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ORIGINAL ARTICLE

Parent perspectives of engagement in the strengthening families program: An evidence-based intervention for families in child welfare and affected by parental substance use

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Abstract

Despite growing use of evidence-based parenting interventions (EBPIs) in child welfare settings, few qualitative studies have obtained parents' direct views and feedback on these programs. Further, engagement in EBPIs continues to present challenges in a child welfare context, particularly for parents affected by substances. We sought to understand parents' experiences of the supports and barriers to engagement in an EBPI. Semistructured interviews were conducted with a purposive sample of 10 parents who were involved in child welfare and a family drug treatment court, affected by parental substance use, and had recently completed the Strengthening Families Program. Our results indicated that barriers and supports comprised individual, provider, and programmatic factors. A prevalent theme was providers' abilities to build supportive helping relationships and facilitate a dynamic group effectively. Also significant were pragmatic program features that directly assisted families' access and ongoing participation, such as transportation and scheduling.

KEYWORDS

child welfare, evidence-based practice, foster care, misuse (parental), parenting/parenthood, substance

1 | INTRODUCTION

Families served by child welfare systems for parental substance use face unique challenges. Parents affected by substance use are more likely to exhibit neglectful behaviours, characterized by a high degree of instability in multiple life domains (Grella, Needell, Shi, & Hser, 2009). Children who have experienced maltreatment and parental substance use are more likely to have experienced trauma, witnessed violence, and have behavioural problems as compared with children without these experiences (Staton-Tindall, Sprang, Clark, Walker, & Craig, 2013). Parental substance use poses known risks to both physical and emotional safety of children and undermines children's healthy development and well-being (Akin, Brook & Lloyd, 2015a; Haight et al., 2005; Haight, Ostler, Black, Sheridan, & Kingery, 2007; Hohman, Oliver, & Wright, 2004).

Parental substance use is associated with multiple forms of maltreatment and estimated to contribute to 11–14% of child protective services referrals, 18–24% of substantiated maltreatment cases, and 50–79% of foster care cases (Testa & Smith, 2009). Children in foster care because of parental substance use are less likely to be reunified and experience longer times in foster care prior to reunification (Brook, McDonald, Gregoire, Press & Hindman, 2010; Green, Rockhill, & Furrer, 2007). When families do reunify, they experience higher rates of re-entry (Barth, Gibbons, & Guo, 2006; Brook & McDonald, 2007).

Child welfare opinion leaders have identified evidence-based behavioural parenting interventions (EBPIs) as a critical strategy for addressing maltreatment and improving child welfare outcomes (Barth et al., 2005; Horwitz, Chamberlain, Landsverk, & Mullican, 2010), including for families affected by substance use (Barth, 2009). Brook and colleagues have also shown that a group-based EBPI promotes

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reunification among parents affected by substances with children in foster care (Brook, Akin, Lloyd, Johnson-Motoyama, & Yan, 2016; Brook, Akin, Lloyd, & Yan, 2015; Brook, McDonald, & Yan, 2012). Despite efforts to expand EBPIs to child welfare, a formidable barrier is parental engagement and service completion as an intervention has little chance of improving outcomes unless families engage in the intervention (Berliner et al., 2015). Dropout rates in child welfare range from 30% to 88% (Beasley, Silovsky, Ridings, Smith, & Owora, 2015; Chaffin, Bonner, & Hill, 2001; Damashek, Doughty, Ware, & Silovsky, 2011) and may be particularly high among parents affected by substances (Akin & Gomi, 2017; Marsh & Smith, 2011). To maximize the potential impact for positive outcomes among this target population of families, challenges with parental engagement in EBPIs warrant more research.

1.1 | Definition of engagement

Engagement has been examined in multiple ways. Scholars have centred engagement within general child welfare practice, offering important conceptualization of engagement as positive involvement in a helping process. Specifically, Yatchmenoff developed and tested a four-factor, 19-item engagement scale for child protective services. The four factors comprise receptivity, buy-in, working relationship, and mistrust (Yatchmenoff, 2005). Others have defined engagement as initial involvement in services, acceptance of services, attendance, compliance, retention, and completion or adherence to an intervention's minimum requirements (Yatchmenoff, 2005). This study considers initial engagement as closely aligned with active participation and inextricably connected to intervention completion. In short, the expected outcomes of EBPIs rely on engagement and its link to intervention completion.

1.2 | Frameworks for considering parental engagement

This study was informed by two conceptual frameworks. First, the growing literature on implementation science and evidence-based interventions provides an important foundation for understanding multiple aspects of implementation (Mildon & Shlonsky, 2011). Implementation scientists have developed dozens of frameworks to describe and organize a wide range of factors that may influence the success of implementation (Moullin, Sabater-Hernández, Fernandez-Llimos, & Benrimoj, 2015; Nilsen, 2015). In a prior review of child welfare implementations, six implementation factors relevant to the study of EBPIs were identified: (a) process, (b) provider, (c) innovation/program, (d) client, (e) organizational, and (f) structural (Akin, Mariscal, Bass, McArthur, Bhattarai & Bruns, 2014). Second, Kazdin's model of barriers to treatment participation is pertinent to an exploration of parental engagement in EBPIs. Kazdin reported that two decades of studies have shown that the most robust predictor of participation in parent management training (an EBPI) has been parental report of barriers to participation, comprising four areas: (a) stressors that compete with participating, (b) perceived treatment demands, (c) perceived treatment relevance, and (d) obstacles in relation to the practitioner (Kazdin, 2017).

1.3 | Barriers and supports for parental engagement in parenting interventions

A sizable literature exists on EBPIs and parental engagement and completion of these programs (for a detailed review, see Akin & Gomi, 2017). The vast majority of studies used quantitative approaches to examine factors that contribute to parental engagement and/or treatment completion. Although multiple factors have been studied, most could be characterized within an implementation framework as client factors, comprising demographics, clinical characteristics, socio-economic factors, and caregiver functioning. Across this wide range of client factors, few consistent and distinguishable patterns have been found (Akin & Gomi, 2017; Morawska & Sanders, 2006), leaving the field with a lack of consensus on who completes EBPIs and who does not (Knox & Burkhart, 2014), and little insight into the reasons why families stop coming to treatment (Nock & Ferriter, 2005). These quantitative studies have largely omitted the study of the other implementation factors, such as provider, organization, or innovation/program characteristics.

Beyond quantitative research, qualitative studies on parental engagement in parenting or child welfare programs were reviewed. Among this literature, individual/client factors were commonly considered a potential obstacle to engagement. One study of interviews with caregivers of a Multiple Family Group suggested that programs must attend to individual factors, which may be either clinical or pragmatic, such as parental mental health and parents need for transportation, respectively (Gopalan, Fuss, & Wisdom, 2015). Other studies were distinct in revealing the involuntary and potentially coercive nature of child welfare services, calling out parents' experiences of fear, intimidation, and powerlessness (Ayón, Aisenberg, & Erera, 2010; Buckley, Carr, & Whelan, 2011; Dumbrill, 2006). Koerting et al.'s (2013) synthesis of 12 parenting studies echoed findings on parents' psychological barriers, which may include fear, worry, lack of confidence, shyness, stigma, and distrust. Another study based its findings on a literature review and case study of an EBPI (the Incredible Years) also identified pragmatic strategies for reducing individual's access barriers (e.g., increase program accessibility and improve recruitment processes; Axford, Lehtonen, Kaoukji, Tobin, & Berry, 2012).

This qualitative literature also revealed recommendations that centred on provider factors, which would support Kazdin's model and its emphasis on effective provider–client relationships. In a study of mandated family group meetings, researchers indicated that providers' ability to promote parents feeling respected, heard, and supported were key (Darlington, Healy, Yellowlees, & Bosly, 2012). Similarly, a study of interviews with parents investigated by child protective services found that parents reported greater engagement when they perceived caseworkers as competent, using clear communication skills and providing emotional or concrete supports (Schreiber, Fuller, & Paceley, 2013). Indeed, much of the existing literature supports the notion of the worker–client relationship as central to the helping process and indicates that providers' approach and skills are vitally important to parents' participation and completion (Arbeiter & Toros, 2017; Beasley et al., 2015; Buckley et al., 2011; Gopalan et al., 2015; Kane, Wood, & Barlow, 2007; Koerting et al., 2013; Olofsson, Skoog, & Tillfors, 2016; Staudt, 2007; Turney, 2012).

Program factors were prominent in the reviewed literature (e.g., Beasley et al., 2015; Gopalan et al., 2015; Koerting et al., 2013). As described below, program factors align with Kazdin's areas of treatment demands and treatment relevance. For example, the case study of the Incredible Years suggested that EBPIs must have realistic expectations for attendance and provide opportunities for make-up sessions (treatment demands; Axford et al., 2012). Both conceptual literature (e.g., Morawska & Sanders, 2006) and empirical studies (Gallitto, Romano, & Drolet, 2017; Gopalan et al., 2015) made recommendations in accordance with treatment relevance (e.g., give rationale for homework; encourage parents to own goals; make activities fun/helpful; use simple language; and include skill practicing). This area of scholarship has also extended to research on cultural adaptations of parenting programs. In a study of Parent Management Training Oregon model, Domenech Rodríguez, Baumann, and Schwartz (2011) described cultural adaptations for Latino parents/communities. Consistent with the concept of treatment relevance, they found that making cultural adaptations, including using content reflective of the target group and treatment processes in keeping with cultural values of the target group, could enhance engagement by marginalized communities.

Collectively, this literature highlights the current knowledge base on barriers and engagement, indicating that various programmatic, provider, and client factors are related to engagement in child welfare and EBPIs. Although studies have documented the effectiveness of EBPIs, no empirical studies, to our knowledge, have been conducted on the specific EBPI of this study with the purpose to gain the perspectives of parents. Further, although engagement in child welfare services has been well-documented as a critical need for successful outcomes (Cooper Altman, 2008; Gladstone et al., 2012; Littell & Tajima, 2000; Mirick, 2014; Staudt, 2007; Yatchmenoff, 2005), more studies are needed that include parents involved in the child welfare system to seek their input on the topic. Indeed, we identified only three qualitative studies with parents as the primary data source that considered engagement in EBPIs among families involved in child welfare (Gallitto et al., 2017; Gopalan et al., 2015; Lewis, Feely, Seay, Fedoravicis, & Kohl, 2016) and none with an explicit sample of parents affected by substance use. Given the complexity of parental substance use and child maltreatment, as well as the substantial challenges with engaging child-welfare involved parents, we sought to hear directly from this target group of parents. In sum, this study sought to fill a gap in the literature pertaining to parent perspectives of EBPIs in child welfare, specifically aiming to expand parent voices and views on the barriers and supports to engagement.

2 | METHOD

2.1 | Project setting

This study was part of a larger, federally funded evaluation of family drug treatment courts (FDTC) in one Midwestern state. The study was conducted at the end of a 3-year evaluation and aimed to enhance the capacity of communities to respond to trauma-related needs of child welfare involved families participating in FDTCs. Five counties were engaged by the state office of the Supreme Court to implement the Strengthening Families Program (SFP) and Celebrating Families!. Because Celebrating Families! was eventually dropped from the project, the current study examined the SFP. Semistructured phone interviews were conducted with parents who participated in and completed SFP. The Institutional Review Board of the University of [blinded] approved all of the study's procedures.

SFP was originally developed in the early 1980s in a National Institute on Drug Abuse randomized trial with children of parents with a substance use disorder. Since then, numerous studies have cited its effectiveness for improving parenting practices, family relationships, parent depression, parent substance use, and children's behaviours (Kumpfer, Alvarado, & Whiteside, 2003; Kumpfer, Whiteside, Greene, & Allen, 2010).

SFP includes components for parents, children, and family. The program is delivered in a closed-group format, with 14 consecutive weekly sessions lasting from about 3 hr, guided by a manualized age- and developmentally centred curriculum. Sessions begin with a family meal, then children and parents attend age appropriate groups, and the family is brought together again for supervised practice and interaction. The format includes both didactic and experiential activities.

Notably, the SFP does not centre on substance use treatment or education. Only one of 14 sessions focuses exclusively on substance use and recovery. In other sessions, substance use information is interspersed throughout, and the focus is on session content, risk reduction strategies, parenting, and family interactions. Weekly topics include physical, mental, social, and emotional development of children; developmentally appropriate expectations for children; promoting children's desired behaviours though increased attention, positive reinforcements, and behavioural goal statements; stress and anger management; communication training; alcohol and drug education; problem solving; compliance requests; limit-setting; generalization and maintenance; and children's behaviour programs.

2.2 | Sampling and recruitment

This study obtained a purposive sample of program completers. Providers within the five FDTCs called and distributed recruitment postcards to all SFP completers between December 2015 and December 2016. Ten participants were recruited.

2.3 | Procedures

Once participants expressed interest in the study, a consent form was provided that explained the study purpose, voluntary nature of the study, potential risks and benefits, and participants' right to cease study participation at any time. As part of the consent process, participants were assured that current and/or future services would continue regardless of their study participation.

Participants conducted interviews in a private room at the provider's office or from a location of their choice. The interviewer called participants at a scheduled date, time, and location to review the consent form. Participants signed the consent prior to the start of the interview. The researcher then conducted a 60- to 90-min

interview with the participant. Interviews were semistructured and conducted by a single researcher, following an interview guide and predetermined protocol, which was developed by the researchers and reflective of the study's methodology. The interview guide's main topics were participants' attitudes towards the intervention's structure and features and perceived facilitators and barriers to participation in the intervention. As part of the larger project's purpose to understand trauma-related needs, participants were also invited to complete the 10-item Adverse Childhood Experiences scale (ACEs; Felitti & Anda, 2010). Participants received a $25 gift card to compensate their time.

Interviews were audio-recorded, transmitted securely for verbatim transcription to a HIPAA-compliant transcriptionist. Transcriptions were reviewed for accuracy and imported into NVivo 10 for coding.

2.4 | Data analysis

Transcripts were independently analysed in an asynchronous fashion by two researchers using a modified version of thematic analysis (Braun & Clarke, 2006) and following a five-step process. First, researchers read transcripts to become familiar with the data themes. Second, an initial list of codes was generated based on the data. Some of this coding was expected by researches to be present, as it was prompted a priori, through a question on the interview guide; other information was new, inductively derived, and emerged from the data. Third, codes were combined into themes representing categories of data. Fourth, themes were reviewed to ensure they fit the breadth and range of data that emerged. Researchers reread the transcripts to ensure that any data that were not included in a code category did not exclude any consistently expressed idea, concept, or parent perspective. Further, researchers double-checked the work to ensure that codes, which were collapsed into themes, were accurately aggregated. Finally, the themes were named and defined. To strengthen rigour and trustworthiness, after the second researcher completed coding, the research team met to address questions, discuss findings, and confer trends across code categories. The second researcher was then responsible for comparing the findings between the first and second coders, and collapsing code categories between the two sets of coding. This activity was conducted in consultation with the study team. The results were largely consistent between coders. The research team discussed findings, identified additional materials, and addressed the fit of the findings to the interview guide and process.

3 | RESULTS

3.1 | Sample characteristics

Study participants were 10 parents who had completed the SFP. Ninety percent of parents were mothers and one was a biological grandmother with legal custody of the child. Most participants identified as White (60%); 20% identified as White and American Indian; 10% identified as Hispanic and American Indian; and 10% had unknown race/ethnicity information. Regarding family status, information was available on eight of the participants, and seven of these eight participants (88%) were single parents. These participants reported mainly low incomes; income data were available on eight of the participants and showed that six of the eight participants (75%) had incomes between $0 and $10,000. One of these eight participants, one was employed full-time; three were employed part-time; and the other four were not employed. Finally, the administration of the 10-item ACEs (n = 10) indicated that the average score was 5.2 (SD = 2.4). Eighty percent of the participants had an ACEs score of ≥4, and 50% had a score of ≥5. According to a report by the Center for Disease Control and Prevention (2010), a probability sample of adults indicated 41% of adults reported no ACEs, 22% reported ≥1, and 10.3% of females reported ≥5 ACEs. Thus, this sample of parents reported much higher ACEs than the general population.

3.2 | Barriers and supports for parental engagement

Study participants described their perspectives on the factors that influenced meaningful involvement in the SFP. They included both barriers and supports to engagement, which we have grouped into three areas: individual factors, provider/relationship factors, and programmatic factors.

3.2.1 | Individual factors

A few parents described individual characteristics or feelings about the program as primarily barriers to participation. One parent indicated that being shy about meeting new people made it difficult in the beginning. Another parent said a barrier was her own defiance to participating in a required program: "I'm defiant, just really dislike that I didn't have an option." A few of the participants also expressed feeling as if their group did not apply to them or was unnecessary, pointing to the issue of treatment relevance. "I never really did the homework; once again I felt it wasn't applicable." Only one parent expressly said that her enjoyment of the program helped her stay engaged.

3.2.2 | Provider/relationship factors

Numerous parents spoke highly of the SFP group instructors, drawing out the importance of their relationship with the provider. Instructors were described as "very well prepared … they knew what they were talking about … they've done this before" and "they are very hands on and positive and friendly". Parents valued instructors who were good with their children: "I have a four year old who is very active. It was nice that (the instructors) were able to help her to calm down and pay attention a little bit and have a little bit of fun and learning at the same time." Parents established relationships with their SFP instructors that helped them stay engaged. One parent explained

> *I just love her … she's really therapeutic, she's not pushy, but she lets me know what works for her and what doesn't work for her. Then she puts it out there like this works, I've seen it work. Then there was a couple of other instructors that were really laid back, and shared from their own experience, and I think that in itself is helpful.*

In contrast to the support described above, one participant discussed frustration with an instructor who she felt was "too personal." She described how the instructor came to other service meetings the

parent had outside of the SFP group and how she felt this was inappropriate.

Within the area of provider factors, parents also mentioned group dynamics and how the instructor's facilitation of these dynamics could support or hinder engagement. Group dynamics included the ways in which parents perceived other group members and instructors. Group dynamics were a barrier when parents perceived other parents or instructors as disruptive, negative, or disrespectful. One participant described her group as "… [V]ery chatty. That was probably the only thing I actually had an issue with is side talk." The same participant indicated that "Some people had (an) attitude about being there and that kind of made it irritating." Another participant explained

> *… People in the class were really disrespectful. They ruined the class at times for me because they were all talking over each other and the coordinator would have to tell them to be quiet and it was kind of kindergarten-ish.*

Parents' comments showed that provider factors were important because they could serve as an engaging factor when parents had positive feelings about their instructor and the instructor was able to facilitate rapport building between the instructor and parents, as well as among the group members. One parent indicated that "A lot of my friends were doing it as well so that really made a comforting impact" on her involvement in the group. Thus, provider factors—particularly relationships with instructors and their abilities to promote relationships among parents—could act as both a barrier and a method of engagement.

3.2.3 | Program factors

Program factors discussed by parents touched on three subthemes: timing, format, and transportation. According to parents, the timing of the SFP group could function as both a barrier and engagement strategy, although among this set of parents it acted primarily as an engaging factor. The main barrier was regarding the timing of the group and revealed issues related to treatment demands. One parent specified that the group "… would be better a little earlier, maybe like an hour earlier because they (the children) would be tired by the time it would be, you know, almost done or whatever." Another parent agreed with the timing issue and suggested weekend groups might be better because "… it's always exhausting after school and after work for everybody. They don't really put their all into it. Or they let it roll off 'cause they're so tired. It's like, you know, 'whatever, get this over with' … I've seen a lot of that." A third parent said that weekday evenings were difficult because "I had so much other stuff going on. I didn't like being there that late."

Primarily, the timing and structure of the groups helped parents stay engaged in the program. Most participants liked that the group was scheduled around dinnertime. "We would have dinner and then the group and then coming together for the group, too, so it was kind of great timing because it was after everything throughout the day." Another parent said, "It was actually pretty perfect format and the time of day because 5:30-7:30 which is like a good time because we have dinner right when we get there."

In terms of the format or structure of the group, parents discussed how they appreciated having dinner first, then separating into parent and child groups, and then coming back together for family time. Parents also felt different program features helped them to stay engage. One parent said that she felt "it was something that was required that I needed to do in order to get my kids back." Two others discussed the importance of having make-up sessions or opportunities when they had to miss a group due to illness or other life circumstances. "I did miss one activity and then I went back over it and they got to let me take my book home and I thought … that was great." When asked what helped her complete the program, one parent said

> *… them being willing to work with me, me being able to take a week off if (my son) was contagious, and them wanting me there, and cheering me on. 'You can do it, you can make it', that kind of thing.*

One parent said she felt the group was childish: "I felt like it could have been presented in a more adult forum than not a child. It's, kind of, I wish it would have been more professional like."

Another prominent program factor was transportation. Parents' comments on transportation revealed that it could be a major stressor or obstacle to their engagement in the parenting group. Two parents explained the transportation difficulties. "It's just it was hard because I don't have any transportation. I have to take the bus and so when it got done, it ran after, the bus has already stopped, but my mom was a great help. If it wasn't for my mom, I wouldn't have been able to do that class." When asked what made it difficult to participate, another parent said, "It was the transportation for me, 'cause I don't have transportation. I had to get picked up and then they'll pick our kids up and a couple times we were late." In contrast, another parent described how the SFP group provided transportation and that helped her stay engaged: "They accommodated everything, like because I don't have my own transportation so they provided transportation for the participants who didn't have vehicles."

4 | DISCUSSION

This study aimed to use parent perspectives to understand how barriers and supports to parents' meaningful engagement in the program and their eventual completion of the program. Given the negative consequences of parental substance use and lengthy foster care stays (Akin, Brook & Lloyd, 2015b; Haight et al., 2005; Haight et al., 2007; Hohman et al., 2004; Testa & Smith, 2009), it is imperative to improve upon programs for this target population. This study contributes to the empirical literature on EBPIs by providing an understanding of how parents perceive these programs. Our analyses were informed by two overarching frameworks: (a) an implementation science framework, which outlines six broad implementation factors (client, provider, innovation/program, organization, structure, and process; Akin et al., 2014) and (b) a model of barriers to treatment participation, which includes four main areas (stressors/obstacles, treatment demands, treatment relevance, and relationship with provider; Kazdin, 2017). With regard to the implementation factors, this study's findings showed that parents' perceptions centred on three factors: individual/

client, provider/relationship, and programmatic factors. Additionally, our analyses revealed that all four areas of the barriers to treatment participation model were supported. These findings are discussed in light of the current literature on parenting interventions and parental engagement.

Individual factors were identified by parents, though their prominence as a theme was less punctuated than other themes. This is to say that individual factors did not emerge thematically across participants, except those few that generally described resistance to the parenting intervention. These findings are consistent with prior studies that have identified a range of individual factors that influence engagement in the child welfare context, including parents' experiences of fear, shyness, stigma, distrust, intimidation, powerlessness, etc. (Buckley et al., 2011; Dumbrill, 2006; Koerting et al., 2013). The coercive and involuntary aspects of the child welfare system likely contribute towards these views. One implication may be for EBPI providers to acknowledge the system's power imbalances and provide a safe, confidential space for parents to give voice to their experiences of it.

Our findings, such as some of the existing EBPI and child welfare research (Arbeiter & Toros, 2017; Beasley et al., 2015; Gopalan et al., 2015; Kane et al., 2007; Koerting et al., 2013; Schreiber et al., 2013), suggest that provider factors may play a critical role in parental engagement and intervention completion. More specifically, this study's parents discussed the importance of provider competence in establishing good relationships between parents and providers and in facilitating an effective group process. As found in prior research, parents valued providers who were caring, nonjudgmental, strengths-oriented, and supportive. Further, parents' noticed and appreciated providers' positive interactions with them and their children. Regarding group dynamics, providers should establish ground rules about expected behaviour in order to minimize interpersonal conflict or rude behaviours. Along these lines, team-building activities could be facilitated to increase rapport among participants in order to encourage parents to establish relationships and increase their motivation for attending groups. Additionally, providers should attend to interpersonal issues or disrespectful behaviour as it arises. In this way, facilitators should be trained on relationship development and establishing appropriate boundaries with participants. This could help reduce the feeling that some participants had that their instructor was too engaged in their case outside the parenting group.

Consistent with the existing literature, this study's parents identified programmatic factors as one of the most significant themes for promoting parental engagement. Especially important are the specific factors parents identified that helped them stay engaged or acted as barriers to participation. Understanding these factors may help improve parents' involvement, engagement with the material, and completion rates. Several of these factors are reflected in the current literature. For example, Gopalan et al. (2015) and Koerting et al. (2013) identified group location, setting, and transportation as important factors to engagement, and Axford et al. (2012) suggested the use of make-up sessions parents who miss a meeting. These findings demonstrate the importance of addressing specific and concrete features of the program in a way that is meaningful to parents and will eliminate logistical barriers to their engagement (Kazdin, 2017). Our findings indicate that to minimize barriers and optimize parents' participation, child welfare systems should consider a range of logistical issues including scheduling options for holding parenting groups (e.g., holding them on weekends). A survey of potential participants could be administered prior to scheduling the SFP in order to establish the best day/time for the meetings. Further, transportation is a substantial barrier for some parents and solutions should be fully considered when implementing group-based EBPIs. Ignoring these logistical barriers to participation and engagement fails to consider basic supports necessary to set parents up for success.

Two additional specific program factors were important to this study's participants: sharing a family meal and having a designated time for family interactions. Although these components are essential and integrated in SFP, they are not included in all group-based EBPIs and we found that they were mentioned only occasionally in the existing literature (Gopalan et al., 2015). These were important aspects of the program, which promoted and increased parents' engagement and enjoyment. As a practical matter, the family meal may address the treatment demands issue (Kazdin, 2017) by helping families manage the addition of a group into their busy schedules. It may also support the area of provider/relationship factors as it allows time for building rapport with the provider and peer parents. Further, the designated time for parents and children to interact seems to support the treatment relevance area (Kazdin, 2017) by ensuring an opportunity for parents to practice newly learned skills and apply them to their own families. Although other scholars have discussed similar components as best practices for family interventions (Kogan et al., 2012; Small, Cooney, & O'Connor, 2009), additional research could help confirm their role and relevance for parent engagement and successful completion of EBPIs.

5 | LIMITATIONS

This study has several limitations worth noting. First, telephone interviews were used due to the large distance between participants and between the participants and interviewer. In-person interviews were not feasible given resource limitations and the duration of the study (i.e., 12 months). Although phone interviews precluded direct observation, this limitation was lessened by the use of digital recordings and verbatim transcription. Second, although this study is strengthened by its inclusion of participants from all participating counties, the sample included only parents who completed the intervention. It is unknown whether this sample of completers may have included parents who had already been more open to or engaged in the intervention. Parents who dropped out of the program may have encountered additional or different barriers than the parents in this study. Future research should be conducted with a broader group of parents to compare and contrast the perspectives of those who do and do not complete EBPIs. Third, the sample comprised predominantly single mothers, and although 40% of the sample may be identified as people of colour, most were of mixed racial/ethnic heritage. Given child welfare's poor record with engaging fathers and people of colour, future study is needed to gain additional views on EBPIs, including fathers', nonsingle parents, and parents of other racial/ethnic backgrounds. Finally, this study may be limited by

the power dynamics and involuntary nature of the child welfare system in that parents may not feel safe to express their full and honest opinions about a system that has removed their children from them or threatens to. Findings must be considered within this context of dramatic power differentials.

6 | CONCLUSION

Despite its limitations, this study is strong in its use of qualitative methods to explore parental perceptions of an EBPI and highlight parents' voices. Although individual factors were identified, we found program and provider factors were the most prevalent and important aspects of parental engagement. Regarding program structures, the most basic logistical issues, such as scheduling and transportation, are practical components that parents may experience as substantial facilitators or barriers to their participation in an EBPI. Parents valued program features that eased their participation, such as beginning with a group meal, and provided them with time to practice newly learned skills with their children. Also important was the care and competence of the provider delivering the intervention. Parents viewed providers positively when providers built rapport and effective communication among all group members. Parents' comments about their experience of the group fundamentally pointed to how effective the provider was at facilitating the program's content in context of a dynamic group. Providers were also valued for demonstrating their positive regard and support of parents and children. In sum, parents' insights suggested the need for practical supports to overcome obstacles, supportive relationships and a positive social climate to promote comfort and learning, and program content that was directly relevant to their needs as parents.

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REFERENCES

Akin, B. A., & Gomi, S. (2017). Non-Completion of Evidence-Based Parent Training: An Empirical Examination among Families of Children in Foster Care. *Journal of Social Service Research*, *43*, 52–68.

Akin, B. A., Brook, J., & Lloyd, M. H. (2015a). Co-Occurrence of Parental Substance Abuse and Child Serious Emotional Disturbance: Understanding Multiple Pathways to Improve Child and Family Outcomes. *Child Welfare*, *94*, 71–96.

Akin, B. A., Brook, J., & Lloyd, M. H. (2015b). Examining the role of methamphetamine in permanency: A competing risks analysis of reunification, guardianship, and adoption. *American Journal of Orthopsychiatry*, *85*, 119–130.

Akin, B. A., Mariscal, S. E., Bass, L., McArthur, V. B., Bhattarai, J., & Bruns, K. (2014). Implementation of an evidence-based intervention to reduce long-term foster care: Practitioner perceptions of key challenges and supports. *Children and Youth Services Review*, *46*, 285–293.

Brook, J., Akin, B. A., Lloyd, M. H., Johnson-Motoyama, M., & Yan, Y. (2016). Family Drug Treatment Courts As Comprehensive Service Models: Cost Considerations. *Juvenile and Family Court Journal*, *67*, 23–43.

Brook, J., Akin, B. A., Lloyd, M. H., & Yan, Y. (2015). Family drug court, targeted parent training, and family reunification: Did this enhanced service strategy make a difference? *Juvenile & Family Court Journal*, *66*, 35–52.

Brook, J., & McDonald, T. P. (2007). Evaluating the effects of comprehensive substance abuse intervention on successful reunification. *Research on Social Work Practice*, *17*, 664–673.

Brook, J., McDonald, T. P., Gregoire, T., Press, A., & Hindman, B. (2010). Parental Substance Abuse and Family Reunification. *Journal of Social Work Practice in the Addictions*, *10*, 393–412.

Brook, J., McDonald, T. P., & Yan, Y. (2012). An analysis of the impact of the Strengthening Families Program on family reunification in child welfare. *Children and Youth Services Review*, *34*, 691–695.

Arbeiter, E., & Toros, K. (2017). Parental engagement in child protection assessment: A qualitative analysis of worker and parent perspectives. *International Social Work*, *60*, 1469–1481.

Axford, N., Lehtonen, M., Kaoukji, D., Tobin, K., & Berry, V. (2012). Engaging parents in parenting programs: Lessons from research and practice. *Children and Youth Services Review*, *34*, 2061–2071.

Ayón, C., Aisenberg, E., & Erera, P. (2010). Learning how to dance with the public child welfare system: Mexican parents' efforts to exercise their voice. *Journal of Public Child Welfare*, *4*, 263–286.

Barth, R. P. (2009). Preventing child abuse and neglect with parent training: Evidence and opportunities. *Future of Children*, *19*, 95–118.

Barth, R. P., Chamberlain, P., Reid, J. B., Rolls, J., Hurlburt, M. S., Farmer, E. M. Z., … Kohl, P. L. (2005). Parent-training programs in child welfare services: Planning for more evidence-based approach to serving biological parents. *Research on Social Work Practice*, *15*, 353–371.

Barth, R. P., Gibbons, C., & Guo, S. (2006). Substance abuse treatment and the recurrence of maltreatment among caregivers with children living at home: A propensity score analysis. *Journal of Substance Abuse Treatment*, *30*, 93–104.

Beasley, L., Silovsky, J., Ridings, L., Smith, T., & Owora, A. (2015). Understanding program engagement and attrition in child abuse prevention. *Journal of Family Strengths*, *14*, 1–24.

Berliner, L., Fitzgerald, M. M., Dorsey, S., Chaffin, M., Ondersma, S. J., & Wilson, C. (2015). Report of the APSAC task force on evidence-based service planning guidelines for child welfare. *Child Maltreatment*, *20*, 6–16.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101.

Buckley, H., Carr, N., & Whelan, S. (2011). 'Like walking on eggshells': Service user views and expectations of the child protection system. *Child & Family Social Work*, *16*, 101–110.

Center for Disease Control and Prevention (CDC) (2010). Adverse childhood experiences reported by adults—Five States, 2009. MMWR. Morbidity and Mortality Weekly Report. 59, 1609–1613.

Chaffin, M., Bonner, B. L., & Hill, R. F. (2001). Family preservation and family support programs: Child maltreatment outcomes across client risk levels and program types. *Child Abuse & Neglect*, *25*, 1269–1289.

Cooper Altman, J. (2008). A study of engagement in neighborhood-based child welfare services. *Research on Social Work Practice*, *18*, 555–564.

Damashek, A., Doughty, D., Ware, L., & Silovsky, J. (2011). Predictors of client engagement and attrition in home-based child maltreatment prevention services. *Child Maltreatment*, *16*, 9–20.

Darlington, Y., Healy, K., Yellowlees, J., & Bosly, F. (2012). Parents' perceptions of their participation in mandated family group meetings. *Children and Youth Services Review*, *34*, 331–337.

Domenech Rodríguez, M. M., Baumann, A. A., & Schwartz, A. L. (2011). Cultural adaptation of an evidence based intervention: From theory to practice in a Latino/a community context. *American Journal of Community Psychology*, *47*, 170–186.

Dumbrill, G. C. (2006). Parental experience of child protection intervention: A qualitative study. *Child Abuse & Neglect*, *30*, 27–37.

Felitti, V. J., & Anda, R. F. (2010). The relationship of adverse childhood experiences to adult health, well-being, social function, and healthcare. In R. Lanius, E. Vermetten, & C. Pain (Eds.), *The hidden epidemic: The impact of early life trauma on health an disease* (pp. 77–87). Cambridge: Cambridge University Press.

Gallitto, E., Romano, E. & Drolet, M. (2017) caregivers' perspectives on the Safecare® programme: Implementing an evidence-based intervention for child neglect. *Child & Family Social Work*, n/a-n/a.

Gladstone, J., Dumbrill, G., Leslie, B., Koster, A., Young, M., & Ismaila, A. (2012). Looking at engagement and outcome from the perspectives of child protection workers and parents. *Children and Youth Services Review*, *34*, 112–118.

Gopalan, G., Fuss, A., & Wisdom, J. P. (2015). Multiple family groups for child behavior difficulties retention among child welfare–involved caregivers. *Research on Social Work Practice*, *25*, 564–577.

Green, B. L., Rockhill, A., & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review*, *29*, 460–473.

Grella, C. E., Needell, B., Shi, Y., & Hser, Y.-I. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment*, *36*, 278–293.

Haight, W., Jacobsen, T., Black, J., Kingery, L., Sheridan, K., & Mulder, C. (2005). “In these bleak days”: Parent methamphetamine abuse and child welfare in the rural Midwest. *Children and Youth Services Review*, *27*, 949–971.

Haight, W., Ostler, T., Black, J., Sheridan, K., & Kingery, L. (2007). A child's-eye view of parent methamphetamine abuse: Implications for helping foster families to succeed. *Children and Youth Services Review*, *29*, 1–15.

Hohman, M., Oliver, R., & Wright, W. (2004). Methamphetamine abuse and manufacture: The child welfare response. *Social Work*, *49*, 373–381.

Horwitz, S. M., Chamberlain, P., Landsverk, J., & Mullican, C. (2010). Improving the mental health of children in child welfare through the implementation of evidence-based parenting interventions. *Administration and Policy in Mental Health*, *37*, 27–39.

Kane, G. A., Wood, V. A., & Barlow, J. (2007). Parenting programmes: A systematic review and synthesis of qualitative research. *Child: Care, Health and Development*, *33*, 784–793.

Kazdin, A. E. (2017). Parent management training and problem-solving skills training for child and adolescent conduct problems. In J. R. Weisz, & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 142–158). New York, NY: Guilford Press.

Knox, M., & Burkhart, K. (2014). A multi-site study of the act raising safe kids program: Predictors of outcomes and attrition. *Children and Youth Services Review*, *39*, 20–24.

Koerting, J., Smith, E., Knowles, M. M., Latter, S., Elsey, H., McCann, D. C., … Sonuga-Barke, E. J. (2013). Barriers to, and facilitators of, parenting programmes for childhood behaviour problems: A qualitative synthesis of studies of parents' and professionals' perceptions. *European Child & Adolescent Psychiatry*, *22*, 653–670.

Kogan, S. M., Brody, G. H., Molgaard, V. K., Grange, C. M., Oliver, D. A. H., Anderson, T. N., … Sperr, M. C. (2012). The strong African American families–Teen trial: Rationale, design, engagement processes, and family-specific effects. *Prevention Science: The Official Journal of the Society for Prevention Research*, *13*, 206–217.

Kumpfer, K. L., Alvarado, R., & Whiteside, H. O. (2003). Family-based interventions for substance use and misuse prevention. *Substance Use & Misuse*, *38*, 1759–1787.

Kumpfer, K. L., Whiteside, H., Greene, J. A., & Allen, K. C. (2010). Effectiveness outcomes of four age versions of the strengthening families program in statewide field sites. *Group Dynamics: Theory, Research, and Practice*, *14*, 211–229.

Lewis, E. M., Feely, M., Seay, K. D., Fedoravicis, N., & Kohl, P. L. (2016). Child welfare involved parents and Pathways Triple P: Perceptions of program acceptability and appropriateness. *Journal of Child and Family Studies*, *25*, 3760–3770.

Littell, J. H., & Tajima, E. A. (2000). A multilevel model of client participation in intensive family preservation services. *Social Service Review*, *74*, 405–435.

Marsh, J. C., & Smith, B. D. (2011). Integrated substance abuse and child welfare services for women: A progress review. *Children and Youth Services Review*, *33*, 466–472.

Mildon, R., & Shlonsky, A. (2011). Bridge over troubled water: Using implementation science to facilitate effective services in child welfare. *Child Abuse & Neglect*, *35*, 753–756.

Mirick, R. G. (2014). Engagement in child protective services: The role of substance abuse, intimate partner violence and race. *Child & Adolescent Social Work Journal*, *31*, 267–279.

Morawska, A., & Sanders, M. (2006). A review of parental engagement in parenting interventions and strategies to promote it. *Journal of Children's Services*, *1*, 29–40.

Moullin, J. C., Sabater-Hernández, D., Fernandez-Llimos, F., & Benrimoj, S. I. (2015). A systematic review of implementation frameworks of innovations in healthcare and resulting generic implementation framework. *Health Research Policy and Systems*, *13*, 16.

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science*, *10*, 53.

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

Olofsson, V., Skoog, T., & Tillfors, M. (2016). Implementing group based parenting programs: A narrative review. *Children and Youth Services Review*, *69*, 67–81.

Schreiber, J. C., Fuller, T., & Paceley, M. S. (2013). Engagement in child protective services: Parent perceptions of worker skills. *Children and Youth Services Review*, *35*, 707–715.

Small, S. A., Cooney, S. M., & O'Connor, C. (2009). Evidence-informed program improvement: Using principles of effectiveness to enhance the quality and impact of family-based prevention programs. *Family Relations*, *58*, 1–13.

Staton-Tindall, M., Sprang, G., Clark, J., Walker, R., & Craig, C. D. (2013). Caregiver substance use and child outcomes: A systematic review. *Journal of Social Work Practice in the Addictions*, *13*, 6–31.

Staudt, M. (2007). Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. *Journal of Child and Family Studies*, *16*, 183–196.

Testa, M. F., & Smith, B. (2009). Prevention and drug treatment. *Future of Children*, *19*, 147–168.

Turney, D. (2012). A relationship-based approach to engaging involuntary clients: The contribution of recognition theory. *Child & Family Social Work*, *17*, 149–159.

Yatchmenoff, D. K. (2005). Measuring client engagement from the client's perspective in nonvoluntary child protective services. *Research on Social Work Practice*, *15*, 84–96.

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