1997). Interactive videodisk parent training for parents of difficult pre-teens. *Child and Family Behavior Therapy*, 21, 1-22.
- Kaiser Family Foundation. (2002). *Communication: A series of national surveys of teens about sex*. Washington, DC: Kaiser Family Foundation.
- Kalil, A., & Danziger, S. (2000). How teen mothers are faring under welfare reform. *Journal of Social Issues*, 56, 775-798.
- King, B. M., Parisi, L. S., & O'Dwyer, K. R. (1993). College sexuality education promotes future discussions about sexuality between former students and their children. *Journal of Sex Education and Therapy*, 19, 285-293.
- Kirby, D. (1984). *Sexuality education: An evaluation of programs and their effects*. Santa Cruz: Network Publications.

References

- Kirby, D. (2001). *Emerging answers: Research findings on programs to reduce teen pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy.
- Kirby, D. (2002). The impact of interventions designed to promote parent-child communication about sexuality. In *Innovative approaches to increase parent-child communication about sexuality: Their impact and examples from the field*. (pp. 1-56). New York: Sexuality Information and Education Council of the United States.
- Kirby, D., Barth, R., Leland, N., & Fetro, J. (1991). Reducing the Risk: Impact of a new curriculum on sexual risk-taking. *Family Planning Perspectives, 23*, 253-263.
- Kirby, D., Korpi, M., Barth, R., & Cagampang, H. (1997). The impact of the Postponing Sexual Involvement curriculum among youths in California. *Family Planning Perspectives, 29*, 100-108.
- Kirby, D., & Miller, B. C. (2002). Interventions designed to promote parent-teen communication about sexuality. *New Directions for Child and Adolescent Development, 97*, 93-110.
- Klein, K.J. & Knight, A.P (2005). Innovation implementation: Overcoming the challenge, *Current Directions in Psychological Science, 11*, 243-246.
- Koniak-Griffin, D., & Turner-Pluta, C. (2001). Health risks and psychosocial outcomes of early childbearing: A review of the literature. *Journal of Perinatal and Neonatal Nursing, 15*, 1-17.
- Kotchick, B. A., Shaffer, A., & Forehand, R. (2001). Adolescent sexual risk behavior: A multi-system perspective. *Clinical Psychology Review, 21*, 493-519.
- Kring, T. C. (1998 February). Letter to Regional Health Administrators. Washington, DC.
- Lamborn, S. D., Mounts, N. S., Steinberg, L., & Dornbusch, S. M. (1991). Patterns of competence and adjustment among adolescents from authoritative, authoritarian, indulgent, and neglectful families. *Child Development, 62*, 1049-1065.
- Lederman, R., Chan, W., & Roberts-Gray, C. (2004). Sexual risk attitudes and intentions of youth aged 12-14 years: Survey comparisons of parent-teen prevention and control groups. *Behavioral Medicine, 29*, 155-163.
- Lederman, R., & Mian, T. S. (2003). The parent-adolescent relationship education (PARE) program: A curriculum for prevention of STDs and pregnancy in middle school youth. *Behavioral Medicine, 29*, 33-41.
- Lefkowitz, E., Sigman, M., & Au, T. (2000). Helping mothers discuss sexuality and AIDS with adolescents. *Child Development, 71*, 1383-1394.
- Levy, S. R., Perhats, C., Weeks, K., Handler, A., Zhu, C., & Flay, B. (1995). Impact of a school-based AIDS prevention program on risk and protective behavior for newly sexually active students. *Journal of School Health, 65*, 145-151.
- Logsdon, M. C., Birkimer, J. C., Ratterman, A., Cahill, K., & Cahill, N. (2002). Social support in pregnant and parenting adolescents: Research, critique, and recommendations. *Journal of Child and Adolescent Psychiatric Nursing, 15*, 75-83.

- Manlove, J., Terry, E., Gitelson, L., Papillo, A., & Russell, S. (2000). Explaining demographic trends in teenage fertility. *Family Planning Perspectives, 32*, 166-175.
- Manlove, J., Terry-Humen, E., Franzetta, K., & Moore, K. A. (2004). *Family influences on the timing and circumstances of first sex*. Paper presented at the Society for Research on Adolescence, Baltimore, MD.
- Manlove, J., Terry-Humen, E., Papillo, A., Franzetta, K., Williams, S., & Ryan, S. (2001). *Background for community-level work on positive reproductive health in adolescence: Reviewing the literature on contributing factors*. Washington, DC: Knight Foundation.
- Manlove, J., Terry-Humen, E., Papillo, A., Franzetta, K., Williams, S., & Ryan, S. (2002). *Preventing teenage pregnancy, childbearing, and sexually transmitted diseases: What the research shows*. Washington, DC: Child Trends and the Knight Foundation.
- McCullough, M., & Scherman, A. (1991). Adolescent pregnancy: Contributing factors and strategies for prevention. *Adolescence, 26*, 809-816.
- Miller, B. (1998). *Families matter: A research synthesis of family influences on adolescent pregnancy*. Washington, DC: The National Campaign to Prevent Teenage Pregnancy.
- Miller, B., Benson, B., & Galbraith, K. (2001). Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental Review, 21*, 1-38.
- Miller, B., Norton, M., Curtis, T., Hill, E., Schvaneveldt, P., & Young, M. (1997). The timing of sexual intercourse among adolescents: Family, peer, and other antecedents. *Youth & Society, 29*, 54-83.
- Miller, B., Norton, M., Jenson, G., Lee, T., Christopherson, C., & King, P. (1993). Impact evaluation of Facts & Feelings: A home-based video sex education curriculum. *Family Relations, 42*, 392-400.
- Miller-Heyl, J., MacPhee, D., & Fritz, J. (1998). DARE to Be You: A family support, early prevention program. *Journal of Primary Prevention, 18*, 257-285.
- Miller, K. S., Forehand, R., & Kotchick, B. A. (1999). Adolescent sexual behavior in two ethnic minority samples: The role of family variables. *Journal of Marriage & the Family, 61*, 85-90.
- Miller, K. S., Levin, M. L., Whitaker, D. J., & Xu, X. (1998). Patterns of condom use among adolescents: The impact of mother-adolescent communication. *American Journal of Public Health, 88*, 1542-1544.
- Minkler, M. (1999). Intergenerational households headed by grandparents: Contexts, realities, and implications for policy. *Journal of Aging Studies, 13*, 199-219.
- Moberg, D. P., & Piper, D. L. (1998). The Healthy for Life Project: Sexual risk behavior outcomes. *AIDS Education and Prevention, 10*, 128-148.
- Nelson, B. V., Patience, T. H., & MacDonald, D. C. (1999). Adolescent risk behavior and the influence of parents and education. *Journal of the American Board of Family Practice, 12*, 436-443.
- Noller, P. (1995). Parent-adolescent relationships. In M. A. Fitzpatrick, & A. L. Vangelisti (Eds.), *Explaining family interactions* (pp. 106-111). Thousand Oaks, CA: Sage.

References

- Nutt, P.C. (2004). *Why decisions fail*. San Francisco: Berrett-Koehler Publishers, Inc.
- Office of Population Affairs. (2001). *Program guidelines for project grants for family planning services*. Rockville, MD: U.S. Department of Health and Human Services, Office of Family Planning.
- Office of Population Affairs. (2004a). *Office of Adolescent Pregnancy Programs*. Retrieved November 18, 2004, from <http://opa.osophs.dhhs.gov/titlxxx/oapp.html>
- Office of Population Affairs. (2005). *Family Planning Annual Report: 2005 National Summary*. Retrieved September 11, 2007, from http://opa.osophs.dhhs.gov/titlex/ofp_references.html
- Oldenburg, B., Hardcastle, D. M., & Kok, G. (1997). Diffusion of innovations. In K. Glanz, F. M. Lewis, & B. K. Rimer (Eds.), *Health behavior and health education: Theory, research, and practice* (2nd ed. pp. 270-286). San Francisco: Jossey-Bass Publishers.
- Oliver, D. P., Leeming, F. C., & Dwyer, W. O. (1998). Studying parental involvement in school-based sex education: Lessons learned. *Family Planning Perspectives, 30*, 143-147.
- Parke, R. D., & Ladd, G. W. (1992). *Family-peer relationships: Modes of linkage*. Hillsdale, NJ: Erlbaum.
- Pearce, M. J., Jones, S. M., Schwab-Stone, M. E., & Ruchkin, V. (2003). The protective effects of religiousness and parent involvement on the development of conduct problems among youth exposed to violence. *Child Development, 74*, 1682-1696.
- Philliber, S., & Allen, J. (1992). Life options and community service: Teen outreach program. In B. Miller, J. Card, R. Paikoff, & J. Perterson (Eds.), *Preventing adolescent pregnancy: Model programs and evaluations* (pp. 139-155). Newbury Park, CA: Sage Publications.
- Philliber, S., Kaye, J., & Herrling, S. (2001). *The national evaluation of the Children's Aid Society Carrera-Model program to prevent teen pregnancy*. Accord, NY: Philliber Research Associates.
- Philliber, S., Kaye, J., Herrling, S., & West, E. (2002). Preventing pregnancy and improving health care access among teenagers: An evaluation of the Children's Aid Society-Carrera program. *Perspectives on Sexual and Reproductive Health, 34*, 244-251.
- Prochaska, J. O., Redding, C. A., & Evers, K. E. (1997). The transtheoretical model and stages of change. In K. L. F. M. Glanz, & B. K. Rimer (Eds.), *Health behavior and health education: Theory, research, and practice* (pp. 60-84). San Francisco: Jossey-Bass Publishers.
- Public Health Service Act. (1981). 42 U.S.C. § 2001 [300z] et seq.
- Public Health Service Act. (2000). Vol. 1, Part 59, 42 C.F.R. § 407-416.
- Quint, J., Bos, J., & Polit, D. (1997). *New Chance: Final report on a comprehensive program for young mothers in poverty and their children*. New York: Manpower Demonstration Research Corporation.
- Reddy, D. M., Fleming, R., & Swain, C. (2002). Effects of mandatory parental notification on adolescent girls' use of sexual health care services. *Journal of the American Medical Association, 288*, 710-714.

- Repetti, R. L., Taylor, S. E., & Seeman, T. E. (2002). Risky families: Family social environments and the mental and physical health of offspring. *Psychological Bulletin*, *128*, 330-366.
- Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., Tabor, J., Beuhring, T., Sieving, R. E., Shew, M., Ireland, M., Bearinger, L. H., & Udry, J. R. (1997). Protecting adolescents from harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association*, *278*, 823-832.
- Robin, L., Dittus, P., Whitaker, D., Crosby, R., Ethier, K., Mezoff, J., Miller, K., & Pappas-Deluca, K. (2004). Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: A decade in review. *Journal of Adolescent Health*, *34*, 3-26.
- Rodgers, K. B. (1999). Parenting processes related to sexual risk-taking behaviors of adolescent males and females. *Journal of Marriage & the Family*, *61*, 99-109.
- Romer, D., Stanton, B., Galbraith, K., Feigelman, S., Black, M., & Li, X. (1999). Parental influence on adolescent sexual behavior in high-poverty settings. *Archives of Pediatrics & Adolescent Medicine*, *153*, 1055-1062.
- Romo, L. F., Lefkowitz, E. S., & Sigman, M. (2002). A longitudinal study of maternal messages about dating and sexuality and their influence on Latino adolescents. *Journal of Adolescent Health*, *31*, 59-69.
- Roye, C. F., & Balk, S. J. (1997). Caring for pregnant teens and their mothers, too. *MCN, The American Journal of Maternal/Child Nursing*, *2*, 153-157.
- Sackett, D. L., Haynes, R. B., Guyatt, G. H., & Tugwell, P. (1991). *Clinical epidemiology: A basic science for clinical medicine* (2nd ed.). Boston: Little, Brown and Co.
- Scaramella, L., Conger, R., Simons, R., & Whitbeck, L. (1998). Predicting risk for pregnancy by late adolescence: A social contextual perspective. *Developmental Psychology*, *34*, 1233-1245.
- Sexuality Information and Education Council of the United States. (2002). *Innovative approaches that encourage parent-child communication about sexuality*. New York: Sexuality Information and Education Council of the United States.
- Simons-Morton, B., Chen, R., Abroms, L., & Haynie, D. L. (2004). Latent growth curve analyses of peer and parent influences on smoking progression among early adolescents. *Health Psychology*, *23*, 612-621.
- Smith, C. (1997). Factors associated with early sexual activity among urban adolescents. *Social Work*, *42*, 334-346.
- Smith, K., McGraw, S. A., Crawford, S., Costa, L., & McKinlay, J. B. (1993). HIV risk among Latino adolescents in two New England cities. *American Journal of Public Health*, *83*, 1395-1399.
- SmithBattle, L. (1996). Intergenerational ethics of caring for adolescent mothers and their children. *Family Relations*, *45*, 56-64.

References

- Society of Adolescent Medicine. (2004). Protecting adolescents: Ensuring access to care and reporting sexual activity and abuse: Position paper of the American Academy of Family Physicians, The American Academy of Pediatrics, The American College of Obstetricians and Gynecologists, and The Society for Adolescent Medicine. *Journal of Adolescent Health, 35*, 420-423.
- Solomon, J., & Marx, J. (1995). "To grandmother's house we go": Health and school adjustment of children raised solely by grandparents. *The Gerontologist, 35*, 386-394.
- Solomon, R., & Liefeld, C. (1998). Effectiveness of a family support center approach to adolescent mothers: Repeat pregnancy and school drop-out rates. *Family Relations, 47*, 139-144.
- Spencer, M. S., Kalil, A., Larson, N., Spieker, S., & Gilchrist, L. (2002). Multigenerational coresidence and childrearing conflict: Links to parenting stress in teenage mothers across the first two years postpartum. *Applied Developmental Science, 6*, 157-170.
- Steinberg, L., Lamborn, S. D., Dornbusch, S. M., & Darling, N. (1992). Impact of parenting practices on adolescent achievement: Authoritative parenting, school involvement, and encouragement to succeed. *Child Development, 63*, 1266-1281.
- Strecher, V. J., DeVellis, B. M., Becker, M. H., & Rosenstock, I. M. (1986). The role of self-efficacy in achieving health behavior change. *Health Education Quarterly, 13*, 73-91.
- Strecher, V. J., & Rosenstock, I. M. (1997). The health belief model. In K. L. F. M. Glanz, & B. K. Rimer (Eds.), *Health behavior and health education* (pp. 41-59). San Francisco, CA: Jossey-Bass.
- Substance Abuse and Mental Health Services Administration. (2007) *NREPP: SAMHSA's National Registry of Evidence-Based Programs and Practices*. Retrieved April 4, 2007, from <http://www.nrepp.samhsa.gov/about.htm>
- Sugland, B. W., Leon, J., & Hudson, R. (2003). *Engaging Parents and Families in Adolescent Reproductive Health: A Case Study Review*. Baltimore: Center for Applied Research and Technical Assistance.
- Tinsley, B., Lees, N., & Sumartojo, E. (2004). Child and adolescent HIV risk: Familial and cultural perspectives. *Journal of Family Psychology, 18*, 208-224.
- Title X: Population Research and Voluntary Family Planning Programs. (1970). P.L. 572 Sec. 1001[300](a).
- Turner, T. A., Irwin, C. E., Tschann, J. M., & Millstein, S. G. (1993). Autonomy, relatedness, and the initiation of health risk behaviors in early adolescence. *Health Psychology, 12*, 200-208.
- U.S. Department of Health and Human Services . (1997) *Sexually transmitted disease surveillance—1996*. Retrieved June 14, 2004, from <http://wonder.cdc.gov/wonder/STD/STDD016.PCW.html>
- U.S. Department of Health and Human Services. (2000). *Healthy people 2010: Understanding and improving health*. Washington, DC: U.S. Department of Health and Human Services.
- Unger, D., & Cooley, M. (1992). Partner and grandmother contact in Black and White teen parent families. *Journal of Adolescent Health, 13*, 546-552.

- Unitarian Universalist Association. (2002) *Our Whole Lives: What is Our Whole Lives?* Retrieved November 29, 2004, from <http://www.uua.org/owl/what.html>
- Wakschlag, L., Chase-Lansdale, P., & Brooks-Gunn, J. (1996). Not just “ghosts in the nursery”: Contemporaneous intergenerational relationships and parenting in young African-American families. *Child Development, 67*, 2131-2147.
- Weed, S. (2004). *Choosing the Best research results: Executive summary*. U.S. Department of Health and Human Services.
- Weeks, K., Levy, S. R., Gordon, A. K., Handler, A., Perhats, C., & Flay, B. (1997). Does parental involvement make a difference? The impact of parent interactive activities on students in a school-based AIDS prevention program. *AIDS Education & Prevention, 9*(Supplement A), 90-106.
- Whitaker, D., Miller, K. S., May, D., & Levin, M. (1999). Teenage partners; communication about sexual risk and condom use: The importance of parent-teenager discussions. *Family Planning Perspectives, 31*, 117-121.
- Whitaker, D. J., & Miller, K. S. (2000). Parent-adolescent discussions about sex and condoms: Impact on peer influences of sexual risk behavior. *Journal of Adolescent Research, 15*, 251-273.
- Winett, R., Anderson, E., Moore, J., Sikkema, K., Hook, R., Webster, D., Taylor, C. D., Dalton, J., Ollendick, T., & Eisler, R. (1992). Family/media approach to HIV prevention: Results with a home-based, parent-teen video program. *Healthy Psychology, 11*, 203-206.
- Winett, R., Anderson, E., Moore, J., Taylor, C., Hook, R., Webster, D., Neubauer, T., Harden, M., & Mundy, L. (1993). Efficacy of a home-based human immunodeficiency virus prevention video program for teens and parents. *Health Education Quarterly, 20*, 555-567.
- Wood, M. D., Read, J. P., Mitchell, R. E., & Brand, N. H. (2004). Do parents still matter? Parent and peer influences on alcohol involvement among recent high school graduates. *Psychology of Addictive Behaviors, 18*, 19-30.
- Wu, Y., Stanton, B. F., Galbraith, J., Kaljee, L., Cottrell, L., Li, X., Harris, C. V., D’Alessandri, D., & Burns, J. M. (2003). Sustaining and broadening intervention impact: a longitudinal randomized trial of 3 adolescent risk reduction approaches. *Pediatrics, 111*, e32-e38.
- Xiaoming, L., Stanton, B., & Feigelman, S. (2000). Impact of perceived parental monitoring on adolescent risk behavior over 4 years. *Journal of Adolescent Health, 27*, 49-56.
- Zaslow, M., & Eldred, C. (1998). *Parenting behavior in a sample of young mothers in poverty. Results of the New Chance observational study*. New York: Manpower Demonstration Research Corporation.
- Zavodny, M. (2004). Fertility and parental consent for minors to receive contraceptives. *American Journal of Public Health, 94*, 1347-1351.

***Appendix A: List of Agencies Participating in
Site Visits and Telephone
Interviews***

Title X Programs

Family Planning Council – Philadelphia, PA

Donna Garner, Regional Program Consultant

Roberta Herceg-Baron, Program Director

Dorothy Mann, Executive Director

Family Planning of Clallam County – Olympia, WA

Martina Kerr, Clinical Operations Manager

Cherie Reeves-Sperr, Assistant Director

Janet Wildeboor, Regional Program Consultant

JSI Research and Training Center – Boston, MA

Susan Grantham, Director of Region 1 Family Planning Training Center

Myriam Hernandez-Jennings, Program Manager of Region 1 Family Planning Training Center

Kathy Stratford, Acting Regional Program Consultant

Kentucky Department of Public Health – Frankfort, KY

Emily Anderson, Title X Program Director, Division of Adult and Child Health Improvement

Joy Hoskins, Supervisor of Women's Health (former Title X Director)

Betsy Neale, Consultant and Trainer

Cristino Rodriguez, Regional Program Consultant

Planned Parenthood of the Inland Northwest – Spokane, WA

Janet Wildeboor, Regional Program Consultant

C.J. Gribble, Chief Executive Officer and President

Margaret Mount, Director of Education Programs

Title XX Prevention Programs

Colorado State University – Cortez, CO

Susan Blair, Parent Trainer/Research Coordinator/Case Manager

Dana Cox, Parent Trainer

Jan Miller-Heyl, Program Director

Fifth Ward Enrichment Program – Houston, TX

Jorge Batres, Project Manager

Gayle Manning, Parent Liaison

Ernest McMillan, Chief Executive Officer

Brian Purnell, Lead Manager of School Projects

Billy Reese, Juvenile Mentoring Coordinator

Frank Richardson, Project Manager

Charles Savage, Chief Operations Officer

Charles Williams, Project Manager

Roanoke Chapel Baptist Church – Roanoke Rapids, NC

Catherine Moody, Program Director

Southern Nevada Area Health Education Center – Las Vegas, NV

Karla Banda, Adolescent Family Life Bilingual Program Coordinator

Karla Narcesse, Adolescent Family Life Outreach Coordinator

Mary Rosenthal, Adolescent Family Life Program Manager

St. Luke's Roosevelt Hospital – New York, NY

Cydelle Berlin, Program Director

Robert Moreira, Outreach Coordinator

Owen Panttieri, Outreach Coordinator

Amanda Schill, Outreach Coordinator

Narda Skov, Program Coordinator

Title XX Care Programs

Arlington Independent School District – Arlington, TX

Cindy Finberg, Counselor

Rachel Ibarra, Program Nurse

Electra Kitchen, Counselor

Keith McGee, Teen Dad Coordinator

Tori Sisk, Program Director

Josie Torres, Counselor

Belinda Williams, Counselor

Gerri Wright, Day Care Coordinator and Counselor

Healthy Families of Garrett County – Enhanced Teen Services – Oakland, MD

Earleen Beckman, Healthy Families of Garrett County Program Director

Emilie Bentley, Parent Educator and Family Support Worker

Lucia Biers, Garrett County Partnership for Children and Families Research and Evaluation Director

Michelle Ford, Clinical Coordinator/RN

Becky Friend, Lactation Consultant, Parent Educator and Family Support Worker

Karen Keefer, Enhanced Teen Services Coordinator/Parent Educator and Family Support Worker

Yvonne McConnell, Clinical Coordinator/RN

Christa Moran, Parent Educator and Family Support Worker

Bonnie Paugh, Parent Educator and Family Support Worker

Kathy Powell, Parent Educator and Family Support Worker

La Clinica de Raza’s Teen Clinic Program – Oakland, CA

Stephanie Pepitone, Case Manager

Tina Simeon, Program Director

Minneapolis Public Schools – Minneapolis, MN

Rebecca Fee, Univ. of MN National Teen Pregnancy Prevention Research Ctr., Field Coordinator

John Jackson, Patrick Henry High School Teenage Pregnancy and Parenting Program (TAPPP) Liaison

Kirsten Johnson, Edison High School TAPPP Liason

Barbara Kyle, Program Director, Minneapolis Public Schools Teen Parent Coordinator

Jeanne Kumlin, Public Health Nurse

Chuing Wang, School Based Clinic Mental Health Counselor for the City of Minneapolis

Siouxland District Health Department – Sioux City, IA

Kellie Collins, Family Support Worker for Luther Services in Iowa

Jane Dixon, Family Support Worker for Siouxland Health Department

Shelby Kroona, Program Director, Quality Assurance Coordinator

Tami Pfaffle, Family Support Worker for Crittenton Center

Mona Scaletta, Maternal and Child Health Services Coordinator

Judy Yellowbank, Family Support Worker for Native Family Resource Center

Appendix B: Example Interview Guide

Introduction

Study Description and Background

This interview is part of a study funded by the Office of Population Affairs, which is being conducted by RTI International and Child Trends. The study's goal is to learn more about outreach and intervention strategies to involve parents and families when providing services to adolescents. In particular, we are interested in:

- Strategies used in the Title X service setting to comply with the family involvement mandate
- Whether parent involvement strategies have resulted in positive outcomes
- Barriers faced by clinics in implementing their parent involvement strategies
- What parent involvement strategies have worked

Our goal is to identify promising practices (or adaptation and application of evidence-based strategies) for possible implementation across additional program settings. We are interviewing a variety of staff in Title X clinics and Title XX programs, as well as Title X regional program consultants. It is important to note that our questions will cover a wide range of possible activities your clinic may or may not be engaged in, and we do not expect any clinic to have done everything we ask about.

Consent and Confidentiality

- Your participation in this interview is voluntary and will have no effect on any level of federal assistance given to the clinic.
- If there are any questions you prefer not to answer, let us know and we can move to the next question.
- Information you provide, along with that from others, will be used as the basis for a report about parent involvement strategies in clinics serving adolescents which will be made publicly available through the OPA's Web site.
- We would like to identify persons interviewed by their name and role if quoted in the text of the report. However, specific statements do not need to be identified by name, and we will ensure confidentiality if there are topics you would like to discuss without attributing them to your name or to this site, so please let us know if that is the case, and we will include them only in a general discussion. We also will list all persons interviewed in an appendix to the report.
- We will summarize our written notes within the next few weeks and ask you to review them for accuracy.
- (Skip if telephone interview): We would like to tape record this interview as a backup to our written notes. These tapes will be used only by the RTI project team. Do we have your permission to tape record this interview?

(Turn on tape recorder)

We are asking about adolescents. By adolescents we mean young people aged 19 or younger.

1. Interviewee Role

Can you give us an overview of your current role and how long you have worked in this clinic, specifically as it relates to involving parents in providing services to adolescents aged 19 or younger?

2. Program Setting (Skip if this has been verified)

- a. Tell me a little about how many adolescents your clinic serves annually, what services are provided to them, and a little about the adolescent populations you serve (gender, ages, race/ethnicity, urban/rural, SES, etc.)
- b. Do you have a standard reporting form that captures how many adolescents are served? (Ask for a copy)
- c. Is there a particular staff member responsible for parent involvement work?

3. Parent Involvement Strategies and Lessons Learned

- a. Can you describe the strategy (or strategies) your clinic uses to comply with the family involvement mandate?

Prompt: Ask about parent involvement if not mentioned. If needed, mention clinic information we have collected prior to the site visit.

Prompt: (If only counseling mentioned): Are there any other strategies (such as outreach or workshops) that your clinic has used to enhance parent involvement?

- b. (If clinic serves both boys and girls): Do you use different strategies to involve parents of adolescent boys versus girls?
- c. What would you say that you've learned that other clinics should do to involve parents?
- d. Now that you have experience, if you had to implement parent involvement strategies all over again, what (if anything) would you do differently?
- e. When did your clinic begin using this strategy? Has the strategy changed over time?
- f. How did your clinic select the strategy or approach you use?
- g. To your knowledge, is the approach your clinic uses evidence based (that is, based on scientific research findings that suggest the approach is effective)?

- h. Do any of the strategies you've mentioned require additional funding sources beyond Title X funding? (If yes): What additional funding sources have been involved?
- i. What proportion of your clinic's services would you say have a parent involvement objective or component?
- j. Do staff receive special training for parent involvement work?

4. Engaging Parents

- a. Some clinics try to do different things to increase the likelihood that parents will become engaged, for example, providing extra services, prizes or child care; changing schedules; partnering with schools, communities or faith-based organizations; establishing clinic facilities in creative locations; or advertising. What types of things, if any, has your clinic done in this regard? (If yes to any): Can you provide a copy of the advertising (or other material) you have used?
- b. What proportion of adolescents is accompanied by a parent when they receive services?

5. Outcomes

- a. How do you determine how successful your clinic's parent involvement strategies are?
- b. What proportion of parents would you say participate in your clinic's interventions?
- c. Once parents participate, can you estimate how many do not continue?
- d. Do you have evidence about whether your clinic's parent involvement approaches have affected outcomes for parents and adolescents? Outcomes may include, for example:
 - Parent involvement/participation
 - Parent knowledge/attitudes/behaviors
 - Adolescent knowledge/attitudes/behaviors
 - Adolescent health outcomes
- e. (If yes): How is evidence of such outcomes gathered? (Possibilities include:)
 - Anecdotal evidence (reported by parents, adolescents, staff, other individuals)
 - Pre- and post-tests
 - Use of comparison groups (describe)
 - Random assignment to intervention and comparison groups (specify whether parents and/or adolescents were randomly assigned)

6. Barriers

- a. What barriers or problems, if any, has your clinic faced in implementing parent involvement strategies?
- b. Has confidentiality regarding adolescent services been a barrier? How?
- c. What barriers do you think keep parents from participating?
- d. Have you faced any barriers with regard to the attitudes or buy-in of community partners, parents, or adolescents?
- e. Can you think of anything that would keep you from implementing additional strategies to involve parents? (If yes): What would keep your clinic from implementing additional parent involvement strategies?

7. Lessons Learned

Is there anything else you want to tell us about that we have not asked?

(Ask note-taker if there are additional questions)

8. Closing

We appreciate your taking the time to talk with us. We will be writing up our notes in the next few weeks, and would like to send you a copy so that you can correct anything we might have recorded incorrectly. We will also be happy to send you a copy of our report once it is available in the fall.

- Verify that we have e-mail and fax information (business card)
- Verify title