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Integrating the Family Check-Up and the parent Coping Power program

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Abstract

Engaging families in school-based preventive interventions for aggressive youth can be especially challenging. The current article describes an integration of a parent engagement model, called the Family Check-Up, with an evidence-based intervention for youth with aggressive behaviours called Coping Power. The overall goal of the integration was to increase parental involvement and exposure to the core elements of the Coping Power programme to optimize impact on families and their children. We describe both models, summarize evidence of their efficacy when implemented alone, and provide a rationale for their integration. We also provide case examples to illustrate the implementation of the integrated programme in schools as well as feasibility data to support its continued study and implementation.

Keywords

parent engagement; parent management training; school-based prevention; integrated models

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Family involvement in educational and mental health services is critical to the success of all students, especially for youth with behaviour problems (Henderson & Mapp, 2002; Kumpfer & Collings, 2003; Spoth, Redmond, Trudeau, & Shin, 2002). Benefits of family involvement include higher academic achievement (e.g., Epstein, 1995), increased support of teachers and schools from parents (e.g., Epstein & Lee, 1995), improved behaviour, and increased likelihood of enrolling in post-secondary education programmes (e.g., Henderson

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&Mapp, 2002). In fact, families have a central role in most evidence-based interventions for youth with emotional and behaviour disorders (Affronti & Levison-Johnson, 2009). Most effective treatments for youth have shifted from the traditional child-focused interventions to more family-centred services that require significant parental participation throughout the process (Affronti & Levison-Johnson, 2009; Dishion & Kavanagh, 2003).

Unfortunately, available evidence suggests that families are frequently not included in school-based services for youth with behaviour problems, and that parents often have limited attendance in parent-oriented intervention services (Lochman, Boxmeyer, Powell, Roth, & Windle, 2006; Owens et al., 2002). In particular, families from low-income backgrounds and those with children with the highest service needs have the lowest level of school participation (Park, Pullis, Reilly, & Townsend, 1994). Even when clinicians use evidence-based interventions for behaviour problems that explicitly require parent participation they often encounter challenges to gaining and maintaining parent involvement in the services (McKay et al., 2004). For these reasons, building parent engagement strategies into existing practices and programmes is essential for the delivery of high-quality services in schools.

In this article, we describe our efforts at integrating parent engagement methods with a specific evidence-based intervention for youth with aggressive behaviours, called Coping Power (Lochman & Wells, 1996). We used a parent engagement model called the Family Check-Up (FCU; Dishion & Kavanagh, 2003) as an alternative platform for delivering the Coping Power (CP) parent component. The overall purpose of the integration was to increase parental involvement and exposure to the core elements of the CP programme to optimize impact on families and their children. After describing the integrated model, we provide a case example to illustrate its application in schools as well as feasibility data to support the model.

Background and rationale for integrating the programmes

Coping power

Coping Power is an empirically-supported indicated intervention for upper elementary school children (i.e., fourth and fifth graders) showing early signs of aggressive and disruptive behaviours (Lochman & Wells, 1996). The original multi-component CP programme was directed at children in the late elementary school years and middle school transition and provides training in social skills and social problem-solving. It includes parent and child components that address critical social-cognitive behavioural risk factors and mechanisms involved in aggressive/disruptive behaviour problems which are delivered over 1 to 1.5 academic years (Lochman et al., 2006; Lochman & Wells, 2004).

The parent component consists of 16 parent group sessions during which parents meet in groups of 10–12 with two co-leaders. The content of the CP parent component is derived from social learning theory-based parent training programmes developed and evaluated by prominent clinician-researchers in the field of child aggression (Patterson et al., 1992). Over the course of the 16 sessions, parents learn the following skills: (1) identifying prosocial and disruptive child behaviours; (2) rewarding appropriate child behaviours; (3) giving effective instructions and establishing age-appropriate rules and expectations for their children in the home; (4) applying effective consequences to negative child behaviours; (5) assisting parents to better monitor and supervise their children’s behaviour; (6) managing child behaviour outside the home; and (7) establishing ongoing family communication structures in the home (such as weekly family meetings). In addition to these ‘standard’ parenting skills, parents also learn additional skills that support the social-cognitive and problem-solving skills that children learn in the CP child component. These parent skills are

introduced at the same time when the respective child skills are introduced, so that parents and children can work together at home on what they are learning. For example, parents learn to set up homework support structures and to reinforce organizational skills around homework completion at the same time when children are learning organization skills in the CP child component. Parents also learn techniques for managing sibling conflict in the home at the same time when children are addressing peer and sibling conflict resolution skills in the group. In addition, parents learn to apply the problem-solving model to family problem-solving so that child skills learned in the group will be prompted and reinforced in the family context. A final module of the CP parent component includes sessions on stress management for parents.

Prior randomized trials of CP have shown that, relative to members of a comparison group, participants experienced lower rates of substance use, reductions in proactive aggression, improved social competence, and greater teacher-rated behavioural improvement among children in late childhood (fourth and fifth graders) (Lochman & Wells, 2004). CP is included on several federally supported lists of evidence-based programmes (e.g., SAMHSA's National Registry of Evidence-based Programs, Hawkins and Catalano [2004]). Further, the CP Programme is one of very few indicated interventions to have evidence of beneficial intervention impact on school-based behaviour problems and on substance use and delinquency at one-year follow-up in two separate trials (Greenberg, Domitrovich, & Bumbarger, 2001; also see Lochman & Wells, 2004).

Although CP is a well-established intervention, engaging parents in the intervention can be difficult, particularly in urban settings. Whereas the overall level of parent participation tends to be rather low, parents' participation in three or more sessions is associated with significant improvements in child outcomes (Wells, Lochman, & Lenhart, 2008). Moreover, our prior feasibility testing of the CP in urban elementary schools indicated that parent attendance at the sessions was a significant challenge. To address this concern, we attempted to integrate parent engagement strategies into the CP framework using another evidence-based model called the FCU to facilitate entry into the CP parent programme.

The Family Check-Up

The FCU was developed as a structured, brief intervention for providing effective family interventions for youth with mild-to-serious emotional and behavioural concerns (Dishion & Kavanagh, 2003). Typical targets of the FCU include parent or teacher behaviours (e.g., discipline practices, monitoring) and child externalizing behaviours. Previous research indicates that the FCU increases parent engagement and leads to reliable reductions in problem behaviour in children and adolescents (Connell, Dishion, Yasui, & Kavanagh, 2007; Dishion & Kavanagh, 2003). Further, the families most in need of family intervention services (e.g., single parents, those from high-conflict homes, those with deviant peer involvement) engage more consistently in the FCU. In addition, engagement and responsiveness to the intervention are similar across racial and ethnic groups, as well as gender (Connell et al., 2007). One potential explanation is that the flexible delivery format and the assessment-driven, collaborative, and tailored nature of the family-centred intervention optimize the engagement of culturally diverse families.

The FCU is based on a data-based model of the development of child behaviour problems. In this model, parent behaviour management directly affects the occurrence of child problem behaviours and also indirectly affects problem behaviours through its impact on child self-regulation skills. That is, effective parenting skills make problem behaviours less likely by providing a structured, positive and predictable family environment, and also improves the ability for child self-regulation of his/her emotions and behaviours. The family context (e.g., stressors, conflict, mental health) influences how well parents are able to manage their

child's behaviour. Likewise, the school context, including school climate and discipline practices, also affects parenting behaviours. Finally, peer and sibling behaviours directly influence the child's likelihood of engaging in problematic behaviour. The adaptability of a child's peers and siblings are also affected by school, family, and parenting contexts. On the basis of this model, the FCU attempts to build parent motivation and capacity to effectively manage their child's behaviour by gathering data about these contextual environments, sharing this data with parents, and helping them make informed decisions about how to best support their child's behaviour.

Motivational interviewing serves as the guiding clinical method in the FCU. Motivational interviewing is a client-centred, non-confrontational, directive approach to treatment designed to help individuals resolve ambivalence and enhance motivation to change (Miller & Rollnick, 2002). While it was originally developed to treat issues related to substance abuse, it also has been used to engage clients in treatments targeting a range of behavioural and mental health concerns (Miller & Rose, 2009). Motivational interviewing provides the ongoing therapeutic style and framework for making it more likely that caregivers will come to perceive the benefits of initial and ongoing help-seeking as outweighing any barriers.

The FCU includes as many as three sessions. The first session involves building a relationship with the family, preparing the family for change, and motivating families to be engaged in intervention. The second session involves collecting assessment data from multiple informants. During the third session, the family receives feedback on the basis of the assessments. In our integrated FCU and CP model, we collapsed the first and second sessions into a single assessment session followed by a feedback session (Reinke, Splett, Robeson, & Offutt, 2009).

Ecological assessments—Data are collected across child, school, and home domains to capture a picture of the youth's functioning within the family, peer relationships, personal adjustment, and academic competence. In addition, it is important to conduct assessments across multiple informants to gain information about the perceptions of those who interact with the youth. Another important aspect of the assessments includes gathering information on strengths, as well as weaknesses, to provide a subsequent feedback session that is motivating and balanced from the caregivers' perspective. Moreover, information about strengths and resources is helping in building holistic and impactful support plans.

The assessment begins with a parent interview about their concerns and perceived needs. The interview includes open-ended questions about family life, relationships and activities, as well as specific questions about how the youth is functioning socially and academically. The interview becomes progressively more structured around family discipline practices and involvement with schooling. Finally, formal assessments are gathered at the end of the interview. These include broad-band ratings of child symptoms and functioning at home and school (e.g., the Child Behavior Checklist [Achenbach, 2001] or the Behavioural Assessment System for Children [BASC-2; Reynolds & Kamphaus, 2004]), family stress, discipline practices, family conflict, and communication/problem-solving. Additional measures are gathered from the youth (e.g., the BASC-2, depression rating scales, perceptions of family relationships, and communication) and from the teacher (e.g., the BASC-2). These formal assessments provide standardized ratings that serve as the basis for the personalized feedback that will be given in the second meeting.

In the original FCU, the ecological assessment encompasses two meetings with the family. The second meeting involves videotaping actual family interactions and discussions about challenging topics. These videotape observations are coded and used to deliver feedback to

the family about the family environment and parenting practices during the feedback session. For practical reasons, our adaptation does not include these videotaped interactions.

Feedback and planning—The feedback session is intended to motivate families to take advantage of intervention opportunities and to become more involved in their child's life. For some families, this is the last session because they elect to address their concerns without the clinician, either independently or with the assistance of another provider. Other families may choose to continue sessions with the clinician. Thus, the feedback session may function as a transition to this next intervention stage.

Capitalizing on the potential of the feedback session to engage parents requires adequate preparation before the meeting. This includes gathering data from interviews, measures and observations, and putting them into a concise feedback session based on integrated norm-referenced scores and clinical judgement. The clinician prepares a single-page feedback form to highlight areas of strength as well as areas of concern during the meeting. During the feedback session the clinician uses a motivational interviewing approach and strategies to facilitate the discussion and to elicit motivational talk from the parent. The session ends with the development of an action plan about next steps on the basis of the needs highlighted in the feedback discussion.

Process and steps to integrate the FCU and CP

Over the past several years, our group has modified the FCU to have a stronger school component, making it more feasible for implementation in schools by school personnel. In the modified FCU model, we have collapsed the first (interview) and second (videotaping) sessions into a single assessment session followed by a feedback session (Reinke et al., 2009). The clinician also meets and interviews school personnel and teachers and conducts school observations prior to the feedback session. In addition to building the parents' motivation to participate in their child's schooling and related services, the purpose of these various meetings is to gather further assessment data, repair negative relations, build positive expectations of all partners, and prepare all partners for a successful team meeting.

In our current pilot work in Baltimore City, we modified the CP parent programme and integrated it with the parent engagement and motivational interviewing principles described above. Two key changes we made were to allow parents to select programme components on which they wanted to work based on the ecological assessment data (rather than having to complete all 16 sessions) and to revise aspects of the CP manual so that the content could be delivered individually to families rather than in the original group format. In the integrated version of CP, the second session ends with a discussion about which CP sessions the parent would like to complete and in what order. The clinician works with the parent to create a plan of action and to evoke their commitment to participate in whatever plan is developed. We developed a manual for all of these procedures (Herman & Reinke, 2011). We identified the core components of the CP programme and separated them into different modules that parents could select to work in any sequence: academic support in the home, stress management, parenting tool kit (positive attention/praise, antecedents, consequences), and family cohesion/problem-solving. Figure 1 depicts the steps and modules in the integrated FCU-CP model.

Specific FCU-CP strategies

In the following paragraphs, we highlight three tools or strategies from our integrated model that clinicians have found to be especially helpful in connecting with families in urban schools with high concentrations of poverty. The methods include a values card sort, rulers, and the FCU Feedback Form.

Values card sort—During the intake session, the clinician asks parents to complete a value card sort task. The purpose of the task is to evoke a discussion about the most important values a parent holds so the clinician can get a better sense of their ideals, dreams, and wishes for their family. Although there are many variations of the task (Frey et al., 2011), the version we use involves presenting parents with a stack of 20–30 cards with a value statement on each (e.g., education, wealth, discipline) and asking them to sort them into three piles from most to least important. The clinician then asks the parent to identify their top three values and explain why each is important to them; if both parents are present they can complete the task independently. This information is often useful in making the parent aware of discrepancies between their values and current life experiences and actions. Moreover, most parents find the task to be challenging and highly engaging.

Rulers—Motivational interviewing uses scaling tools referred to as rulers as one method to elicit motivational talk from clients (Miller & Rollnick, 2002). Importance and confidence rulers are the most common version of this tool. As with the original FCU, parents are routinely asked how important taking a particular action is on a scale from 1 (not important) to 10 (very important). For instance, a clinician might ask a parent at the end of a meeting how important is it for the parent to attend their next meeting. Whatever the response, the clinician follows with, 'And why that number and not one number lower?' The answer to this question is nearly always some version of change talk; that is, why change is important, needed, or desired. Next, the clinician follows by asking how confident the parent is that they can successfully carry out the targeted behaviour (e.g., attend the next session) using the same scale. In addition to eliciting change talk, this method also invites discussion and problem-solving about potential barriers to engaging in the targeted behaviour. In our integrated FCU-CP model, we incorporate the rulers through each session. At a minimum, clinicians ask parents the importance and confidence question at the end of each session and any other time they reach agreement on some targeted next step.

The FCU feedback form—The feedback form is an effective visual tool to concisely communicate information from the ecological assessment to the parent. The left side of the form lists various characteristics grouped into three categories: youth symptoms, family functioning, and school functioning. The *x*-axis of the form has a colour spectrum from green to yellow to red. Prior to the feedback session with the parent, the clinician compiles all of the assessment data and marks each child, family, and school characteristic based on whether it is a strength/in the normal range (green), whether it is an area of mild-to-moderate concern (yellow to orange), or whether it is a serious concern demanding immediate attention (red).

A benefit of the feedback form, in addition to its concise communication, is that it makes the negative feedback less conflictual by drawing attention to the form and away from the clinician as the bearer of bad news. It allows the clinician to identify concrete and specific areas of the child's behaviour that need to be addressed, while also highlighting identified strengths. Because the feedback form compiles all assessments (from parent, teacher, and child), it takes into account everyone's point of view and provides a concise, overall summary.

Case example—We provide a case example to highlight how the FCU was useful in addressing a multitude of common barriers to family engagement in services. Jason was a 10-year-old boy with recurrent aggressive and disruptive behaviours at school. He had difficulty following directions and instead would become disrespectful and verbally aggressive to the teacher and peers around him (engage in name calling and cursing). He also became easily frustrated with his school work and impatient when waiting his turn to be

helped. He would sometimes leave the classroom without permission and not return for extended periods of time. He was diagnosed by his paediatrician with attention-deficit hyperactivity disorder. Although his behaviours improved after starting a regimen of stimulants, his mother discontinued the medication after Jason had a serious seizure. Subsequently, his behaviour problems escalated to the point that the school behaviour support team was considering expulsion and placement in an alternate setting.

In addition, at the time of referral to the school clinician, the mother had grown distrustful of school personnel and expressed her view that teachers and school staff were to blame for her child's behaviour. The mother minimized Jason's behaviours and attributed his problems to teachers who mishandled him or escalated situations. The mother was also annoyed with the school for always calling her for 'every little thing' and not providing her any positive feedback. The child was aware of his mother's opinions and would repeat them to school staff. At the point of contact with the school clinician, the mother had stopped attending school meetings and conferences and did not return calls from the school. She reported the school became a source of stress for her. She believed the school was 'out to get him' and just wanted him 'put out' (i.e., expelled). Likewise, school personnel were frustrated with the child and had negative perceptions of the mother. They believed she was uncooperative and contributed to the problems at school.

During the assessment session, the clinician used several strategies to join with the mother and build commitment and motivation. In particular, the values cart sort task highlighted the values that were important to her that she wanted her son to adopt as well. The mother enjoyed this task and elaborated more specifically about each card and what each 'value' meant to her. For instance, she talked about how important education was to her; she had her high school diploma and wanted the same for her son. The mother placed almost all of the value cards into the 'very important' category. When the clinician asked the mother to pick the top 3–5 cards to rank the mother had an extremely difficult time deciding which cards to pick and even how to rank them. The mother stopped and said, 'This is too hard! All of these things are so important.' Through discussion, summarizing, and reflecting comments from the clinician, the mother decided that it was hard to pick and rank these values because they were so closely interconnected to one another. The clinician elicited examples and reasons each value was important and used these beliefs in later discussions to highlight discrepancies between her values and current behaviours.

At the end of the first session, the mother rated the importance of attending future meetings as '10' and her confidence in returning as '10'. She provided a list of reasons for rating both of these dimensions so high. In sum, the mother concluded that she needed to do something to help her son become successful in school because it is a value that she held dearly; therefore, she decided that being active in this intervention was her best step to help her child.

At the feedback session, the mother enjoyed hearing about areas in which her son was placed in the green zone. She enjoyed talking about the strengths of her child and especially about their parent–child relationship bond, which was confirmed through statements made during the initial meeting, child meeting and specific examples from the assessments. The mother was not surprised by many areas placed in or towards the red, but hearing direct feedback and specific examples (made by herself, the teacher, and the scales) from a non-judgemental/neutral person (clinician) was very impactful in developing the working and therapeutic relationship.

After discussing the feedback, the mother picked three areas she felt were the most important for her child to improve: rule violations, non-compliance, and home–school

communication. The mother expressed relief and optimism at the end of the feedback session because (1) there was something she could do herself to help address these areas and (2) she had someone to help support her in doing this by working with the clinician. The mother expressed positive self-statements noting that she was proud of herself for making a commitment to helping her son and participating in the intervention. She was hopeful that her son would improve and that her work would help reduce stress from school that she was experiencing.

At the end of the session, the mother decided to focus on building behaviour management strategies at home. She developed a plan for meeting with the clinician on a weekly basis. Subsequently, she completed all seven sessions of the Parenting Tool Kit and reported improvements in home behaviours. At the end of the meetings, she rated the intervention to be very effective (4 out of 4) and her confidence in continuing to implement the intervention as very high (4 out of 4).

Preliminary feasibility/acceptability support for the new practice

Three school-based clinicians in urban schools were trained and supervised to deliver the integrated FCU-CP parent intervention. The clinicians were recruited on the basis of their involvement in a school mental health service programme affiliated with Johns Hopkins Center for Prevention and Early Intervention. Their full-time work assignment was to provide preventive and early intervention services to youth in their assigned buildings. These clinicians implemented the integrated programme with several elementary schoolchildren and their caregivers. Feasibility data indicated that all clinicians were highly satisfied with the training and supervision and found the intervention to be feasible; and they also were highly confident that they could deliver the intervention in the future. The clinicians reported very favourable attitudes towards the FCU-CP and saw it as a practical strategy with great promise for benefiting families in Baltimore City schools.

On the basis of five families who completed the feedback session in the FCU pilot, clinicians rated the FCU as helpful to the families ($M = 5$; 1 [not true at all] to 5 [very true]) and indicated they would use the FCU with other families ($M = 5$). They also indicated that the FCU was easy to implement ($M = 4.2$), increased their chances of helping the family ($M = 4.4$), and fit with the cultural needs of the families ($M = 4.2$). Four of the families completed social validity ratings at the end of the school year. On a four-point scale (with higher scores indicating more positive ratings), all four families rated the intervention as very important and very effective ($M = 4.0$ on both items). The families also indicated that they had a positive impression of the intervention; that the intervention required a reasonable amount of time; and that it bolstered their confidence in creating changes in their family ($M = 3.75$ for each rating).

Strengths and challenges of the integrated model in the school setting

Implementing the integrated FCU-CP model in the school setting has presented both strengths and challenges from an administrative perspective. The school mental health programme leadership team, which employed all participating clinicians, reported an eagerness to participate in the FCU-CP project for several reasons. First, the project was consistent with the programme's goal of increasing the use of evidence-based interventions and allowed for some of the typical costs associated with training and implementation support to be absorbed by the grant-funded project. Consistent with the growing demand by insurance agencies and other funders for the use of empirically supported interventions, school mental health programmes like the one in this project are increasingly being asked to document the use of research-based protocols by their funding network. Second, programme administrators have reported that the professional development opportunities afforded by

participation in the project, including initial and ongoing training and supervision, are a highly desired 'perk' by participating clinicians. Given the time demands of the school and the fact that all clinicians were already licensed, the intensive supervision and support would not likely otherwise be available. Further, the clinicians appreciated the iterative process in developing the FCU-CP model, throughout which their input was solicited and valued. Finally, the leadership team reports that the FCU integration has added a valuable 'tool' in their toolkit for enhancing family engagement, an area with which the programme has consistently struggled despite consistent efforts to engage families.

While the positives have outweighed the negatives, implementation has not come without administrative challenges. As with most evidence-based interventions, the time involved in training and supporting ongoing practice implementation can present a burden on clinicians' already overloaded schedules. While the research team worked hard to ensure that training days fell on school professional development days when possible, and that supervision calls occurred outside of school hours, clinicians were ultimately losing some time from frontline service hours. In addition, clinicians reported that while they valued the opportunity to implement FCU-CP, it was often more demanding than 'treatment as usual'. Specifically, the protocol requires more preparation and assessment time for each session than their typical family sessions, limiting the time they had to meet their other clinical demands. On the other hand, clinicians have provided consistent feedback about the value of the intensive assessments collected in the FCU approach. When given the option to reduce or eliminate the use of standardized measures like the BASC-2 to reduce assessment burden, clinicians repeatedly indicated that they preferred to retain the measures because of the insights they provided to improve the quality of care. This feedback is valuable and supports the notion that when clinicians are trained and supported to use high-quality assessments, they prefer to include them in their practice. Thus, an important step for future research will be to maximize the efficiency of collecting, scoring, and interpreting these assessments.

A related concern, clinicians have sometimes reported that the intensity of the FCU-CP model allows for intensive, quality intervention with a few families, possibly at the expense of other students and families who may have traditionally been seen for briefer visits, but who clinicians can no longer 'fit in'. On the other hand, clinicians reported that the individualized FCU-CP model had greater parent participation and less logistical burden than the standard group format, which had been tried in previous years. In addition, the services provided outside the context of evidence-based interventions such as the FCU and CP programmes have unknown impact, so serving fewer families with higher-quality interventions may be more beneficial than providing brief contacts with a larger number of families.

Finally, the programme's leadership team has had to negotiate with school administrators to convey the importance of implementing a structured, evidence-based model like FCU-CP. Without such negotiation to protect clinician time and activities, it is likely that clinicians would be expected to 'drop everything' to respond to other mental health concerns in the school building, often at the cost of effective implementation of the structured intervention. Advocating for quality mental health services and demonstrating the impact of these services on desired school outcomes are key challenges in protecting clinician time in school settings so they can continue to support student mental health.

Conclusions and future directions

Taken together, the preliminary findings from the feasibility study suggest that the integrated FCU-CP model is acceptable and feasible for implementation with families of children with disruptive behaviour problems in urban schools. Additional pilot work is

currently under way to examine acceptability with a larger sample of families and to determine some preliminary evidence of efficacy. On the basis of feedback from clinicians and families, our team will make final revisions to the integrated FCU-CP protocols. A critical future step will be to conduct a larger-scale efficacy trial to determine the effectiveness of the integrated model in promoting parent participating in the CP programme and ultimately fostering improved parenting practices.

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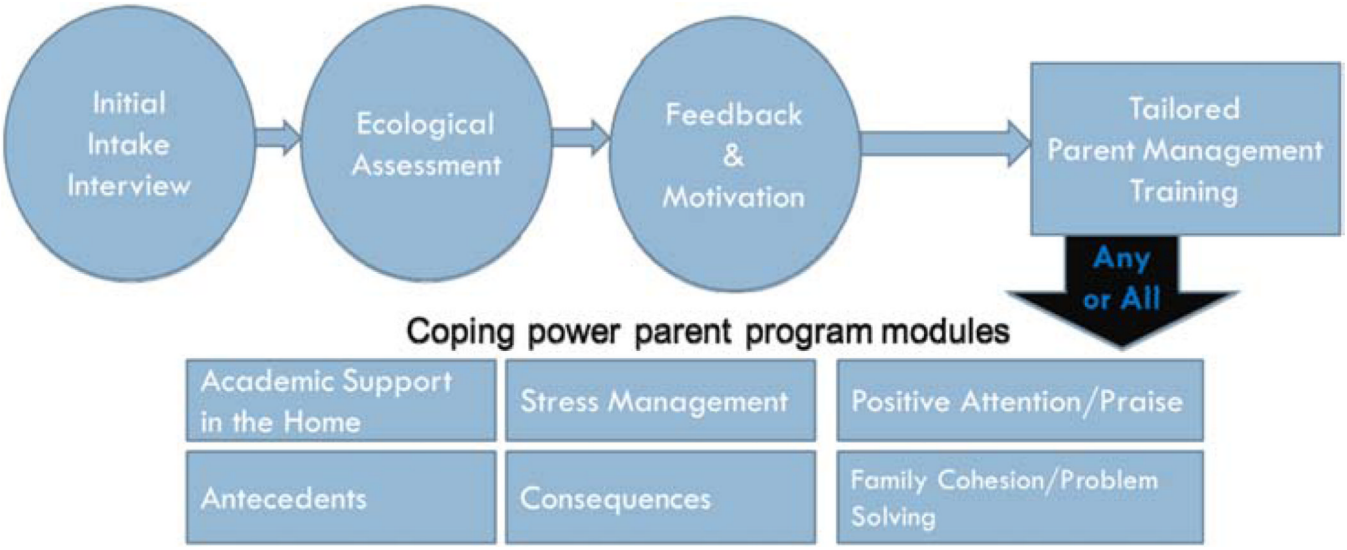

Figure 1.
Steps in the FCU-CP Programme