

An Assessment of Parent Involvement Strategies in Programs Serving Adolescents

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

INTERIM REPORT Literature and Program Report Review

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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; a reduction in the number of adolescent sexual partners; and increased adolescent condom and other contraceptive use. 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.

This report presents findings from a literature review of evidenced-based parent involvement strategies and a review of program reports from Title X and Title XX providers about parent involvement strategies. Our literature review identified 26 studies of the effectiveness of parent involvement strategies; fourteen were randomized controlled trials, and 12 were nonrandomized studies. Our findings from the literature review include the following:

- The evidence base for the benefit of parent involvement programs is weak.
- 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 impacted adolescent behavioral outcomes, four concluded that the program did not, and one found short-term impacts but no long-term impacts.
- 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 by sending skills-based videos to the homes of program participants for them to watch with their parents, although no rigorous study has shown impact for 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 were personal calls from classroom teachers.

Both the Title X Family Planning and Title XX Adolescent Family Life programs emphasize the importance of family involvement in family planning, prevention, and care for adolescents. While some information on individual providers' strategies for parent involvement is available, little is known about the entire range of parent involvement strategies that are employed by these programs and how these strategies are being implemented. This interim report is part of a larger project examining outreach and intervention strategies used by Title X Family Planning and Title XX Adolescent Family Life programs to involve parents and families, with a focus on improving communication between parents and adolescents about sexuality.

Our review of program reports examined parent involvement strategies, strategies for encouraging parent participation, program outcomes, and lessons learned. Our findings from this review include the following:

- Title X, XX prevention, and XX care programs employed a variety of parent involvement strategies
- Programs also employed a variety of strategies to encourage parent participation
- Generating and maintaining parent (especially father) interest and involvement is challenging and contingent on a wide range of factors
- Many Title X and Title XX prevention programs did not evaluate adolescent behavioral outcomes in relation to parent involvement and instead focus on measures of parent participation or other outcomes, such as parent beliefs, knowledge, behavior, and program satisfaction.

- Among Title XX care programs, evaluation outcomes included adolescent behavior, psychosocial functioning, and knowledge.

Title X programs encouraged parent involvement by counseling adolescents to involve parents in decision-making about reproductive health, training of staff to provide such counseling, offering workshops to help parents communicate with their adolescents about sexuality and reproductive health issues, and providing educational materials for parents, including magazines, booklets, and websites. Title X programs also offered opportunities for parents and adolescents to attend workshops together, and as in the evidence-based literature, workshops were stratified by adolescent gender and age. Many Title XX prevention programs employed a combination of multiple parent involvement strategies in promoting abstinence, including parent workshops or training sessions and parent-child communication workshops with no accompanying adolescent component. Several programs also addressed the larger issues of providing sex education in the community or improving parent-staff relationships. Many programs have developed curricula that are appropriate to the age and cultural experiences of adolescents in their target populations. A large number of Title XX care programs provided services, assessments, and referrals through home visits to pregnant and parenting adolescents; several programs offered counseling and case management services to parents. Some Title XX care programs offered parents of participating adolescents classes, prevention education workshops, and training on parenting, grandparenting, basic First Aid, and/or medical care. Other Title XX care providers incorporated a parent sexuality education program to improve parent-child communication and increase parent knowledge and skills regarding sexuality and reproductive issues.

Title X and XX programs employ multiple strategies to encourage parent participation in program activities, such as providing newsletters and informational packets; hosting special events and dinners; and convening parent advisory groups. Evaluations of community-based or grassroots approaches for involving parents have shown that involving established, respected community agencies and members and trying to reach adults at church, work, or home are effective in drawing participation among community adults and parents in workshops or other activities. Recruiting and training parent leaders to reach out to other parents appears to be another effective strategy. 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.

Parents' ability to participate and their likelihood of attending appear to be contingent on a range of factors, such as work schedules, other family responsibilities, and timing of workshops, as well as comfort level with materials on sexuality. Some programs mentioned staff turnover as a contributing factor for parent attrition, an issue that is further compounded by the difficulty and time spent establishing parent-provider rapport. 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. Across program types, when parents participated, they responded positively and found the workshops and other experiences to be

valuable. It is anticipated that results from program staff interviews during May through July of 2005 will provide additional insights about parent involvement strategies, efforts to encourage parent participation, program outcomes, barriers to involving parents, and lessons learned. Overall, this project will yield important guidance for implementing parent involvement strategies across additional program settings. Such research is an important first step toward understanding how best to involve parents within the context of government-funded adolescent services and demonstrate desired outcomes.

1. INTRODUCTION

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 parent 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 do not allow causal inferences to be drawn, the literature suggests that parent involvement is beneficial for adolescents.

There are many ways in which parents may influence their children's behavior. 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 the well-being of their children is by steering them toward membership in prosocial peer groups (Parke & Ladd, 1992). Parent involvement therefore negatively affects 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 adolescent behavior; higher levels of parent involvement have been associated with weaker relations between peer influences and problem behaviors (Wood, Read, Mitchell, & Brand, 2004). The absence of parent involvement can lead to deficits in parenting, which have been associated with poor adolescent outcomes. For example, in longitudinal studies, lack of parental monitoring has been shown to be a risk factor for adolescent tobacco use beyond the effects of parent tobacco use (Biglan, Duncan, Ary, & Smolkowski, 1995).

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, 1997; U.S. Department of

Health and Human Services, 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 condom and other contraceptive use (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

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 contraceptive use and/or condom use, 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 & Rubinson, 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 a diverse array of 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

¹ 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, preventing conclusions that parent involvement caused the observed outcomes. 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.

first sex, fewer sexual partners, increased contraceptive use, and condom use (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 only significant if 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).

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 adolescents with diverse backgrounds and experiences, 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).

Other Parenting Behaviors

Similar associations have been found between other parenting behaviors and adolescents' sexual risk behaviors. Turner and her colleagues (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 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; Miller et al., 2001). 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 more risky 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).

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

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

for the pregnant or parenting adolescent comes primarily from her parent(s) (McCullough & Scherman, 1991) and from the father of the baby (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 grandchildren's improved outcomes, in particular for those grandchildren whose 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 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).

Overview of this Report

This report is organized into four sections:

- Section 2 reviews previous research on the effectiveness of strategies designed to enhance parent involvement in programs serving adolescents
- Section 3 describes parent involvement strategies in Office of Population Affairs (OPA) programs
- Section 4 discusses the overall findings and implications and presents conclusions

2. EFFECTIVENESS OF PARENT INVOLVEMENT STRATEGIES

Reviews of effective reproductive health programs for adolescents have not specifically highlighted parent involvement as a key factor that may impact program effectiveness (Robin et al., 2004). This section 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. (Additional studies of abstinence education programs and programs for pregnant or parenting adolescents that did not meet all inclusion criteria are described in *Appendices A* and *B*.) 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.

A total of 26 studies were identified; 14 were randomized controlled trials, and 12 were 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 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 impacted adolescent behavioral outcomes. It is striking that there have been only nine randomized experimental studies in this important area that measured adolescent behavioral outcomes. It is even more striking that there are almost as many randomized experimental studies that 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 impacted 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

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.

**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	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 work 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	7 th -, 8 th -, and 9 th -grade adolescents 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	12 to 16 year old black adolescents from 35 low-income communities	Home-based videos	1-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 7 th and 8 th 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	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)	45 families	12 to 14 year old boys and girls in Roanoke, VA	Home-based videos	Either: 1) 2-hour, 4-video program covering HIV/AIDS prevention, STI education, and adolescent assertiveness and family problem-solving strategies; or 2) no video	No video	At 6-month follow-up: Increased knowledge and skills only among parents and adolescents who received the video
Family/ Media AIDS Prevention Project (Winett et al., 1993)	69 families	12 to 14 year old boys and girls in Roanoke, VA	Home-based videos	Either: 1) 2-hour, 4-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		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
Postponing Sexual Involvement (PSI)/ Education Now and Babies Later (ENABL) (Kirby, Korpi, Barth, & Cagampang, 1997)	10,600	7 th and 8 th grade students 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	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	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	High-risk 7 th - to 9 th -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 5 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	6 th , 7 th , and 8 th grade adolescents 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, Sigman, & 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

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 et al., 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, programs for parents only, 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.

A. 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 are discussed below concerning these types of parent involvement strategies.

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 1-session videotape and discussion session 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, 4-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).

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 impacted 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 1 ½- 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 percent of

parents and youth in the California study) of the ENABL initiative utilized PSI for Parents (Kirby et al., 1997). Further, only about 19 percent 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.

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 has 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 for mother/daughter groups or for father/son groups, separated by gender and by age for adolescents aged 9 to 12 or aged 13 to 17, 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 did not receive any 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 difference 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 six 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 made up 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 initiate 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 old adolescents 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 (Building Partnerships for Youth—(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.

Homework Assignments

This approach enables programs to reach out to a large number of parents through supplementary homework assignments and activities that facilitate more 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 5 additional “booster” classes one 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 the school to receive the CDC information. Thus, interactive homework assignments constituted the main difference between the two treatment conditions; between 65 and 74 percent 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. 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., one month), they suggest that homework assignments may facilitate parent involvement and increase parent-child communication (Barnett & Hurst, 2003; Crawford et al., 1990).

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-grade students, respectively. Students received homework assignments requiring them to interview their parents; school sites held one-hour training sessions for parents; and the program distributed “The Big Talk Book” to parents to reinforce the abstinence message and to provide ten 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).

B. 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).

C. 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.

D. 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 (Roye & 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 were mothers of the adolescents, while a small number were the adolescents' grandmothers or were mothers of the adolescents' boyfriends. 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 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. Detailed information is presented in *Appendix B*.

3. PARENT INVOLVEMENT IN OFFICE OF POPULATION AFFAIRS (OPA) PROGRAMS

Both the Title X Family Planning and Title XX Adolescent Family Life programs emphasize the importance of family involvement in family planning, prevention, and care for adolescents. This section describes parent involvement strategies in selected Title X family planning, Title XX prevention, and Title XX care programs.

A. 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 cancer, STI, and HIV screening; 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 4,500 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, 2004b). The program provides family planning and related preventive health care services to approximately 5 million persons each year (Office of Population Affairs, 2004b); 29 percent 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 of less than 100 percent of the federal poverty level) will not be charged for services. Low-income families 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.

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).

Selection of Programs for Review in this Report

Office of Population Affairs (OPA) staff identified 12 Title X programs with known parent involvement activities to highlight in this report.⁴ Information about two of these programs was presented at a 2004 poster session (Planning Healthy Families National Title X Grantee Meeting). Information described in this report comes from descriptions of parent involvement activities provided by OPA and program staff. In some cases, we supplemented these descriptions with additional information from internet searches. The following sections describe parent involvement strategies, strategies for engaging parents, program outcomes, and lessons learned.

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.

Parent Involvement Strategies

Four types of strategies were described by Title X programs: counseling adolescents to involve parents, joint attendance programs, parent workshops, and educational materials for parents and caregivers.

Counseling Adolescents to Involve Parents: Several Title X programs reported counseling adolescents or training practitioners to do this. For example, practitioners at *Planned Parenthood of Northern New England* in Vermont inquire about whether adolescents talk to their parents and, when appropriate, encourage and counsel them to do so. During an adolescent's initial family planning visit and at visit intervals thereafter, family planning providers at the *Family Planning Council* in Philadelphia, Pennsylvania, encourage adolescents to involve their parents or caregivers in their receipt of and decisions regarding family planning services. The *Family Planning Council* supports and promotes clinic staff participation in training opportunities that address the unique challenges of providing reproductive health services to minors. An important source of these trainings is TRAINING 3 (T3), the DHHS Region III family planning training center housed at the *Family Planning Council*. T3 is highly involved in providing training that encourages family participation and has developed training aids that are used by the *Family Planning Council's* family planning provider network to frame the discussion with adolescents. Objectives included developing a counseling and/or education model that encourages family participation in the decision of minors to seek family planning services, designing and delivering Region-wide training events, and creating training materials. *The Rhode Island Department of Health Family Planning Program* provides all minor Title X clients (females and males) documented counseling encouraging them to involve their families in their decision to seek family planning services. In May of 2004, this program collaborated with the regional training center *JSI Research and Training Center* to provide training to Title X staff on utilizing a parent-child communication-enhancing model to conduct effective family involvement counseling. Agency staff refer parents of minor clients who express an interest in involving their families in their decision to seek family planning services to one or more resources, including a website and parenting workshops.

With funding from a Region VI Family Planning Training Grant, the *Center for Health Training* in Austin, Texas, developed a training manual for use with family planning clinic staff and by community educators as an approach to reach adults who play key roles in adolescents' lives (Hanson, 2004). The comprehensive manual includes evidence-based interventions and innovative strategies to encourage family involvement in adolescents' sexual health and decision-making. Experiential learning activities help trainees assess their own skills about sexuality education; increase awareness about the meaning and importance of family involvement; identify barriers to family involvement;

learn concrete strategies and counseling interventions to assist adolescents in communicating their needs to parents; explore ways to connect with, educate, and support parents; and employ these strategies in clinics and other community settings. Examples include practice asking questions of a young client to encourage family participation, samples of media materials that support family involvement, strategies to help parents identify and utilize “teachable moments,” and role-playing scenarios to facilitate discussions about sexuality when a parent accompanies an adolescent to an appointment. A Training of Trainers was provided to family planning clinic staff and community health educators in August 2004 to ensure the fidelity of training activities, goals, and objectives (Hanson, 2004).

The JSI Research and Training Center in Boston, Massachusetts, has provided trainings in Region I to support Title X clinic providers 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. *Health Care of Southeastern Massachusetts* in Brockton, Massachusetts, provides an interactive training, Encouraging Family and Adolescent Communication, for family planning providers to develop strategies that will encourage adolescent family planning clients to involve their families in their sexual decision-making. The training involves lecture, small group activities, and role-plays, allowing participants to practice skills to implement techniques.

Parent Workshops: Title X providers have offered workshops for parents to help them communicate with their adolescents about sexuality and reproductive issues. Can We Talk, a two-session parent sexuality education program, was implemented by *Family Planning of Clallam County* in Washington State. Can We Talk is a project designed to prevent unplanned adolescent pregnancies and help families develop stronger emotional bonds. The first round of Can We Talk sessions was offered at a federally subsidized (Section 8) apartment development. A similar approach to involving parents in Title X programs was employed by *Mt. Baker Planned Parenthood* in Washington State, which offered adolescent sexuality workshops for parents in 2003 and 2004.

The *Family Planning Council* in Philadelphia, Pennsylvania, directly provides community education workshops, and some of its delegate agencies also offer community-based workshops. The *Family Planning Council’s* program offers sexuality education workshops for parents in community-based settings throughout the 5-county area of Southeastern Pennsylvania. These workshops support a statewide program, Communicating Healthy Advice for Teens (CHAT). The four family planning councils in Philadelphia collaborate by each delivering this locally customized program to parents, caregivers and professionals in their Title X service area to support their efforts in educating

adolescents aged 9 to 18 about healthy sexual development and decision-making. CHAT provides workshops and resources to address issues related to normal adolescent development as well as parent-child communication.

The Kentucky Department for Public Health's program, entitled Talking with Your Child about Sex, is a 2-hour workshop designed for parents of middle school or elementary school children. Parents learn about parent-child communication, child and adolescent development, and ways to help children avoid risk behaviors. The goal of the workshop is to encourage and enable parents to develop open and ongoing communication with their children about issues of sexuality and about their values regarding sexual involvement. Parents are provided handouts listing further resources on parent-child communication about sexuality. *Planned Parenthood of Northern New England* provides formal workshops and informal opportunities for dialogue around the topic of sexual health and communication. Such events have included free parent nights held prior to a professional training, on-line parent workshops, and a parent expo, a home show-style event with resource booths for parents (in collaboration with other organizations and groups that work with parents).

The Rhode Island Department of Health Family Planning Program provides parenting workshops on enhancing communication between parents and adolescents or pre-adolescents. A statewide parenting skills workshop, Active Parenting Today/Padres Activos de Hoy, helps parents teach their adolescents responsibility and how to deal with peer pressure. This workshop also educates parents about encouragement skills. These workshops are conducted periodically, upon request, and in Spanish. Statewide interactive English and Spanish workshops, Can We Talk Rhode Island?, help parents to talk with their pre-adolescents about self-esteem, sexuality, HIV, and peer pressure. English and Spanish discussion groups for parents of sexually or physically abused adolescents are also held statewide.

Joint Attendance Programs: Title X grantees have also offered programs for parents to attend with their adolescents. These workshops facilitate communication between parents and children about family planning and values about sexuality. Some programs extended into other related topics, facilitating a holistic view of sexuality. The Mother-Daughter Talks program was implemented by the *Family Planning Association of Chelan-Douglas Counties* in Washington State. The program consists of a series of facilitated sessions with groups of five to eight mothers and their daughters. The sessions address puberty, anatomy, body image, self-esteem and self-respect, communication, friendships, dating, and dating violence. The series culminates with a discussion about contraception and a tour of the clinic. Recently, the agency added a Grandmother/Granddaughter group for families in which a grandparent is the primary caregiver.

The Northeast Community Action Corporation (NECAC) in Jefferson City, Missouri, implemented the Parent-Child Human Sexuality Education Training program in local communities. The primary goals are to provide necessary factual information; explore sexual attitudes, feelings and values; promote positive self-esteem and acceptance of sexuality; and enhance parent-child communication on the topic of sexuality. Two curricula are offered: one for adolescents aged 9 to 12 and one for those aged 13 to 17. Separate classes are offered for parents and their son(s) or parents and their daughter(s). The classes span 2 to 3 hours per week for 5 weeks, reaching 10 parent-child pairs per course. The curriculum includes basic male and female reproductive anatomy and physiology, puberty, menstruation, health and hygiene, human reproduction, pregnancy and childbirth, self-esteem, decision-making, peer pressure, responsibility, and personal values. Depending on the age of the adolescent and parental wishes, the curriculum can include information about contraception and sexually transmitted disease. *Planned Parenthood of the Inland Northwest* in Washington State presented several classes for parents and adolescents based on *Our Whole Lives*, a non-religious, values-based curriculum developed by the Unitarian Church and the United Church of Christ. *Our Whole Lives* is a series of sexuality education curricula for five age groups: grades K-1, grades 4-6, grades 7-9, grades 10-12, and adults. *Our Whole Lives* 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 (Unitarian Universalist Association, 2002). 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 (Unitarian Universalist Association, 2002). *Planned Parenthood of Northern New England* also offered parent-child workshops and retreats through schools.

Educational Materials: The *Family Planning Council* in Philadelphia, Pennsylvania, also supports community education through the development and distribution of educational materials for parents. The *Family Planning Council* 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 parent, and contact information for the *Family Planning Council's* Title X-funded family planning agencies. Individuals featured in this article and on the front cover are patients (adolescents and mothers) from the *Family Planning Council's* Title X family planning provider agencies. *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. In June, 2004, *Parent Probe* won the 2004

Distinguished Achievement for Excellence in Educational Publishing award from the national Association of Educational Publishers. With funds from Title V, the *Family Planning Council* has also produced and periodically revised a 100-page booklet on puberty for young adolescents and their parents, entitled *Puberty's Wild Ride*. The book is designed to be fun, easy to read, and informative, containing games; quizzes; cartoons; puzzles; a reading list; national toll-free telephone help-lines and websites for adolescents and parents; and chapters on puberty, body image, eating disorders (for girls and boys), personal grooming, inhalants, suicide, methods of birth control (including emergency contraception), STIs, HIV, AIDS, abstinence, internet safety, hallway harassment, and school violence. *Puberty's Wild Ride* is organized into short pages, and each topic is matched to an activity, with a strong, recurring theme about the importance of communicating with parents, clinicians, relatives, and faith leaders. The booklet has been distributed free to the *Family Planning Council's* Title X family planning agencies and throughout the community. *Puberty's Wild Ride* has been used in CHAT parent workshops. 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,

A website, www.ParentLinkRI.org, supported by the *Rhode Island Department of Health* in partnership with the Rhode Island Department of Education, provides parents with links to parenting workshops on family communication, educational services and recreational activities for adolescents and pre-adolescents, counseling services, after-school programs and activities, and services for adolescents with special needs. In addition, the website issues Tips on Raising Pre-Teens and Teens monthly.

Engaging Parents

Many Title X programs have organized partnerships with other agencies in order to engage parents. CHAT from the *Family Planning Council* in Philadelphia, Pennsylvania, focused its efforts on targeting 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. 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. *The Family Planning Council* has also sold *Puberty's Wild Ride* to youth-serving organizations around the country. Flyers for Talking with Your Child about Sex from the *Kentucky Department of Health* were sent home by host agencies with school report cards. The Parent-Child Human Sexuality Education training courses in Jefferson City, Missouri, are provided in partnership with local schools or community groups, such as the Girl or Boy Scouts. The endorsement and support of local organizations have facilitated the introduction of the parent-child sex education concept in local communities. Community partners have also been instrumental in recruiting participants for these classes.

Additional strategies for engaging parents include advertising, creative scheduling, and offering incentives. The Can We Talk program from *Family Planning of Clallam County* in Washington State encouraged participation through a significant publicity campaign and included press releases, print and radio advertising, internet resources, public service announcements, flyers, invitations, to social service agencies and direct phone messages. *Puberty's Wild Ride* is for sale through Amazon.com. The Can We Talk program also held sessions in the evenings to accommodate working parents, as well as away from the family planning site to reduce discomfort a parent may have about visiting the clinic. Talking with Your Child about Sex is offered simultaneously with a school dance, with free dance admission for the adolescent for bringing a parent to the workshop, and provided parents with a light meal, refreshments, or child care without cost to enhance parent participation. A contest among homerooms for the greatest number of positive replies to flyers was conducted, and raffle prizes were given at the workshops to encourage participation.

Program Outcomes

Although no 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. 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. *The Mt. Baker Planned Parenthood* in Washington state adolescent sexuality workshop for parents is in high demand, and the agency plans to add a second health educator to its staff in order to offer the workshop on a quarterly basis. Workshops based on *Our Whole Lives*, offered by *Planned Parenthood of the Inland Northwest* in Washington State, have also been well received. *Puberty's Wild Ride* from the *Family Planning Council* in Philadelphia, Pennsylvania, is well received by parents as a self-educational tool.

Although the *Family Planning Council* in Philadelphia, Pennsylvania's CHAT program served 490 parents in 2004, and despite enthusiasm from parent participants and partnering agencies, several Title X providers have experienced difficulty in attracting parents to attend workshops. Two sessions of Talking with Your Child about Sex have resulted in no one attending. Three Can We Talk programs offered by *Family Planning of Clallam County* in Washington State garnered 12 parents at the first session, 8 parents at the second session, and no parents at the third session. The *Family Health Council* in Pittsburgh, Pennsylvania, has invited parents on several occasions to attend Teen Advisory Council meetings and/or events, and over the course of a 4-year period, only about 5 parents have ever attended any of these activities.

Lessons Learned

Successes and frustrations with parent participation occurred in parent-child workshops, parent-only workshops, and other events. The *Kentucky Department of Public Health's* Talking with Your Child About Sex program found that parent and child participation may be difficult to muster during the summer months, even if the workshop is not sponsored by a school. Partnering with other community agencies, such as schools, Girl and Boy Scout troops and other organizations, seems to be an effective way to encourage parent participation. A community partner provides a target population and a familiar setting for people who may already be engaging in other activities with the organization. *Planned Parenthood of the Inland Northwest* has found that its classes based on *Our Whole Lives* work best if they are presented in someone's home. However, despite its success in developing partnerships and community interest, the *Family Planning Council* of Philadelphia, Pennsylvania, CHAT program has faced some challenges. Funding for a number of longstanding children and family service agencies was cut in FY 2004, and more than a few of the *Family Planning Council's* community partners had to shut their doors and no longer could host CHAT programs. Due to these challenges, 11 CHAT programs were cancelled and will be rescheduled in the current funding period.

Another challenge the *Family Planning Council* in Philadelphia, Pennsylvania, 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. The *Family Planning Council* and providers conducted chart reviews of adolescent family planning clients to see what was documented in the counseling notes. In doing so, they discovered that providers needed clarification about the intent of the *Family Planning Council's* family involvement policy and assistance to maintain consistency in documenting this counseling in the chart. Questions were discussed among *Family Planning Council* staff and with providers and were subsequently addressed in a policy revision and in training courses offered to provider staff. 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.

Title X program staff identified unhelpful parents as a potential barrier to parent involvement. For example, some parents have reacted to their adolescents' showing interest in the opposite sex by insisting to staff that birth control be prescribed, even though the adolescents may refuse such a prescription and the staff may agree that the parent is overreacting. Some parents have also expressed anger inappropriately to their adolescents about positive pregnancy tests by, for example, saying they are happy that their adolescent is pregnant because the parent experienced an adolescent pregnancy, and now the adolescent will see how hard that is. In such cases, Title X staff has instead provided counseling to parents about parenting skills. Title X staff may, in fact, feel that parent education and counseling may be needed before parent involvement is promoted because some parents lack the maturity needed to help their adolescents. Unfortunately, staff is unaware of programs that address these types of issues.

B. 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 Public Health Service Act of 1981 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. 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.

Selection of Programs for Review in this Report

OPA staff identified 45 Title XX programs with known parent involvement activities to highlight in this report. Information described here comes from descriptions of parent involvement activities provided in Title XX grant applications. For some providers, evaluation and annual reports were also available. Title XX prevention activities are presented first, followed by Title XX care activities.

Title XX Prevention Programs

Title XX prevention programs aim to reduce adolescent pregnancy by providing abstinence education. The grantees serve 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 list goals related specifically to parent involvement. The common goals of these programs are to improve parents' knowledge about abstinence and to increase abstinence education resources available to parents and the larger community. Many programs also seek 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. This section highlights innovative parent involvement strategies, strategies to engage parents, program outcomes, implementation issues related to improving parent attendance, and lessons learned.

Parent Involvement Strategies: The 21 providers described here employ a variety of parent involvement strategies, including parent workshops or training sessions, joint attendance programs, homework assignments, and multiple parent involvement approaches (*Attachment A*).

Multiple Parent Involvement Strategies

Many Title XX prevention grantees employ a combination of parent involvement strategies. All such programs use parent workshops in combination with home visits, homework assignments, or community awareness components, and some include one-on-one case management; special events, such as camps, annual conferences, day or evening parent events, health fairs, or field trips; newsletters; parent support groups; advisory councils; philanthropic activities; media campaigns; and referral services. Below are descriptions of five programs with particularly strong or innovative program designs.

The *Children's Council* in South Carolina is a multiple-strategy program for middle- and high-school aged adolescents, offering communication exercises for parents, a parent support group, and weekly parent and adolescent groups. The Can We Talk curriculum is used to instruct parents on parent-child communication techniques. Larger, community-wide efforts include business sponsorship of "lunch and learn" brown bag discussions about how parents can serve as effective sex educators for their adolescents and an educational television broadcast component to heighten community awareness about abstinence. The *Children's Council's* Community Awareness Campaign (CAC) involved partnering with a local cable access station that assisted program participants in developing public service announcements and broadcasts. In addition, the Families

and Schools Together (FAST) component provides parent-child communication exercises, adult social support exercises, a parent self-help group, and a fixed lottery system allows each family to host sessions; the program provides family meals.

The *Cumberland YMCA* in Maryland employs a youth development approach that emphasizes parenting as an effective intervention in preventing, mediating, or eliminating adolescent sexual activity and pregnancy. The Guys and Gals program offers middle school nights with abstinence education and recreation, as well as separate abstinence education sessions for parents of participating adolescents. During sessions, parents are expected to participate in academic and recreational enrichment activities. While children continue with activities, parents participate in parenting workshops aimed to improve parenting skills and relationship quality. The program also includes a media campaign. *Fifth Ward Enrichment Program (FWEP)* in Houston is another multiple-strategy program for adolescents aged 9 to 19, incorporating parents as mentors, teachers, and role models. The program publishes regular parent newsletters; hosts monthly parenting classes; holds a regular parent involvement day at the schools; sponsors a booth during community health fairs; hosts a yearly leadership camp for parents and adolescents; and conducts home visits to provide support to parent-child pairs, establish a rapport with the adolescent's family, and assess the adolescent's environment. Choosing the Best and Sex Can Wait curricula are used by the program. Staff then assess whether referral services are needed and schedule subsequent home visits based on need.

Mercy Hospital's program in Pennsylvania is open to all preadolescent and adolescent middle and high school students. Weekly educational sessions are offered to adolescents and parents, as well as support groups, mentoring, tutoring, and summer enrichment programs for adolescents. *Mercy Hospital* also conducts parent-child field trips. Trained program staff offer parenting services and mediate unresolved parent-child conflicts. The program provides monthly Time Out for Parents nights with a Pampering Parents Night celebratory dinner to mark the end of program cycles.

Switchboard of Miami in Florida is a school-based abstinence education program implemented through 9th-grade social studies courses. Adolescents attending the program receive homework assignments to complete at home with parents. Additional Title XX prevention programs employing multiple parent involvement strategies include *Alabama State University*; *BETA Center* in Florida; the *Boys and Girls Club of Sarasota* in Florida; *Colorado State University*; *Heritage Community Services* in Georgia; *Northridge Hospital Foundation* in California; *People's Regional Opportunity Program (PROP)* in Maine; *Roanoke Chapel Baptist Church* in North Carolina; and *Wise Women Gathering Place* in Wisconsin.

Parent Workshops

Several Title XX prevention providers conduct activities for both parents and adolescents, including parent workshops or training sessions. Most programs provide complementary curricula materials for parents and adolescents for program consistency. For example, the *JOVEN* program in Texas provides parenting workshops using the Can We Talk parent curriculum that complements the Can We Talk school-based curriculum. The *Morehouse School of Medicine* after-school youth development program in Georgia starts in the 4th grade and continues for 5 years. Parents receive an initial orientation packet, participate in parenting classes, chaperone field trips, and participate in project activities to facilitate greater child and parent investment in meeting program objectives. The *Morehouse School of Medicine* uses an adaptation of the CHOICES program, a holistic character-building and life skills development program emphasizing social, psychological, and health gains experienced by those who choose abstinence from sexual activity.

The *St. Luke's Roosevelt Hospital Nitestar* program in Manhattan sponsors theater productions that use plays and skits as communications tools to convey messages about abstinence to students as part of the STARLO program—an interactive classroom curriculum based on these performances. In an accompanying 4-session parent training workshop, parents view the same theater productions and receive an overview of the adolescent component. Program facilitators provide information on puberty, values clarification, reproductive health, HIV/AIDS, sexual abuse, and the importance of abstinence in prevention. Parents can exchange contact information to set up a support network. The Nitestar program replicates a program was previously demonstrated to be effective in another community in increasing beliefs that teaching abstinence will results in delay of adolescent sexual activity (St. Luke's Roosevelt Hospital, 2002). Previous interventions using this curriculum suggest high support and satisfaction among parents who attended. Other programs that have conducted parent meetings, workshops, or training sessions include the *Baptist Children's Home Ministries Decisions for Life* in Texas, *Dallas Independent School District* in Texas, and *University of Maryland* in Baltimore.

Parent-Only Approaches

The *Southern Nevada Area Health Education Center (SNAHEC)* is a parent-only program with no accompanying adolescent component. It provides parent workshops to improve parent-child communication and reinforce parents' role as sex educators for their adolescents. One 2-hour workshop addresses risk and protective factors, pressures facing children during early adolescence, and strategies for parents facing these challenges. Parents can take additional classes

that meet weekly for 4 weeks to focus on skill-building activities or join an Asset-Building Club (ABC), held monthly to provide ongoing support. *SNAHEC* recruits and trains local parents as ABC coordinators to further enhance their communication skills.

Strategies for Engaging Parents: Title XX prevention programs employ multiple strategies to reach parents, including informational packets, incentives, social marketing, partnerships, advisory councils, and special events. Several programs send home program orientation materials by mail or through adolescents. The *Morehouse School of Medicine* in Georgia initiates follow-up phone calls to parents who do not complete consent forms in order to reach a greater number of parents. *PROP* in Portland, Maine, conducts one-on-one interviews with all parents in order to provide a supportive, private environment for responding to parent questions or concerns and to enhance parental accountability to the project and program staff. Other programs offer incentives and perks to entice parent participation in workshops and family fun events. For example, the *BETA Center* in Florida hosts Family Fun Nights to recruit potential parent participants and to advertise services. Several programs also offer family meals, food, prizes, child care, or transportation as incentives. *Alabama State University* includes local celebrities or “famous” speakers for special events in order to increase program visibility and attendance. Additionally, *Colorado State University* offers parents a \$200 incentive at the completion of the program and evaluation to encourage parent participation and reduce attrition. In addition, the program provides a great deal of flexibility by offering makeup classes as needed.

SNAHEC in Nevada uses incentives and a unique social marketing approach to enhance participation in its 2-hour parent-only workshops. The workshops are usually conducted in a host parent’s home, where an outreach coordinator can provide assistance with babysitting, refreshments, small incentives for all participants, and a special incentive for the host parent. After the workshop, participants are encouraged to recruit at least five other parents and host a workshop in their home. *SNAHEC* refers to this social marketing strategy as the “Tupperware Party Approach” and reports that the approach has tripled attendance at its workshops. Numerous project grantees partner with other community agencies as a way to gain access to parents already involved in the community. Both the *JOVEN* program in Texas and *Roanoke Chapel Baptist Church* in North Carolina partner with local Parent-Teacher Associations (PTAs) to implement parent workshops. Similarly, *PROP* in Maine uses a referral service to address issues that go beyond the scope of the program.

Advisory councils are an additional way of involving parents in program development and information dissemination. *Northridge Hospital Foundation* in California has an advisory council, consisting of parents, students, and community members, to ensure cultural relevance in program design. To this end, many programs also use local and peer facilitators. *Roanoke Chapel Baptist Church* in North Carolina involves parents in its Institutional Review Board (IRB) process. Special

events are often hosted as a means to reach parents. Family fun nights are a popular technique for increasing parent participation. Yearly leadership camps, summer camps, annual day-long seminars, and field trips are additional events that programs develop to reach parents.

Some programs have developed strategies to specifically increase father involvement. *Alabama State University*, for example, attempted to improve father recruitment efforts by hiring male facilitators and recruiting through sports and recreation facilities or other community venues frequented by males. Similarly, the *Boys and Girls Club of Sarasota* in Florida facilitated a partnership with the Nurturing Dads initiative, an awareness-raising program which emphasizes the vital roles fathers play in their children's lives.

Program Outcomes: 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. The *Children's Council* in South Carolina reported an 86 percent participation rate in all *FAST* program activities and improved parent-child communication, family functioning, social connectedness, and community attitudes toward adolescent sexual activity. The *Dallas Independent School District* in Texas found that two-thirds of parents reported increased comfort level and knowledge in discussing abstinence with their adolescents. *JOVEN* in Texas reported that 99 percent of parents felt an increase in knowledge and comfort discussing sexual risks. *Northridge Hospital Foundation* in California reported a statistically significant increase in participating parents' intention to discuss sexuality and related issues with their adolescents. *Cumberland YMCA* in Maryland reported improved parent-child interaction, parent understanding of parenting, and adolescent academic performance. However, despite multiple efforts to engage parents, 11 of the 21 programs specifically cited a lack of parent participation. In addition, some programs were successful in engaging parents in initial workshops or events but were not able to sustain parent involvement over the long run. Numerous programs also reported that father participation was particularly low. Evaluation results were not yet available for 9 of the 21 programs.

Lessons Learned: Despite multiple and innovative efforts, programs did not share similar levels of success in recruiting parents. For example, some programs found that offering family meals, food, and child care as incentives did not always result in successful attendance. Some programs noted that their recruitment efforts were ineffective in reaching their target population and in distinguishing their programs from other services already available in the community. For example, the *Boys and Girls Club of Sarasota* in Florida and *Cumberland YMCA* in Maryland noted previous participation in similar programs as an implementation barrier that reduced enthusiasm for their programs. Other programs noted that their services overlapped or competed with other local programs for parent participation. Some program providers noted a mismatch between the time of day services were

offered and when parents were available. In addition, some stated that many in the target parent population had work schedules and family responsibilities that did not permit weekly or sustained attendance; this appeared to be a particular problem for fathers. *Northridge Hospital Foundation* in California cited discomfort with program material related to sexual topics as a reason for parental avoidance of activities among its predominantly Hispanic population. The program organizers suggested that cultural considerations may be important when choosing program approaches and developing materials. *PROP* in Maine cited staff turnover as a contributing factor for attrition. Programs suggested that low father participation may be due to the lack of recruitment efforts specifically aimed at fathers or cultural norms that place mothers as the providers of sex education information for adolescents.

Title XX Care Programs

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. The target populations of the Title XX care programs vary across providers, although many programs focus on adolescent parents and their children from low-income or impoverished households. Adolescent mothers and their children are the primary client population for most programs, and many programs also target adolescent mothers' male partners, parents, younger siblings, and other family members. In general, the programs tend to focus on adolescent parents aged 16 or younger, although several serve a wider age group. Overall, the size of the participant population varies greatly, with most programs serving between 75 to 250 adolescent mothers and their families.

Parent Involvement Strategies: The 24 Title XX care programs reviewed in this section employ a number of approaches, including home visits; counseling and case management; parent classes, workshops, and meetings; and sexuality education programs (*Attachment B*). Within these categories, programs use a variety or combination of approaches, including parent-child, parent-only, and family groups to involve parents and families of pregnant and parenting adolescents. In this section, we describe the commonalities across programs and highlight programs with innovative approaches or that offer comprehensive services.

Home Visits

A large number of programs provide services, assessments, and referrals through home visits to pregnant and parenting adolescents. Many programs use home visits to assess pregnant and parenting adolescents' level of family support and adjust program services accordingly. For example, the *Garrett County* program in Maryland and *Rural America Initiatives* in South Dakota

use home visits to design individualized family support plans developed by program staff in conjunction with adolescents and their families. Other programs use home visits to inform parents of the program's goals and objectives and to provide informational material and referrals.

Counseling and Case Management

Several programs offer counseling and case management services to parents, typically in conjunction with their adolescents. Thus, the goal for most programs is to foster and enhance parent-child relationships, mediate parent-child conflict and problems, and generally improve the home environment of pregnant and parenting adolescents and their children. The *Camden Board of Education* in New Jersey, for example, offers parent-child counseling sessions facilitated by a program case manager. Sessions are held every other month and focus on helping parents and adolescent mothers address issues around adolescent parenting, academic progress, and parent-child relationships. These counseling sessions are further supplemented by quarterly family workshops on sexual, reproductive, and health issues. In addition to parent-child counseling and case management, a small number of programs provide additional parent-only counseling and case management, as needed.

Parent Workshops

Some programs offer parents classes, prevention education workshops, and training on parenting, grandparenting, basic First Aid, and/or medical care. Some programs provide parent-only workshops and groups as a platform for parents to meet and discuss issues and concerns and to share support, advice, and information with their peers. In addition, these groups are used to encourage parent involvement in the lives of their adolescents' children and disseminate developmentally appropriate parenting techniques and activities.

Parent Sexuality Education Programs

Providers that incorporate a parent sexuality education program seek to improve parent-child communication and increase parent knowledge and skills regarding sexuality and reproductive issues. The *Centers for Youth and Families—Young Moms/Healthy Families* in Arkansas, for example, utilize the Parents as Sex Educators (PASE) curriculum in the workshops and trainings offered to parents of adolescent participants. Similarly, the *Children's Shelter—Project Mothers and School (MAS)* in San Antonio, Texas, administers the Can We Talk curriculum to parents of pregnant and parenting adolescents.

Engaging Parents: Programs employ several strategies, alone or in combination, to recruit and garner parent participation and involvement, including special events, newsletters, incentives, parent advisory boards, and the provision of program services to all family members. Several programs host special events, such as family dinners, family workshops, field trips, holiday parties, carnivals, grandparent conferences, day or summer camps, and parents' night out to encourage family participation. These events also provide an opportunity for staff members to meet and establish relationships with adolescent parents' family members. For example, in the PATH program run by the *Arlington Independent School District* in Texas, counselors discuss adolescents' progress and challenges with parents during their parents' night out events. In general, the programs' special events have an intergenerational and family focus with activities available for all age groups, although some programs host parent-only or joint attendance events. Most events are centered on entertainment (e.g., raffles, campfires, family portraits) and food, but many include educational classes and informational components. For example, in the *Garrett County, Maryland*, program's annual Nurturing Camp, participants can take part in CPR and child safety classes and communication skills workshops. Other programs feature informational and motivational speakers during lunch and dinners. The *Truman Medical Center's* Annual Grandparent Conference in Kansas City, Missouri, for instance, includes keynote speakers on children's mental health and child abuse and neglect. Newsletters provide a simple and inexpensive way to inform parents of program activities, services, and events. The *Arlington Independent School District's* PATH program designed and distributed a grandparent newsletter to keep parents abreast of program services and upcoming events. In addition, the grandparent newsletter provides information and helpful hints on parenting adolescent parents and on grandparenting. *Children's Hospital and Health Center* in Boston and *Garrett County* in Maryland formed parent advisory groups as a way to foster parent participation and encourage parent and community involvement and input in program development and goals. Several programs provide educational, health, and vocational services; counseling; referrals; and outreach to parents and extended family members.

Program Outcomes: Approximately 50 parents of the 81 adolescents served by the *Truman Medical Centers* in Kansas City, Missouri, attended the Annual Grandparent Conference. Parents rated the conference as informative, helpful, and fun and requested additional information on grandparents' rights, child development, and how to balance relationships between their adolescent and grandchild. The *Truman Medical Centers* receive support and assistance from the AARP and the Family Friends Program in hosting the conference, and thus the visibility and resources of the cosponsors may have been helpful in drawing parent participation and interest. Few other grantees reported attendance and levels of family participation, but the available information suggests that despite multiple efforts, program activities and special events experienced low to moderate levels of success in garnering parent involvement and participation, and parent involvement continues to be a problem for many

programs. For example, *Garrett County* in Maryland had to cancel its grandparent support group program because no one attended the meetings, only 14 percent of parents attended its adolescent support meetings, and only one parent attended the second annual Nurturing Retreat, held over a three-day weekend and including classes on health and well-being, massages, campfires, family portraits, free meals, and child care. The lack of participation in the support group is particularly puzzling because parents designed the content and structure of the groups and in earlier groups had voiced a strong desire for a grandparent support group. Similarly, only 12 parents of the 129 adolescent mothers participating in the *Mercy Hospital* program in Pittsburgh attended the first session of a monthly parent discussion group. Paradoxically, the same strategies sometimes yielded different results across programs and even within programs across time. Nevertheless, the information provided in the program reports suggests that programs have greater success engaging parents than male partners, and programs are more successful in involving adolescents' mothers than their fathers.

Lessons Learned: Several explanations for unsuccessful parent involvement were reported. The *BETA Center, Inc.*, home visiting program in Orlando, Florida, faced difficulties locating participants and arranging home visits because it served a highly mobile client population. *La Clinica de Raza's Teen Clinic Program* in Oakland, California, reported low father participation because of conflicting work schedules. However, the *Children's Hospital and Health Center* in California reported some participant resistance to home visits because of immigration concerns. Many of the programs reviewed are serving increasingly diverse populations and are working to adapt curricula and programs to be culturally sensitive and recognize cultural differences. For example, the *Minneapolis Public Schools* are adapting their curriculum and program content to better serve the Hmong community. Other programs are translating their newsletters and information packets and recruiting bilingual staff. The relative success of the *Truman Medical Centers' Grandparent Conference* in Kansas City, Missouri, suggests that programs may benefit from partnering with larger and well-known businesses and groups.

4. DISCUSSION AND IMPLICATIONS

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, 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. This section discusses OPA program activities in light of this inconclusive literature and suggests next steps.

A. Title X Programs

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). Though 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). Researchers have noted that family planning clinics encourage adolescents to voluntarily talk to their parents, but relatively little information is available about the extent to which activities to promote parent-child communication have been adopted (Jones & Boonstra, 2004).

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 websites.

A review of the Title X program reports suggests some evidence-based curricula currently available may not be ideal for the Title X setting. Many contraceptive health curricula are school-based and involve multiple sessions, requiring a substantial investment of staff and parent time. Title X programs report difficulty in convincing parents to attend even brief, 2-session workshops, and parent participants have complained about the length and focus of these short offerings. It is possible that a combination of homework assignments and enhanced counseling techniques and strategies, perhaps borrowing from other fields (such as theoretically-based motivational interviewing, cognitive-behavioral therapy, or brief couples therapy approaches), would yield a feasible strategy for Title X staff, clients, and parents. Title X program staff also identified unhelpful parents as a potential barrier to parent involvement that is largely unaddressed in evidence-based curricula. Program staff reported that occasionally parent education and counseling may be needed before parent involvement is promoted because some parents lack the maturity needed to help their adolescents. 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.

B. Title XX Prevention Programs

Our assessment of evidence-based programs suggests that there are multiple approaches to improving parent involvement regarding abstinence. Title XX prevention programs have employed many of these types of parent involvement strategies in promoting abstinence, including parent workshops, joint attendance programs, homework assignments, youth development models, and various combinations of these. Several programs also address the larger issues of providing sex education in the community or improving parent-staff relationships. Many programs have developed curricula that are appropriate to the age and cultural experiences of adolescents in their target populations. However, 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.

More than half of Title XX prevention programs reported a lack of parent participation in spite of multiple efforts to engage parents. Evaluations of community-based or grassroots approaches for involving parents have shown that involving established, respected community agencies and members, as well as reaching adults where they are located (church, work, home, etc.), is effective in drawing the participation of community adults and parents (Smith et al., 1993). Recruiting and training parent leaders to reach out to other parents is another effective strategy. 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 homes and communities. Pairing the Tupperware Party approach with identified parent leaders may be even more effective. Such a model would identify parent leaders in small communities (the smaller the community is defined, 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 (need citation), which could be cost-effective and access many more parents and families than traditional workshop approaches. Homework assignments also may be an ideal way to involve parents because they place fewer demands on busy parents, reach a wider range of parents, and can provide a comfortable platform for parents and children to have face-to-face conversations about issues related to abstinence.

It also appears that programs may need to pay specific attention to the marketing of their services, particularly in markets already saturated with community outreach efforts. Accordingly, programs

might need to develop strategies or approaches that help to distinguish them from other programs already available or previously offered. Programs may benefit from a market assessment or parent focus groups to identify existing gaps in services and needs. Programs also mentioned staff turnover as a contributing factor for parent attrition, an issue that is further compounded by the difficulty and time spent establishing parent-provider rapport.

C. Title XX Care Programs

Parents are by far the most significant source of support for pregnant adolescents, and the literature suggests that a carefully developed program for mothers of pregnant and parenting adolescents helps all parties involved, including the infants. Traditionally, health care for pregnant adolescents has taken an individual approach, with the pregnant adolescent the only one receiving care. However, this approach fails to consider how much adolescents rely on their parents, especially during pregnancy. Health services should include strategies that help parents of pregnant or parenting adolescents confront and cope with their own feelings so they can, in turn, help their adolescents (Roye & Balk, 1997). An added plus is that adolescents' mothers, many of whom have younger children, become better able to discuss sexuality and contraception with their other children, thus possibly preventing additional unwanted pregnancies (Roye & Balk, 1997).

Title XX care programs are uniquely set up to involve parents through home visits and case management for pregnant and parenting adolescents and their families. While adolescent mothers may benefit from the sharing of parental responsibilities and child care, prolonged reliance or over-dependence on parents may hinder the timely acquisition of parenting skills and confidence among adolescent mothers. In some cases, such as when adolescent mothers come from disadvantaged or troubled homes, when the adolescent's parents themselves lack resources and parenting skills, or when the adolescents' parents have problems with drug or alcohol abuse that interfere with the adolescents' ability to participate fully or continue in the program, parent involvement may not be ideal. In particular, the research suggests that parents may act as an important barrier or facilitator to service delivery and impede or encourage the adoption of skills, values, and experiences taught by programs; it behooves programs serving pregnant or parenting adolescent to gain trust and buy-in from the adolescent's parents. In short, without parent buy-in, the skills and lessons learned by adolescents while in the programs may be nullified, questioned, or undermined at home. At a minimum, programs may need to provide training and support for parents, as well as for the adolescent. The individualized approaches described in the literature and in Title XX care program reports seem ideal for these situations.

Although all of the Title XX care programs we reviewed 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. Title XX care programs have employed a wide spectrum of parent involvement strategies and involve parents to varying degrees and with varying success.

Among both Title XX prevention and care programs, few describe offering a receptive, reciprocal forum of parent participation. We identified little evidence of programs specifically listening to the needs, concerns, experiences, and goals of parents as an approach to involvement, although facilitated support groups may serve some of this function. It is possible that some parents resist being “taught” and would welcome ways of being involved that engaged them as consultants, partners in prevention, and the experts on their children. At least one program utilized a parent advisory group, and another trained parents as peer educators, both consistent with an empowerment approach. However, such approaches have not always yielded positive results. For example, the advisory council of *Garrett County* in Maryland recommended formation of a support group for parents of adolescents, which was then disbanded due to zero attendance.

D. Other Approaches for Consideration

Participants in national, state, or local campaigns to increased parent-child communication about sexuality cite numerous factors that are needed in order for organizing 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 representative of the population served, and incentives for attending and hosting Home Health Parties (S.I.E.C.U.S., 2002). Practitioners experienced in implementing these approaches emphasize the importance of having strong, innovative facilitators, using established community agencies to reach adults (church, workplace, etc.), or going to their homes, whichever is most desirable for parents (S.I.E.C.U.S., 2002). However, recruiting men has been a challenge for many of these programs (S.I.E.C.U.S., 2002). Individuals seeking to implement a community-based strategy should heed warnings about lengthy participant involvement, slow results in the first year, and a need to be flexible (Douglas, 1998). Still, community members who participated in these programs strongly believe in their bottom-up approach and feel that the community empowerment skills that they acquired through these programs can be applied to other social improvement efforts (Walker & Kotloff, 1999). In addition, large scale media approaches that often accompany community-based programs are credited for increasing awareness about adolescent sexuality, although it is difficult to determine whether these same efforts can be credited for changes in actual behavior (Kirby, 2002).

In addition, several Title X male involvement programs have identified goals to increase parent-child communication on sex and strengthen the role of parents and other adult family members in promoting sexual responsibility and increasing their understanding of involvement in and responsibility for adolescent pregnancy prevention. For example, the National Organization of Concerned Black Men, Inc., in Washington, D.C., offers parents advice on helping their children make better decisions about sexual behavior. Although the funding, mandate, and structure of Title X male involvement programs differ from that of programs reviewed in this report, it is possible that information about parent involvement strategies used by Title X male involvement programs could be useful to Title X family planning and Title XX Adolescent Family Life programs.

E. Parent Participation

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. Results from the national implementation study of abstinence education programs suggest that programs using a variety of methods to foster parent involvement in meetings and workshops still face many challenges in achieving optimal participation by more than a small fraction of parents (Devaney, Johnson, Maynard, & Trenholm, 2002). Limited attendance by fathers was particularly cited as a problem in programs. 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 better.

Programs may need to continue to pay attention to important relationship factors that may increase or decrease involvement and retention, including staff-parent relationship and rapport, longevity of program, staff turnover (cited in one program as a barrier to rapport building), 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. While there is little empirical data about culturally appropriate programs, Title XX prevention and care programs noted disconnect between program content and cultural norms among some parents, the need to engage parents in assuring cultural sensitivity, and the need to tailor programs to different subpopulations within a large community.

Programs could also consider including (and evaluating) approaches that emphasize parental expertise and voice. For example, parent focus groups could help program planners assess what types of information that parents want and need, what type of relationship with staff they are seeking, what

their concerns and fears are, and how they can best be empowered to become effective sexuality educators of their children. Another possible method of enhancing relationships between parents and staff is providing incentives for parents such as prizes or food, which can demonstrate that staff value parent participation.

F. Engaging Parents

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.

Implementation evaluations of programs for pregnant and parenting adolescents demonstrate the continuing influence of parents and other family members on the adolescent's involvement in the program and decision-making, more generally. Results from implementation evaluations show the importance of gaining the trust and "buy in" of parents and family members of adolescents served by programs. These evaluations suggest that programs can gain the trust and support of parents and community members but that such ties take time to build. Thus, programs that are funded for limited periods of time may be unsuccessful in recruiting and gaining parent involvement.

When resources allow, offering a variety of approaches for parents to become involved with a program may enable greater participation, since parents' abilities and likelihood of participation appear to depend on a range of factors, such as work schedules, other family responsibilities, and timing of workshops, as well as comfort level with materials on sexuality. Programs that are starting out, those with limited resources, and those serving communities with several barriers (such as scheduling or transportation problems) may employ parent newsletters and information packages as an inexpensive way to reach a large number of parents who may be busy and thinly-stretched. 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 that require active participation should work with parents to schedule times that work best for families. Programs that are setting up parent advisory groups may improve recruitment by pairing with other family organizations in the community. Unfortunately, evidence is not available about the effectiveness of such strategies in OPA-funded programs in either engaging parents to participate in interventions, improving parent involvement with adolescents, or improving adolescent outcomes. However, 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.

G. Program Outcomes

Many Title X and Title XX Prevention and Care programs list specific goals related to increasing parent involvement. However, 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. In order to better assess how different strategies are working, it would be helpful for all programs to measure the following for each strategy used: a) parent attendance (by type of activity) and b) changes in parent involvement outcomes as a result of attending (from both the parent and adolescent perspective). In addition, programs and the field would benefit by measuring potential changes in adolescent reproductive health outcomes as a result of program-related parent involvement. Note, however, that few evidence-based programs are able to measure whether parent involvement components are linked to specific adolescent outcomes.

H. Limitations

Much of the existing research that describes the relationship between parent involvement and parent and adolescent outcomes is based on analyses of cross-sectional data, where parenting and adolescent outcomes are measured at the same time, preventing conclusions that parent involvement caused the observed outcomes. Most of the etiological studies that describe parent involvement with pregnant and/or parenting adolescents were based on small or localized samples, or have focused exclusively on minority and low-income groups. The relative lack of rigorous research in this field limits the representativeness of our literature review findings. Section 2 of this report profiled experimental studies, which provide the only appropriate research approach for determining causality. It is risky to generalize from the small number of experimental studies whether (and which) parent involvement strategies are effective in producing desired ultimate outcomes. Research is most lacking regarding parent involvement with pregnant and/or parenting adolescents. We identified only one quasi-experimental evaluation of a program for pregnant and parenting adolescents that involved parents.

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 region. Also, many program activities are conducted by sub-recipients 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 in Section 3 of this report.

Among OPA-funded programs, pre- and post-test analyses of parent involvement were often encouraging in their results, but the effectiveness of programs is better addressed through experimental evaluations with random assignment. Moreover, it was unclear whether parent evaluation participants were representative of the target parent population. For example, evaluation participants might disproportionately include parents who were highly motivated or interested in the program. Additionally, few programs provided response rates in the evaluation reports. Thus, it is difficult to assess the representativeness of these data, particularly in light of the high attrition reported in some programs.

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 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 or media exposure that encourage risky behavior. Optimizing prevention and intervention efforts for adolescents will require a sustainable and coordinated infrastructure to stimulate and support contextual intervention research (DiClemente & Wingood, 2003). Emerging approaches have been described that may prove more effective in the promotion of reproductive health among adolescents (DiClemente, Crosby, & Wingood, 2002b).

I. Implications and Next Steps

The literature suggests that promoting parent involvement in adolescents' decision-making about reproductive health and in supporting pregnant or parenting adolescents may be beneficial. It may be important for Title X and Title XX programs to critically evaluate how their efforts do or do not resemble evidence-based approaches and to assess the feasibility of incorporating or adapting such approaches.

Rigorous program evaluation about Title X and Title XX parent involvement strategies is needed to assess effectiveness and outcomes. Ideally, programs within each program type could develop a standard set or core of 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. It would also be helpful for programs to measure simultaneously parent and adolescent outcomes, in order to assess whether changes in parent involvement are associated with changes among adolescents. Some of the stronger models (with encouraging non-experimental data) should be examined in a random assignment experimental study. The current project will contribute 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 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.

As described above, several evidence-based programs, as well as Title X and Title XX programs, reported problems with parent participation and/or retention. The current project increases understanding of efforts to engage parents, barriers to parent participation, and successes in engaging parents. Innovative strategies identified in this report will be further assessed. Evaluations of the effectiveness of such strategies may be important future research.

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 highlights a unique opportunity to examine strategies to reduce rates of 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 review of program descriptions yielded findings that help to identify innovative ways to encourage or continue the involvement of parents in programs serving adolescents. Identified best practices among Title X and Title XX programs may be helpful for possible implementation across additional program settings. Such research is an important first step toward understanding how best to involve parents within the context of government-funded adolescent services and improve desired outcomes.

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APPENDIX A: ADDITIONAL LITERATURE ABOUT ABSTINENCE EDUCATION PROGRAMS

Mathematica Policy Research and subcontractor, University of Pennsylvania, Graduate School of Education, are conducting an experimental evaluation of abstinence education programs in several states under Title V, Section 510 of the Social Security Act (Devaney, Johnson, Maynard, & Trenholm, 2002). Results of this rigorous study are expected in 2005, but an implementation report provided some details about the parent involvement approaches used in some of the sites. For instance, the sites in Iowa, New York, and South Carolina, sponsor parent workshops, informational training sessions, or monthly meetings. Other parent activities at program sites include parent education programs, parent resource centers, distribution of pamphlets and videos, weekend family retreats, attendance at children's program events, and home visits.

Unfortunately, the report provided little information on how well many of these components were actually implemented. However, some insights based on qualitative observations and focus group responses were included in the report. One specific program effort that appeared to be successful was engaging parents in program events in which their children were involved. Sites where this strategy seemed to draw parents include the *Heritage Community Services* program in South Carolina, the *Recapturing the Vision* program in Miami, and the *Families United to Prevent Teen Pregnancy (FUPTP)* program in Milwaukee.

While inviting parents to their children's program events seemed to prove successful, one of the key lessons learned, according to the implementation report, was that abstinence education programs face challenges in engaging parents in the programs. According to the report, nearly all the programs faced difficulty in attracting the participation of more than a small fraction of parents. The *Not Me Not Now* group program in Monroe County, New York, and the *Youth Abstinence Education Program* in Tooele, Utah, achieved lower than expected attendance at parent-child communication workshops, even though the workshops were widely advertised in a parent outreach campaign. Similarly, staff members at *FUPTP* reported low attendance at monthly parent meetings, even though they provided food, transportation, and child care to encourage parent participation. The study also found displaying videos and pamphlets in local supermarkets so that they can be available for parents was not as successful as they had expected.

Instead of focusing solely on adolescent reproductive health, many pregnancy prevention programs maintain a holistic perspective by applying a youth development approach. This approach aims to prevent at-risk behaviors, including risky sexual behaviors, as well as to promote positive social characteristics among youth. These programs engage parents in the process of their child's development. *Seattle Social Development Program* is an example of this comprehensive strategy. However, it targets low-income elementary schoolchildren rather than adolescents. The program seeks to enhance child socialization and create a bond with the school through three components; teacher training, child development, and parent training. The parent training objectives include information on behavior management, academic support

skills, and parenting skills to reduce future at-risk behavior (Lonczak, Abbott, Hawkins, Kosterman, & Catalano, 2002). Professional project staff facilitates these voluntary parent-only workshops. These workshops emphasize the use of positive reinforcement and consistent consequences, as well as the importance of initiating a conversation with children's teachers, creating a supportive, learning home environment, establishing a family policy on drug use, practicing refusal skills with children, and using self-control to reduce family conflict (Lonczak, Abbott et al., 2002). A high attrition rate (only 60 percent of the original sample was included in the evaluation at the completion of sixth grade) and the voluntary nature of parent participation (which was low) posed problems for the program (Promising Practices Network, 2002). So, while the program seemed to have positive school- and health-related outcomes, parent involvement was not measured. Therefore, it is difficult to assess the level of skill transference to the home.

APPENDIX B: ADDITIONAL LITERATURE ABOUT PROGRAMS FOR PREGNANT AND/OR PARENTING ADOLESCENTS

This Appendix summarizes the existing literature on programs for pregnant and parenting adolescents. In each of the programs reviewed below, the focus of the intervention was either the adolescent mother or the adolescent mother-child pair. Of the studies reviewed, none appeared to have an explicit parent involvement component in the program's initial design. Other studies noted the importance of parent and community buy-in for a program's success and perceived legitimacy. Accordingly, since parent involvement was not a central aspect of any of the programs' design, no evaluation data are available to suggest best practice models or to indicate the potential benefits, if any, of parent involvement in adolescent parenting programs. Nevertheless, the broader literature, coupled with many of the lessons learned from these programs, suggests that parent involvement may be key to the success of programs serving adolescent mothers and their children, as well as beneficial for the well-being of both generations.

The *New Chance* program was a national demonstration project aimed at providing comprehensive services to assist disadvantaged families in acquiring the educational and vocational credentials and jobs skills needed to improve their life circumstances. Program participation was limited to young mothers (aged 16 to 22) who had given birth as adolescents, had dropped out of high school, and were receiving Aid to Families with Dependent Children (AFDC) at the time of enrollment. The program had a two-generational focus that sought to enhance the cognitive abilities and health and socioemotional well-being of participants' children. Accordingly, the program provided high-quality child care to program participants. The program operated in 16 sites across 10 states between 1989 and 1992.

To evaluate the effectiveness of the program's services, young mothers were randomly assigned to either an experimental or control group. Participants in the control group were eligible to receive services already available in their community. Data from study participants were collected at 1, 1 ½, and 3 ½ years after random assignment. Surprisingly, few or minimal differences were observed in the measured outcomes (e.g., GED or high-school completion, AFDC receipt, labor force participation, depression, and birth control use) between the experimental and control groups. The study evaluators suggested that the lack of differences between the two groups reflected, in part, the high levels of services and programs already available in the *New Chance* communities and the high level of participation among control group participants in these programs, as well as the high levels of absenteeism and attrition among participants in the experimental group (Quint et al., 1997; Zaslow & Eldred, 1998).

While the *New Chance* programs did not include a parent involvement component, qualitative interviews with participants and feedback from program providers indicated that parents, partners, and other family members played key roles in the success and involvement of young mothers. In fact, the support of family members, in particular of parents and partners, seemed to be crucial in young mothers' willingness to

participate and invest in the program. Many participants appeared to be discouraged by relatives and partners from attending the program's classes or integrating their newly acquired skills in their lives (see Quint et al., 1997; Zaslow & Eldred, 1998). Specifically, participants in the parenting classes reported difficulty incorporating newly taught parenting techniques or disciplinary methods because family members disapproved of or disagreed with the use of such techniques. For example, family members were reluctant or skeptical about the use of "time-outs" and preferred more familiar disciplinary methods (Quint et al., 1997).

Evaluators of the *New Chance* program also found that family members hindered the program's effectiveness in reducing the rate of repeat pregnancies and births. Specifically, some adolescent mothers reported receiving pressure from their partners and their parents to have more children or to shorten the spacing between births (Quint et al., 1997). Also, a significant proportion of participants had relatives or partners whose drug or alcohol abuse interfered with their ability to participate fully or continue in the program. Overall, approximately one in five participants in the experimental group were identified by caseworkers as having a family member with an alcohol or drug abuse problem or as being discouraged from participating in the program (Quint et al., 1997). In short, the evaluators of the *New Chance* program concluded that the lack of supportive figures in the young mothers' lives—whether parents, partners, friends, or other family members—was a barrier to program participation and success.

An evaluation of the *Family Growth Center* also found that it was important to gain the trust of family members. The *Family Growth Center* was created in the mid-1990s to address the needs of adolescent low-income mothers in the Pittsburgh area and, in particular, to reduce repeat pregnancies and school dropout rates. Home visits and comprehensive family and adolescent parent services are components of the center's programs. Key features of these programs include establishing early contact with the mothers (i.e., during prenatal doctors visits or during delivery in the hospital), involving families of the adolescent mother, implementing parenting groups, and involving the community (Solomon & Liefeld, 1998).

Evaluators of these programs reported that it took between 6 and 15 months to gain the trust of community and family members, and that many of the adolescent mothers' own mothers were initially skeptical and suspicious of the services and support the center was attempting to provide (Solomon & Liefeld, 1998). Program providers were able to gain the trust and support of these mothers and the larger community by providing comprehensive services including transportation, day care, recreational activities, housing, health care and referral and advocacy services. The study's authors also suggested that programs gained the trust of adolescent mothers' mothers as the older mothers witnessed the level of commitment among staff members in improving the well-being of their children and grandchildren. In response to an apparent demand, a grandmothers' group was organized at the end of the study. In short, key components in the success of the *Family Growth Center* appear to be threefold: 1) longevity, which allowed for the

establishment and nurturance of neighborhood roots; 2) a comprehensive and one-stop service model, which allowed for the provision of a wide range of services ranging from transportation to healthcare; and 3) a strong recognition and response to parent and community concerns, which generated community goodwill.

Nurse home visiting programs have shown a great deal of success in improving the well-being of adolescent mothers and their children. For example, a study of a comprehensive program developed in up-state New York that was conducted with a sample of white low-income adolescent mothers indicated that receiving home visits from professional nurses was associated with more stable employment, fewer subsequent pregnancies, and greater spacing between births four years after program enrollment (Olds, Henderson, Tatelbaum, & Chamberlin, 1988; Solomon & Liefeld, 1998). A subsequent follow-up study carried out 15 years after the program began replicated the findings of the earlier study and found additional long-term benefits to program participation, including fewer incidents of child abuse and neglect, less dependence on government assistance, fewer alcohol or substance abuse problems, and fewer arrests (Olds et al., 1997).

The program was later replicated in Denver and this time included an additional experimental component. Participants were randomly assigned to either a control group or an experimental group with either a professional nurse or a paraprofessional. Those receiving home visits were more likely to quit smoking, had fewer pregnancies, delayed pregnancies for longer intervals of time, and were more stably employed than those in the control group. However, the effect of the paraprofessional group was one-half the size associated with the professional nurse group (Olds et al., 2002). The authors of a study on this intervention suggest that the apparent advantage of professional nurses relative to paraprofessionals was due to the perceived legitimacy and authority that nurses possessed with the adolescent mothers and their parents. This finding coupled with findings from evaluations of the *New Chance* and *Family Growth Center* programs suggests that adolescent and parent “buy-in” is important for the integration of skills and practices taught by programs, and further, that “buy-in” may be more easily obtained when programs are taught by figures perceived to be legitimate and trustworthy. Lastly, though evaluations of both the nurse visiting program in New York and the one in Denver noted that parent and other family member involvement was encouraged during home visits, neither evaluation noted the extent to which this occurred or discussed the possible effect parent involvement may have had on adolescent and child outcomes.

The *Community of Caring* programs seek to assist pregnant adolescents in having successful pregnancies and in becoming loving and caring parents (Miller & Dyk, 1991). The programs center around a values-based curriculum that is structured around seven themes: 1) family, 2) personal responsibility, 3) sexual maturity and commitment, 4) planning for future goals, 5) commitment to parenthood, 6) human and ethical professional practice, and 7) care and responsive institutions. Between 1985 and 1988, a non-

experimental evaluation was carried out to ascertain the extent to which program participation was associated with key desired outcomes, including improved relationships between adolescent mothers and their families (Miller & Dyk, 1991). Two program sites (in Boston and Las Cruces, New Mexico) were selected to be part of the evaluation because of their high level of community recognition, service delivery, and involvement with participants.

The evaluation consisted of a pre-test-post-test control group design without random assignment. It compared the outcomes of adolescents with high levels of program participation to those with low levels of program participation, as well as to a comparison group whose participants were recruited from local Women, Infant, and Children's (WIC) offices and who shared key demographic characteristics (i.e., age, race/ethnicity, and gestation) with program participants. The study's researchers found that adolescent mothers from the "low"- participant group were more likely to rate families as important than those from the comparison group. In addition, adolescent mothers in both the low- and high- participation groups were more likely to report receiving family support and assistance (e.g., financial and emotional support) than those in the comparison group. This was so even after controlling for sociodemographic characteristics and taking into account whether or not the adolescent mother lived with family members. These effects, however, were only observed in the Las Cruces site, and the effects of the values-based curriculum on family ties and support appeared to dissipate over time (Miller & Dyk, 1991).

Attachment A. Parent Involvement Activities in Selected Title XX Prevention Programs

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Alabama State University	Montgomery County, AL	7th, 9th, and 10th graders; urban; 52% black; 48% white	155 parents of participants	Parent workshops, special events, support network	Parent Empowerment Seminars, Parent/Adolescent Empowerment Support Network; monthly support meetings, father involvement and communication styles; home-based parent training using small group learning and discussion techniques	Significant increase in adolescent knowledge about consequences of premarital sex, 30% signed pledge cards to remain abstinent till marriage, 59% have a positive attitude towards abstinence until marriage
Baptist Children's Home Ministries Decisions for Life	San Antonio, TX	Urban 6th graders; 11% black; 84% Hispanic; 5% white; 96% qualify for reduced-price meals	300 adolescents, 250 parents	Parent meetings, home visits, referral services, letters, post cards, calls to participating parents, community events	Uses the <i>Families United to Prevent Teen Pregnancy</i> curriculum, parent meetings, and quarterly family events, such as an annual awards event, communicate with parents through home visits and offer referral services	None yet reported
BETA Center, Inc. FAME: An integrated Family Action Model for Empowerment	Kissimmee, FL	Youths in 4th-9th grade and their parents; rural; high risk and low income; 38% black; 44% Hispanic; 7% white; 11% other	300 4th-8th grade youth and their parents during 1st year of project, will serve 250 4th-9th graders in the coming year, actual: 54 clients under the age of 18, 17 clients over the age of 18, 9 parents	Parent workshops, home visits, case management, community awareness events, philanthropic activities	Follows FAME model (Family Action Model for Empowerment) helps parents to improve child's "Developmental Assets," communication skills, boundary setting, values, child's emotional/physical safety, role modeling; home visits, case management; therapy; family and community awareness events; philanthropic activities	None yet reported
Boys and Girls Club of Sarasota County SMART Moves Program	Bertha Mitchell public housing area, Fruitville, and North Port, FL	Members aged 6 to 18 of Boys and Girls Club of Sarasota County; 66% live in public housing or disadvantaged neighborhoods	752 preadolescents and adolescents	Parent workshops and training sessions, homework assignments	Community-based after-school program, uses the <i>SMART Moves</i> curriculum: age-appropriate abstinence education materials for children aged 6-9, youths aged 10-12, and adolescents aged 13-18; separate parent curriculum; take-home assignments	At 1-year follow-up: 75% of adolescents understand benefits of abstinence, 73% show improved skills in resisting peer and media pressures to have premarital sex, 100% did not become pregnant or impregnate somebody else

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Attachment A. Parent Involvement Activities in Selected Title XX Prevention Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Children's Council 1. <i>Families and Schools Together (FAST)</i> 2. <i>Can We Talk (CWT)</i> 3. <i>Community Awareness Campaign (CAC)</i>	Lancaster County, SC	Rural adolescents from all county middle and high schools and their parents, families, and community members; 26% black; 73% white; 46% of children live below the poverty level; 40% of all county residents lack a high school diploma	<i>FAST</i> : 36 families annually; <i>CWT</i> : 500 through businesses, 1,000 through churches; <i>CAC</i> : primary target is all middle and high school adolescents and their parents; secondary target is the aggregate community	Parent workshops and training sessions, parent support groups, community awareness media campaign	<i>FAST</i> : Family meals, parent-child communication exercises, adult social support exercises, parent self-help group, fixed lotteries to decide family session host; <i>CWT</i> : "Lunch and Learn" program on parent-child communication, community workshops; <i>CAC</i> : Television broadcast component	Improved family functioning, parent-child communication, and parent-child social connectedness; decreased adolescent pregnancy incidence; reduction in favorable community attitudes toward adolescent pregnancy
Colorado State University Cooperative Extension, <i>DARE to be You</i>	Denver and Montezuma County, CO	12-14 year olds, their families, and community volunteers; urban and rural; 25-27% of children are below poverty	360 families (120 families in Year 1, 120 new families in Years 2 and 3); 600 adolescents and 90 volunteers	Parent workshops and joint attendance	<i>DARE to be You</i> curriculum adapted for families; 20 hours of joint parent/adolescent activities and separate sections for adolescents and parents	None yet reported
Cumberland YMCA	Alleghany County and Cumberland, MD	Children aged 4 to 11 and parents; rural; 89% white; 6% black; 4% other; 1% Hispanic	3,829 participants aged 11 or younger, 553 aged 18 or older	Parent workshops or training sessions, media campaign	Child Development, Parenting Sexuality, and Parenting with Abstinence Education educational series offered to parents with children participating in Family Center, Integrity Character Education, or Guys and Gals programs; includes a media campaign	Improved parent-child interaction, improved parent understanding of parenting, 83% of adolescent participants reported A's or B's on report card compared with 75% at pre-test
Dallas Independent School District Students Making Abstinence Real Today - 2 (SMART-2)	Dallas, TX	6 th – 12 th graders; urban; 92% minority population; 60% qualify for free lunches	600 students in first year, more than 200 parents	Parent classes	Parent education classes using the <i>FACTS</i> and <i>Can We Talk</i> curricula; parents and community facilitators are encouraged to teach the sessions	66% of parents reported an increased comfort and knowledge to discuss abstinence with their children, 85% of adolescents feel it is important to wait until marriage to have children, 66% reported ability to make good decisions and follow through (compared with 30% in comparison group), 82% reported learning about abstinence due to program participation

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Attachment A. Parent Involvement Activities in Selected Title XX Prevention Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Fifth Ward Enrichment Program (FWEP), a United Way affiliate 1. <i>Choosing the Best (CTB)</i> 2. <i>Sex Can Wait (SCW)</i>	Fifth Ward Community of Houston, TX	Adolescents aged 9 to 19; urban; at-risk black and Hispanic male adolescents from single-parent households	80 9 to 11 year olds, 100 12 to 19 year olds, plus 50 adolescents who do not attend school, 75 parents	Parent classes, events, health fairs, newsletter, home visits	Monthly parenting classes, Parent Involvement Day at school, booths at health fairs, family outings designed by parent mentors/facilitators, yearly leadership camp, parent newsletter, home visits	Low parent participation, no significant changes in adolescent sexual behavior
Heritage Community Services	Augusta, GA	Rural middle and high school students; majority black; high STI rates in community; large low-income population	1618 total youth	Home visits, community meetings, advisory councils, faith community component, media campaign	Character-based abstinence education resources provided for parents through in-home visits and community meetings, Family Assets and Character to find innovative ways to build internal and external assets in the community	None yet reported
JOVEN: TEJAS (Training and Educating Juveniles in Abstinence Skills)	San Antonio and Bexar County, TX	6th-8th grade with risky and delinquent behavior; urban and rural; primarily black and Hispanic; 80% from households below the poverty line	2000 children, 500 parents	Parent training sessions	Parenting skills-based counseling training using the <i>Can We Talk</i> curriculum conducted in conjunction with the local PTAs and PTOs of participating schools as well as other parent education forums	99% of parents reported increased knowledge and personal comfort level with the topic of sexual risks to their adolescent; 75% of adolescents demonstrated a commitment to abstinence; 75% reported decreased substance use, Juvenile Justice System contact, and sexual activity; 84% increased knowledge about risky sexual behavior
Mercy Hospital Community Based Abstinence Education	Pittsburgh, PA	Predominantly low income; black; preadolescents and adolescents; urban	800 male and female preadolescents and adolescents; 150 parents; 150 mentors, teachers, counselors, siblings	Parent training sessions, events, field trips	Parent educational sessions on adolescent development; program staff offer parenting services and education to parents; <i>Time Out for Parents</i> meets monthly during the year and for 6 weeks in the summer, <i>Pampering Parents Night</i> candlelight dinner; parent/adolescent field trips	Post-test of adolescents survey reports 90% feel better about themselves, 80% improved decision-making and peer pressure resistance skills, 76% reported greater ability to postpone sexual involvement, 90% increased knowledge about responsible choices

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Attachment A. Parent Involvement Activities in Selected Title XX Prevention Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Morehouse School of Medicine: 21st Century Choices	West Central GA counties	4 th -8 th graders with especially high adolescent pregnancy rates; rural; 85% black; high rates of poverty and female-headed households	47 females and 68 males, 41 parents	Parent classes, events	Five year after-school youth development program starting in 4 th grade; parent consent and involvement; parent education; parenting classes; parent involvement in field trips and activities	None yet reported
Northridge Hospital Foundation: Promoting Abstinence for Teen Health Plus (PATH Plus)	North San Fernando Valley of Los Angeles County, CA	Urban; high risk 6 th – 8 th graders; select group of 10 th – 12 th graders serve as peer educators; 70%-95% Hispanic	535 7-8 th grade students; 109 6 th grade students; 65 parents, 19 high school students as peer mentors	Parent workshops and training sessions, advisory councils, newsletters, events	Parent/family outings, representation on the Parent-Student-community Advisory Committee, <i>Let's Talk</i> parent education program, dissemination of PATH Plus newsletters, <i>Talk to Me</i> Annual Parent/Teen Forum	Parent participants said workshop was useful; increased adolescent intentions to be abstinent, self-efficacy, positive outlook, and self-concept
People's Regional Opportunity Program (PROP) - Peer Leader	Portland, ME	Urban adolescents aged 9 to 17 from very low-income public housing neighborhoods; 49% white (includes Middle Eastern descent); 19% black; 32% Asian; nearly all minority families are refugees or immigrants	226 aged 9-14, 50 aged 15-17, 114 parents	Parent workshops, support groups, referral services	Parent support groups; parent education, problem-solving; family connection/values amidst American youth culture; advocacy and support navigating educational/social service systems; resource development and training to become co-provider of services	None yet reported

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Attachment A. Parent Involvement Activities in Selected Title XX Prevention Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Roanoke Chapel Baptist Church-CLIPPERS (Communities Learning and Investing in Pregnancy Prevention; Early Reaching Strategies)	Halifax and Northampton Counties, NC	K-8th and 10th-12th graders; 9th graders participate in Teen Outreach Program (TOP); rural; low-income; high percentage of black and Native American; growing number of Hispanics	6,231 children served	Parent workshops and training sessions, health fairs	Uses <i>Sex Can Wait</i> curriculum for both parents and adolescents; involvement in PTA, health fairs, or other activities; parent participation on IRB to ensure quality of survey items	Increased parent knowledge of and communication with their children; enhanced adolescent academic achievement (motivation) and self-concept; increased pro-abstinence attitudes and refusal skills regarding sex and drug/alcohol use; higher sexual abstinence, school attendance, and graduation rates; lower drop-out, pregnancy and STI rates; increased community awareness and involvement with intervention
Southern Nevada Area Health Education Center - Positive Choices, Positive Futures	Las Vegas, NV	Parents of at risk pre-adolescents and early adolescents; urban; 50% Hispanic; 30% black; 10% white; 5% Asian; 5% Native American	1650 parents 1200 Level 1 workshops, 300 Level 2 classes, 150 Level 3 ABC clubs	Parent classes, support groups	Workshops address risk and protective factors, the pressures children face, and strategies to help parents cope; classes that reinforce and expand the workshop, and parent communication skills; asset Building Clubs (ABCs) provide ongoing support	None yet reported
Switchboard of Miami-“HEART (Holistic Education and Abstinence Reinforced for Teens) Project	Miami-Dade County, FL	Urban; 9th graders; racially diverse	850 diverse 9 th graders to be served each year, 581 actually served	School-based abstinence education including homework assignments completed with parents	Collaborates with Mothers’ Voices: a grass roots agency that educates parents to communicate with their children about sexuality; parent consent; homework; planning parent workshop	Significant increase in adolescent reproductive health knowledge and communication with peers on abstinence/sexual activity, 30% agreed that it is okay for kids their age to have sex, and 68% agreed that the risk of AIDS and other STIs is reason enough to remain abstinent until marriage

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Attachment A. Parent Involvement Activities in Selected Title XX Prevention Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
University of Maryland, Baltimore - Project REACH	Baltimore, MD	Parents and their adolescents aged 9 to 14; urban; predominantly black; 34% living in poverty	180 adolescents yearly, 45-60 parents	Parent classes	Parent or designate participation required; classes cover parenting skills, parent modeling, recognizing a child in trouble, self-esteem, parent-child communication about sex, discipline, healthy relationships and normal adolescent development	None yet reported
Wise Women Gathering Place Community-Based Abstinence Culture (C-BAC) Project	Green Bay, WI	8 th graders at two tribal schools; Native American	60 adolescents, 60 parents/parent figures	Parent workshops, family events, phone calls/home visits, mailings	Family events throughout the year, and parents to chaperone various field trips; provides abstinence information to parents as community members	Family members of at least 67% of the 8 th graders participated in the community outreach presentations, 8 th graders participated in 100% of program

Attachment B. Parent Involvement Activities in Selected Title XX Care Programs

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Arlington Independent School District - PATH (Partners in Action for Teen Health)	Arlington, TX, Tarrant County	Urban pregnant, parenting, or concerned adolescents school-aged or older, including adolescents' children and parents; urban; 47% white; 24% Hispanic; 21% black; 7% Asian; 1% Native American	259 pregnant females, 308 parenting females, 82 parenting males, 264 family members	Intake packet, newsletter, events	Parents informed of upcoming events, given helpful hints for parenting adolescent parents, grandparent newsletter, family dinners, <i>Parents Night Out</i>	72 students returned to school that had previously dropped out, 6% of students had repeat pregnancies
Arlington Public Schools - The Caring Equation	Arlington, VA	13-19 year old pregnant and parenting females, their children, and their male partners; urban; 64% Hispanic; 26% black; 5% white; 5% Asian; 95% qualify for free or reduced price lunch	160 adolescent females and 75 male partners of adolescent females	Workshops, events, referral services, home visit	Communication workshops provided for parents of pregnant adolescents; parents provided appropriate referrals for counseling, health care, etc.; weekly Family Nights; <i>Girls Night Out</i> for Mother's Day for adolescent mother and grandmothers; Recognition Ceremony; Father's Day Picnic for all families; home visits to the young father and parents of both adolescent parents	None yet reported
Atlantic County Division of Public Health - Teen Parent Partnership	Atlantic County, NJ	Pregnant or parenting unmarried adolescents aged 17 or younger; suburban rural and urban communities; 60-90% white; 4-22% black; 3-17% Hispanic; low-income; high infant mortality and adolescent pregnancy rates	100 pregnant or parenting adolescents	Home visits	Family members involved in home visitations whenever possible; educational and vocational counseling are provided for the extended family	At 6 months postpartum: 88% of adolescents remained in school or had graduated from school, increased proportion of adolescent participants engaged in positive health practices and improved parenting attitudes and behavior

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Attachment B. Parent Involvement Activities in Selected Title XX Care Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
BETA Center, Inc.- Project Student Educational Enhancement (S.E.E.)	Orlando, FL	Pregnant/parenting adolescents attending on-site alternative middle/high school; urban; 40% Hispanic; 34% black; 21% white	67 participants, number of parent clients not included in the report	Home visits, events	Family Fun Night events; family counseling offered to adolescents and parents; home visits offered for clients who are homebound after childbirth to provide continuity of care	Statistically significant increase among adolescent participants in physical appearance evaluation and self- esteem, decrease in hopelessness, few repeat pregnancies
Camden Board of Education - School Based Youth Services Program	Camden, NJ	Pregnant and parenting adolescents from Camden High School and Woodrow Wilson High School; urban; 56.4% black; 31.2% Hispanic; 1.9% white; 44% of all households have incomes at or below the poverty level	Per year: 20 pregnant high school students, 32 parenting high school students and their infants and toddlers, 15 dads/partners, and 52 parents or significant family members	Case management, events, workshops	Parent/student counseling sessions with the Case Manager Counselor, which will address adolescent parenting, academic progress, and parent/student relationship; parent/student events and family workshop on sexual and reproductive health issues	None yet reported
Centers for Youth and Families - Young Moms/Healthy Families Young Dads	Pulaski County, AR	Young Moms - pregnant and parenting adolescents aged 12 to 21; Young Dads – adolescent fathers; rural; 80% black; 20% white	75 pregnant and parenting adolescent mothers; 75 babies, 40 adolescent fathers; 200+ grandparents, siblings, boyfriends, and other friends and relatives of the pregnant or parenting adolescent	Home visits, sexuality education, referral counseling services for family members	Home visiting program provides parenting information and modeling; assistance finding preventive and emergency health care; transportation to prenatal and well-baby checkups; education on nutrition and child development; educational/vocational support; assistance with transition to independent living; crisis intervention; help obtaining public assistance and access to other resources as needed; Parent Center provides trainings and workshops for parents, utilizing a curriculum called <i>Parents as Sex Educators</i> (PASE)	None yet reported

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Attachment B. Parent Involvement Activities in Selected Title XX Care Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Children's Hospital - "Raising Adolescent Families Together (RAFT)" Program	Boston, MA	Pregnant and parenting adolescents; 6 under 14 years; 87 15-17 years; 103 18 years or older; urban; predominantly black or Hispanic	188 females, 22 males	Case management, support groups, community advisory board	Comprehensive medical care, parenting support groups, employs some case management	82% of adolescents enrolled or finished school, 16% had repeat pregnancies, 93% of children received immunizations,
Children's Hospital - "The Teen-Tots Program"	Buffalo, NY	Pregnant adolescents aged 12 to 21; urban; 57% black; 21% white; 12% Hispanic; 10% other; 26% below the poverty level	50 pregnant adolescents in year one, a minimum of 50 infants in Teen-Tots, 10-15 parenting males	Workshops, participation in adolescent health care	Provides educational sessions for family members of participating adolescents; encourages family member attendance at health care appointments for both the pregnant adolescent and the child	None yet reported
Children's Hospital and Health Center - Reaching Adolescent Pregnancy (RAP)	San Diego, CA- Imperial County communities - Oceanside, Carlsbad, Vista, San Marcos, Escondido, Encinitas	Pregnant/parenting adolescents (including adolescent fathers) aged 10 to 19; suburban; 46-73% white; 22-43% Hispanic; 4-8% Asian/other; 1-10% black; low-income; high adolescent pregnancy rates	113 pregnant/parenting clients during the first year, 30% of the babies' fathers will be involved, 113 extended family members of the adolescent girls or boys families	Home visits, advisory board, workshops, referral services	Grandparents invited to participate in parenting classes; families are members of the Advisory Board; home visits are conducted by multi-disciplinary team and involve grandparent in initial visit	16% of adolescent fathers involved with the program
Community Counseling Center: "New Directions" AFL Project	Oklahoma City, OK, and surrounding areas	Pregnant or parenting high school students; urban and rural; mostly Hispanic; low-income	200 parenting or pregnant female students	Events, focus groups, home visits, case management, referral services, parent support groups	Family events, adolescent parent-child focus group, program presented to adolescents and parents at initial meeting; Family Advocates facilitate parent support group sessions for parents of adolescent parents; counseling, prevention education, and basic health services for siblings and family member assessed through home visits and implemented through case management	None yet reported

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Attachment B. Parent Involvement Activities in Selected Title XX Care Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Children's Shelter- Project MAS (Mothers and School)	San Antonio, TX	Adolescents in the San Antonio Independent School District; urban; 85.5% Hispanic; 9.9% black; 4.3% white; more than 80% are economically disadvantaged	190 pregnant girls and their families served in Year One, 229 by the end of Year Two, 266 by the third year; including parenting adolescents from the previous years, the total number of pregnant and parenting adolescents is estimated to be 685	Sexuality education, workshops	Counseling for immediate and extended family members; <i>Can We Talk</i> curriculum administered to parents of pregnant and parenting adolescents; parents encouraged to participate in all project activities with the adolescents; family members invited to workshops	98% of adolescent participants did not have a subsequent birth, 100% returned to school, 93% of participating seniors graduated from high school
Delaware Adolescent Program Inc. (DAPI): Project Enhance	Bridgeville, DE	Pregnant and parenting adolescents up to 18 years of age, adolescent fathers, and grandparents; 60% black; 27% white; 8% Hispanic; 5% Other	154 adolescents served 429 parents, siblings, grandparents, other served	Workshops, support groups	Grandparents participate in workshops and grandparent groups, meetings with outreach staff	None reported
Garrett County	Garrett County, MD	Pregnant and parenting adolescent aged 19 or younger, their partners, and immediate family members; low-income; rural	21 currently and newly pregnant and parenting adolescents, 21 infants, 9 parenting males, and 32 other family members	Home visits, support groups, advisory board, camp, classes	Family support plan developed and adjusted based on home visits; separate support groups for parents of adolescent mothers and pregnant/parenting adolescents; parents of adolescent mothers participate on the Healthy Families Garrett County (HFGC) Advisory Board; 3-4 day intergenerational Nurturing camp and classes offered each summer for adolescent parents and family members	Very low (0%-14%) parent attendance at support groups; 21 adolescents, parents, and support persons attended nurture camp; adolescents demonstrated healthy parenting behaviors at follow-up; 78% did not have a repeat pregnancy within 2 years

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Attachment B. Parent Involvement Activities in Selected Title XX Care Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Healthy Connections, Inc. (HCI) -The Western Arkansas Adolescent CARE outreach Program	Polk County, AR	Rural “at risk” families; 60.1% of families live below 200% of the federal poverty level	80 at-risk families, 699 parents in group education classes	Home visits, sexuality education	Frequency of home visits assigned on basis of abuse/neglect or environmental risk factors present in the home; presentations about sexuality and parenting education in area schools and Head Start parent meetings, free video lending library	Reduced rates of unwanted pregnancies among adolescent female participants, no low birth-weight infants or child deaths
La Clinica de Raza-Clinica Alta Vista (Teen Clinic)	Oakland, CA	Pregnant and parenting adolescents aged 12 to 19, their partners, and children; primarily Hispanic; urban	194 pregnant/parenting adolescents, 101 infants, 18 adolescent fathers, 99 male partners	Case management	Family members (including parents of adolescent parents) have access to medical providers and case managers	Reduced incidence of low birth weight infants and repeat adolescent pregnancies, low father involvement due to conflicting work schedule
Mercy Hospital of Pittsburgh	Pittsburgh, PA	Urban pregnant and parenting adolescents and preadolescents; 74% black; 24% white; 2% bi-racial; low-income	175 to 250 pregnant preadolescents/ adolescents each year; 100 adolescent fathers; 150 to 200 parents of adolescents; 150 infants and children born to adolescents; 250 mentors, teachers, counselors, siblings	Home visits, events, education workshops	Educational, medical, and psychosocial support offered by indigenous outreach staff through home visits; structured and informal parent education, utilize parent-child communication materials and training developed by the Mercy Hospital Health Education Center, <i>Time Out for Parents</i> meets monthly during the year and for 6 weeks in the summer, <i>Pampering Parents Night</i> candlelight dinner for parents	Only 3% of adolescent participants became pregnant while enrolled in the program, 92% of the girls graduated from high school or were making progress toward graduation

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Attachment B. Parent Involvement Activities in Selected Title XX Care Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Minneapolis Public Schools	Minneapolis, MN	Urban pregnant and/or parenting adolescents aged 18 or younger; male and female adolescents and their family members; 83% of adolescents come from families with income levels below 135% of poverty	140 pregnant and/or parenting adolescents during the first year, 104 pregnant and/or parenting adolescents during Year 2	Home visits, case management	School-based case management interventions for adolescents; parents invited to evening parent-child classes; weekly case management meets to review the adolescents' status and develop service plans to ensure quality health practices for the adolescent and infant, school enrollment and success, and access to community services, such as daycare and transportation; some parents were informed of the status of child's progress with the service plan	97% of adolescents stayed in school or graduated, only 4% had a subsequent pregnancy during program involvement
Northern Virginia Urban League, Inc.- Alexandria Resource Mothers (ARMS)	Alexandria, VA	Urban pregnant and parenting adolescents aged 18 or younger, the baby's father, young siblings aged 11 or younger; 45-59% white; 23-26% black; 51% qualify for free or reduced price lunch	75-100 adolescents, 50 younger siblings and neighbors; 130 participants total	Home visits, focus groups	Home visits conducted by resource mothers who assist with transportation to prenatal care and meet with the adolescent and her family to develop plans for the future (e.g. school, delay repeat pregnancy).	70% of adolescents graduated from high school, obtained employment, or other opportunities; 90% used a family planning method; 95% did not have a repeat pregnancy
Promise House, Inc.	Dallas, TX	Urban adolescent girls, aged 17 and younger, who are unwed and pregnant, or already parenting, their families, and adolescent fathers; 47% white; 26% Hispanic; 23% black; 4% other; 27% live in poverty	200 youth their families and the adolescent fathers	Case management, events	Case managers serve the entire family of the pregnant or parenting adolescent; family therapy offered to every youth that enters the program; family members invited to agency events; some participants are residents of Promise House and it is unclear how/if their parents are involved	85% of the adolescent clients' parenting skills have improved, 19 of the clients graduated from high school or acquired their GED, 29 are or were enrolled in high school or GED program, two subsequent pregnancies

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Attachment B. Parent Involvement Activities in Selected Title XX Care Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Rural America Initiatives-Project Takoja-Teen Survivor's Circle	Rapid City, SD, and the nearby Ellsworth Air Force Base community of Box Elder and Black Hawk	Pregnant and parenting adolescents aged 12 to 18; Native American; low-income; many are abuse victims and from single-parent households in an area with higher than state average adolescent pregnancy rates	80 pregnant/parenting adolescents, 20 male partners, and 20 extended family members	Home visits, workshops, events	Home visits assess level of family support for parenting adolescent; families are involved in day care, field trips, and holiday celebrations, and trainings or workshops	None yet reported
Saint Paul Public Schools: CAPSS Program (Children and Adolescent Parents Support and Self-Sufficiency)	St. Paul, MN	Urban; high school-aged pregnant or parenting students; mostly black and Asian (Hmong); low income	234 female clients, 87 pregnant adolescents, 214 adolescent mothers; 87 infants; 31 adolescent fathers, 6 male partners; 81 parents, siblings, in-laws, and grandparents of participants served	Home visits, newsletters, events, case management	Case management for adolescent parents which may involve the larger family unit, including grandparents; newsletters; open houses; attendance at conferences; Individual Learning Plan conferences; home visits; and phone contact	Fewer repeat adolescent pregnancies among treatment group
Siouxland District Health Department - Adolescent Family Life Project	Woodbury County, IA; Union County, SD; Dakota County, NE	Pregnant or parenting adolescents aged 13 to 19 and their families and support network; predominantly white; primarily urban	50 pregnant or parenting families served in Year 1, 75 clients each subsequent year	Home visits, events	Family Support Worker encouraged to meet adolescent mom when her support person is available (support person may be extended family); Halloween themed family event; Mid-winter family Carnival	40% of adolescents initially reported using condoms, increasing to 67% a year later
Services United for Mothers & Adolescents, Inc. (SUMA)	Cincinnati, OH	Suburban and urban pregnant and parenting mothers and fathers; 37% 18 or older; 30% aged 11 or younger; 29% aged 15 to 17; 2% aged 12 to 14;;76% black; 24% white	110 pregnant or parenting mothers; 23 grandparents or foster parents; numerous siblings, relatives, or partners	Home visits, events	Participation of families and fathers in home visits and special events	Low father participation; adolescents were more likely to report sexual activity 6 months after intake, but were more likely to be using contraception

(continued)

Attachment B. Parent Involvement Activities in Selected Title XX Care Programs (Continued)

Program Name	Location	Program Population	Program Size	Parent Involvement Strategy	Interventions	Outcomes
Truman Medical Centers	Kansas City, MO	Urban pregnant and parenting adolescents aged 13 to 18, their parents, partners, and/or other significant people; predominantly black	50 people attended Grandparent Conference, 600 monthly newsletters go out, 10 support groups serving more than 280 grandparents/care givers	Events, newsletters, support groups	Grandparent newsletter; family support and education programs facilitate grandparent and significant others' presence in the lives of the children; annual 1-day Grandparents' Conference <i>Responding to the Call</i> ; topics included a keynote speaker, children's mental health, child abuse and neglect, and discipline and punishment, opportunities for networking and recognition, and entertainment; conference put on by AARP and Family Friends Program.	Parent participants in Grandparent conference responded positively about their experience and requested more information on grandparents' rights, child development, balancing the relationships between child and grandchild, and signs of drug use; Decreased number of subsequent births for 5th straight year among adolescents; more adolescents used hormonal contraceptive methods; improved adolescent academic/vocational achievement