A Mixed-Method Investigation of Parent Perspectives on Early Childhood Behavioral Services in Primary Care

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Abstract

Primary care is a key setting for the delivery of parent-focused behavioral interventions. Various methods of intervention show promising efficacy but fail to engage adequate parental participation. This study used a sequential-explanatory mixed-method design to understand factors underlying parents' attitudes toward the content, sources, and delivery methods of behavioral guidance in primary care. Fifteen parents who previously participated in a larger survey study participated in interviews about their experiences and attitudes toward integrated primary care. Qualitative data were analyzed and sorted by quantitative data of interest to identify demographic, child, and parental factors that shape attitudes toward integrated care. Parents emphasized a need for tailored behavioral guidance, and multiple interconnected factors (e.g., trust of providers, perceived convenience of delivery modalities, stigma associated with behavioral health services) drove parents'

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attitudes toward behavioral primary care. These attitudes varied based on socioeconomic status, child behavior symptoms, and reported use of corporal punishment.

Introduction

Delivery of parenting interventions in primary care settings is an important strategy for preventing child maltreatment and improving population health.[1] More than 90% of children in the USA receive care through a primary medical home, including up to 14 scheduled well-visits from birth to age 5 years.[2] Those visits, combined with parents' trust and comfort with the primary care setting, provide an unprecedented opportunity to promote effective parenting during critical developmental periods, thereby mitigating risk, promoting mental health, and reducing costs.[3, 4] Indeed, there is evidence that pediatric primary care–based behavioral services positively impact each of the Triple Aims of health care reform (i.e., population health, patient/family satisfaction, and costs).[5] Despite this potential, primary care providers (PCPs) face a number of barriers to providing behavioral care, including insufficient training and time limitations.[6, 7] As a result, parents' needs for behavioral guidance often go unmet in the course of well-child care.[8]

Promising methods of delivering behavioral parenting interventions in primary care include augmentative training for PCPs, digitally delivered interventions, and the integration of behavioral health specialists.[9] Each of these approaches has garnered some evidence of efficacy,[9] but often struggled to reach and engage parents. A systematic review of parenting interventions in primary care noted enrollment and retention rates as low as 30% and 38%, respectively, and "far from perfect" engagement with intervention components among enrolled parents.[10] These findings highlight a need to study factors that affect parents' participation in behavioral interventions. For example, primary care behavioral services vary in their levels of integration (i.e., the degree to which behavioral services are part of usual medical care), co-location (i.e., the degree to which behavioral services are provided in the same physical location as medical care), and coordination (i.e., the degree of information exchange between medical and behavioral providers),[11] but little is known about how these variations impact parental engagement with available interventions.

Parents' perspectives on behavioral interventions can help guide development, evaluation, and dissemination efforts.[12] Riley and colleagues previously surveyed parents of young children ($N = 396$) regarding potential topics of behavioral guidance in primary care (e.g., aggression, sleep) and possible intervention delivery methods (e.g., PCP, behavioral specialist, handouts) in order to characterize their priorities and preferences.[13] The findings indicated that nearly all parents are interested in some level of behavioral guidance in primary care (96% rated at least one topic as important) and revealed a general preference for behavioral services to be integrated into routine medical care rather than be delivered temporally separate. More parents endorsed interest in receipt of behavioral guidance from PCPs or integrated behavior specialists during routine medical care than all other delivery options, including separate co-located behavioral health visits, phone consultations, parenting groups, and media-based resources. Family, child, and parent characteristics were related to parents' reported preferences in three ways. First, household income was negatively associated with interest in behavioral guidance from both PCPs and behavioral specialists. Second, parents of children with elevated behavioral concerns were significantly more likely to endorse interest in services from both behavioral specialists and digital resources. Third, two negative parenting practices, laxness, and physical control (PC; i.e., corporal punishment) predicted preferences for care delivery, but in opposite directions. Parental laxness positively predicted interest in auxiliary behavioral services from a PCP or behavior specialist, as well as multimedia-based interventions, whereas physical control negatively predicted interest in auxiliary behavioral services from a PCP

or behavior specialist. These findings are important, because they indicate that known risk factors for the development and maintenance of child behavior problems (e.g., lower socioeconomic status [SES], negative parenting) may influence parents' likelihood of pursuing services meant to prevent or ameliorate those problems. Reducing corporal punishment is an especially important target of parenting intervention,[14] so understanding how and why the attitudes of parents who use corporal punishment toward behavioral intervention vary from other parents is imperative.

While research has begun to characterize parents' attitudes toward child behavioral services in primary care using survey methods,[13–17] the experiences underlying those attitudes and their interplay with socioeconomic, parent, and child risk factors are not well understood. As Wu and colleagues[18] noted, mixed-methods research is well-suited for capturing the nuanced perspectives of pediatric caregivers. In this vein, this study involved collecting qualitative data and conducting a mixed-methods analysis to gain an enriched understanding of quantitative findings and gain insight into parents' experiences and attitudes toward behavioral interventions in primary care.

Methods

Study design

This study used a sequential-explanatory design,[19] in which qualitative data are collected and analyzed subsequent to quantitative analysis in order to further interpret and elucidate the findings. The study was designed to address the following research questions (RQs): RQ1: What do parents want with regard to the informational content of behavioral guidance in primary care? RQ2: How do parents value different sources of behavioral guidance? RQ3: What factors underlie parents' preferences for delivery methods of behavioral guidance? RQ4: How do answers to RQ1–3 vary based on family income, child behavioral problems, and use of corporal punishment? The Human Subjects Institutional Review Board at Oregon Health & Science University approved all research procedures.

Participants and procedures

Participants were recruited from a pool of parents (including all legal caregivers) of young children who had previously completed a survey on their priorities and preference for behavioral guidance in pediatric primary care.[13] Recruiting followed a maximum variation sampling approach[20] in order to obtain a sample with adequate variability with regard to annual income, parenting practices, and child behavior problems. Eligible parents had at least one child between the ages of 18 months–5 years who was a patient of one of five pediatric practices in the Pacific Northwest, USA.

The lead author conducted in-person, 1-on-1 interviews with each participant using a semi-structured interview guide. Interviews were audio-recorded and lasted 45–60 min in duration.

Measures

Demographics As part of the initial survey, each parent completed a demographic questionnaire that included information on parent and child age, sex, racial/ethnic identity, family composition (i.e., number of children, marital status, single- or co-parenting), and annual household income (reported on an a 6-point ordinal scale from < $25,000 to ≥ $150,000). Parents were asked to report on their oldest child in the target age range.

Child behavior problems Parents completed the Eyberg Child Behavior Inventory (ECBI) as a measure of child behavior problems.[21] The ECBI is a well-validated measure of child disruptive

behavior that produces scores on two subscales. The intensity scale (ECBI-I) captures the frequency of disruptive behaviors, whereas the problem scale (ECBI-P) assesses parents' perception of those behaviors as problematic. For the purposes of this study, ECBI raw scores were dichotomized based on established clinical cutoffs.

Preferences for behavioral services The Behavioral Information Preferences Scale (BIPS) is a measure of parents' preferences for early childhood behavioral interventions in primary care.[22] This study utilized items from the "Delivery methods" section of the BIPS, which asks parents to indicate their interest in different modalities of behavioral guidance on a 5-point scale, including usual care (e.g., "Talking to my child's doctor during normal visits"), auxiliary care (e.g., "Talking to a behavioral expert as part of one or more separate visits"), and multimedia resources (e.g., "Mobile apps for smartphones or tablets").

Parenting style The Multidimensional Assessment of Parenting Scale (MAPS) is a 34-item measure of parenting practices.[23] This analysis used the Physical Control (PC; 4 items) subscale of the MAPS, which measures use of corporal punishment. Because the MAPS subscales do not produce standardized scores or clinical cut-offs, Z-scores were calculated based on the larger survey sample and those scores were used to categorize interview participants as high ($Z \geq 1$), low ($Z \leq -1$) or medium.

Qualitative and mixed method analysis

Audio recordings of interviews were professionally transcribed and entered into Atlas.ti Version 7.0 for management and analysis. An immersion-crystallization approach was used to analyze qualitative data.[24] Together, several of the authors (AR, BW, PR) read several interview transcripts and identified text relevant to the research questions. The data were then reviewed to build a list of codes. Each transcript was independently coded by at least two team members. Coded transcripts were reviewed in a group in order to identify and resolve any discrepancies via group discussion. The lead author (AR) reviewed and synthesized all coding in consultation with the senior author (DC), an expert in qualitative analysis and mixed methods. The first round of coding focused on identifying and categorizing the topics of conversation. For example, passages were coded if they pertained to the source, content, and/or delivery method of behavioral guidance. During a second round of analysis, prominent themes pertinent to RQs 1–3 were identified. Participants' qualitative findings were then sorted based on their quantitative results to answer RQ4. For example, for the purpose of drawing comparisons between participants at different income levels, qualitative results were sorted into two groups of those who reported incomes above or below $50,000 per year. The dichotomization was based on the distribution of reported incomes within the sample. Similarly, findings were sorted by ECBI cut-off scores and MAPS Z-scores.

Results

Fifteen parents participated in individual interviews. Table 1 summarizes the characteristics of interview participants. In the following results, participants are numbered in the order they were interviewed, denoted as "P[number]." Parents of children with ECBI scores above the clinical cutoffs are denoted by "+ECBI-I," "+ECBI-P," or "+ECBI-Both," and parents with MAPS-PC Z-scores ≥ 1 are denoted with + PC.

Overall, parents strongly endorsed the importance of receiving behavioral guidance as part of primary care and often noted this becomes especially important as children transition from

Table 1
Interview participants' characteristic

Characteristic	Parent/family	Child
Age, years, *M* (SD)	33.00 (5.15)	3.22 (.98)
Female sex, *n* (%)	13 (87)	7 (47)
Ethnicity, *n* (%)		
Hispanic/Latina	2 (13)	3 (20)
Non-Hispanic/Latina	13 (87)	11 (80)
Race		
White	8 (53)	4 (27)
Asian	4 (27)	4 (27)
American Indian/Alaska Native	1 (7)	2 (13)
Native Hawaiian/Pacific Islander	1 (7)	1 (7)
Multi-racial	1 (7)	4 (27)
Marital status, *n* (%)		
Married	10 (67)	-
Never married	5 (33)	-
Parenting situation, %		
Single parenting	1 (7)	-
Couple parenting, same household	12 (80)	-
Co-parenting, separate households	2 (13)	-
Annual household income, %		
$25,001–$49,999	10 (67)	-
$50,000–$79,999	2 (13)	-
$80,000–$119,999	1 (7)	-
$120,000–$149,999	0 (0)	-
$150,000 or more	2 (13)	-
Community type		
Urban	4 (27)	-
Suburban	8 (53)	-
Rural	3 (20)	-
Number of children, *M* (SD), range	1.93 (1.03), 1–5	-
Child behavior problems, *n* (%) ≥ cutoff*		
ECBI-Intensity Scale		4 (27)
ECBI-Problem Scale		5 (33)

ECBI Eyberg Child Behavior Inventory

*Parents were asked to report on their oldest child in the target age range

infancy to toddlerhood. One parent explained, "The first year was a lot of physical and medical questions. Then once she hit two or maybe around 20 months, that was when we started experiencing more behavioral things. That started to outweigh all the physical." (P2). Broadly, parents' attitudes toward the content, sources, and delivery of behavioral guidance in primary

care were interconnected and hinged on perceptions of whether a given approach would both satisfy their particular needs and could be received in a convenient and pragmatic fashion; however, these perceptions varied in important ways based on reported household income, child behavior problems, and use of corporal punishment. Table 2 is a joint display that summarizes the mixed-methods findings for RQ4.

RQ1: Informational content of behavioral guidance

Parents expressed appreciation for receiving information about whether their child's behavior was in the scope of normative development, but also commonly noted the limitations of general information and blanket recommendations. Relative to the rest of the sample, parents with elevated PC and/or behavioral concerns described usual behavioral guidance as insufficient, ineffective, or inapplicable. "They always seem to have this broad advice… 'Take your kid out of the environment, give them choices.' Sometimes those things, those are like your three answers or whatever. They don't work for what's going on." (P9, + ECBI-P, + PC).

Parents with lower incomes emphasized the importance of considering *practicality* of behavioral guidance within socioeconomic constraints. These parents observed that many common recommendations, while perhaps likely to be helpful if implemented, are impractical for their family. For example, one father of two children with developmental disabilities stated:

> I don't think a lot [of providers] come from lower middle class and lower backgrounds... Like my older son had his [selective] eating. They're like, "Just offer him lots of different foods." That's never going to happen, because I can never just go out and buy a bunch of food that I'm planning on throwing away. (P6, +ECBI-both)

Relatedly, some parents stressed the importance of *realism* of informational content and noted that providers often suggest behavioral strategies in generalized or idealized forms that seem unrealistic for their child. This arose when parents were relating experiences of unsuccessful attempts to follow common recommendations (e.g., being unable to keep a child in time-out).

Perceptions that common recommendations may not apply to a particular child or family underscored want of more *personalized* behavioral information. Parents communicated a desire to receive *multiple options* for addressing behavioral dilemmas in order to select the best option for their family. The value of multiple options underscored the perceived importance of providers incorporating parents' expertise and knowledge of their own families. One mother said, "I think a lot of parents are offended when the doctors are like, 'Oh, well, I have a doctor's degree. I'm an expert, blah, blah, blah.' Yes, in general. Specifically for my family? Guess what, I'm the expert." (P3, + ECBI-I) Parents counterbalanced the need for multiple options with an emphasis on not being overwhelmed with too much information.

RQ2: Sources of behavioral guidance

Parents indicated they consider the source of behavioral information when weighing its quality and deciding whether to adopt any recommendations. They also described receiving conflicting advice about parenting from various sources and underscored the difficulty of determining whether a given source of parenting information is trustworthy.

Primary care providers When discussing PCPs as a source of behavioral guidance, parents emphasized trust and continuity of *relationship* as important factors. Parents perceived that PCPs' knowledge of their children's histories would allow for more personalized guidance. However, parents also conveyed awareness that behavioral issues are not the focus of PCPs' training and questioned

Table 2

Joint display of parent characteristics and perspectives on behavioral guidance in primary care

		Experiences and attitudes toward behavioral guidance		
Domain	Parent characteristics	Informational content	Sources	Method of delivery
Corporal punishment	Low or medium (MAPS-PC *Z*-score < 1)	Generally appreciative of normative information and universal guidance, but desire more personalized information	General satisfaction with PCP experiences, but would welcome access to BHS as needed	Open to a variety of delivery methods, with emphasis on convenience and accessibility
	High (MAPS-PC *Z*-score ≥ 1)	Experience common recommendations as insufficient or inapplicable	Previous experiences of invalidating or insufficient care with PCPs; questioning of PCPs' role and expertise; fear of being judged by providers; expertise valued, perceived stigma, and role confusion regarding BHSs	Prefer integration into medical visits to normalize receipt of behavioral services; extra visits indicative of something "wrong"
Child behavioral problems	Low (< ECBI clinical cutoffs)	Generally appreciative of normative information and universal guidance, but desire more personalized information	General satisfaction with PCP experiences, but would welcome access to BHS as needed	Open to a variety of delivery methods, with emphasis on convenience and accessibility
	High (≥ ECBI intensity or problem clinical cutoff score)	Experience common recommendations as insufficient or inapplicable	Greater dissatisfaction with PCP experiences; greater enthusiasm about access to BHS services in the context of primary care	Interest in a range of delivery methods; more open to repeated visits/more intensive services to meet needs

Table 2
(continued)

Domain	Parent characteristics	Experiences and attitudes toward behavioral guidance		
		Informational content	Sources	Method of delivery
Household income	≥$50,000	Generally appreciative of normative information and universal guidance, but desire more personalized information	General satisfaction with PCP experiences, but would welcome access to BHS as needed	Emphasis on convenience and accessibility within usual routines/media habits
	<$50,000	Emphasis on information that is pragmatic and actionable within economic constraints	Experience providers as unaware of economic barriers to accessing and engaging in care	Emphasis on practicality of access within socioeconomic restraints; minimizing repeat visits especially important

MAPS-PC Multidimensional Assessment of Parenting Scale-Physical Control subscale, *ECBI* Eyberg Child Behavior Inventory; *PCP* primary care provider, *BHS* behavioral health specialist

whether *limited expertise* curbs PCPs' roles in behavioral care. Parents also noted that PCPs are usually very busy, potentially limiting their ability to provide behavioral guidance.

> It's not necessarily their education or how much they know or anything, but the fact that they have to see twelve people in an hour or whatever it is. I think the doctors need more time to make the parents feel like we're getting enough time. (P3, +ECBI-I)

This perception of *limited time* was coupled with a sense that raising behavioral concerns may be *burdensome* for PCPs, disruptive to clinic operations, or viewed as a nuisance. Questions about the appropriateness of raising behavioral concerns with PCPs led some parents to stress the importance of being invited to share those concerns, either directly or through the use of questionnaires; however, parents also related frustrating experiences of not having behavioral issues addressed after endorsing them on pre-visit questionnaires.

Compared to others, parents with elevated PC scores felt they previously received *insufficient* or *invalidating* care from PCPs:

> I know giving positive praise. I know doing sticker charts. I know all of that stuff. This is different... It's always like a running joke, "Oh, she's strong-willed. Ha ha ha." Then I'll bring it up, like, "I don't know how to deal with it." Then it's like, "Oh, positive praise." It's like - I don't know. I don't know. It's hard. (P13, +ECBI-both, +PC)

Parents with elevated physical control scores also expressed fear of *judgment* from providers when discussing behavioral concerns, particularly that they would be viewed as bad parents for using corporal punishment. "I feel like you can't be honest with doctors. If you're like, 'Oh, I'm spanking my kids,' or whatever, they're gonna be like, 'No, no, no.' You're afraid to tell the doctors, because you don't want to be judged." (P9, + ECBI-P, + PC).

Integrated behavioral specialists Overall, parents were enthusiastic about integrating behavioral specialists into primary care; however, parents who endorsed minimal child behavioral challenges felt services from a behavioral specialist might be unnecessary in the absence of an identified concern. Parents identified the *expertise* and *focused role* of integrated behavioral specialists as important strengths, mirroring the perceived relative weaknesses of PCP-provided behavioral guidance. "Because I know they're a specialist in it, yeah, and then I could carve out one-on-one time to really dive in deep if I needed to." (P1) In addition to providing guidance on child behavior issues, parents identified direct emotional support to caregivers, without burdening PCPs, as a potential benefit of integrated behavioral health specialists.

> Having other staff come in that can be more of the emotional support and be there for that piece of it is pretty helpful. It'd be nice if, as a parent, I could just compartmentalize that stuff and not spill my guts out when somebody starts asking me about my kids, but having a more appropriate person to talk to is nice. (P6, +ECBI-both)

Parents with higher PC scores were generally desirous of services from integrated behavioral specialists; however, they expressed more ambivalence than other parents. Parents in the elevated PC group cited the perceived *stigma* of mental health services and what it might indicate about their child as an important factor. "The idea that there might be something wrong with their child is so scary that they won't make another appointment… If the doctor suggests, 'Hey, you might want to see this person,' that's pretty scary for a parent." (P11, + PC) Parents in the elevated PC group also expressed more *confusion* about the nature of integrated services. "Are behavioral specialists trying help parents parent, or are they just trying to stop a behavior? I don't really understand what they do." (P9, + ECBI-P, + PC) Some parents in this group reported they had been referred to co-located

behavioral services, but ultimately did not pursue them because they perceived a mismatch with their concerns.

RQ3: Delivery methods of behavioral guidance

Much in the way parents expressed a desire for personalized informational content, they identified a need for personalization of delivery methods to accommodate differences in learning and communication styles. One parent articulated this dynamic in this way:

> Not everyone learns by watching a video. Some people have to read it. Some people have to do it with their hands. I just think that approaching medical care like everyone learns the information the same is doing a disservice to those who don't. (P3, +ECBI-I)

Parents' preferences for the delivery method of behavioral guidance were marked by an overarching theme of *convenience*, but the implications of this theme varied substantially as delivery methods deemed convenient by some were felt to be inconvenient by others.

Integrated medical visits Most parents considered the "one-stop shopping" approach of integrating behavioral care into routine medical encounters as highly convenient, and often expressed a desire to avoid unnecessary multiple appointments. Parents with lower incomes cited socioeconomic factors in explaining their preferences for single-visit care. One mother in a single-parent household said:

> I'm the only one at my company who knows how to do my job, so taking time off is basically impossible. It's hard to schedule multiple appointments... I can basically get away with one half-day per month, so if it was all one appointment, it would just be easier. (P12, +ECBI-P, +PC)

Parents highlighted *immediacy* of services as an advantage of highly integrated care, particularly in contrast to external referrals. Even parents who recognized a need for referrals to external services wanted interim guidance: "What do I do in the meantime? Do I interact with my child differently? What are my resources as a parent dealing with all of the emotions that come with it?" (P5).

Parents felt that receiving behavioral health care as part of usual primary care serves to *normalize* behavioral health services. Notably, this sentiment extended to parents with high PC scores, who as a group were more concerned with the potential stigma of behavioral services.

> I think it really demystifies a lot of the mental health stuff and makes it more of a physical health issue… I think bringing them together helps parents and kids really make that leap that mental health is physical health. It's all one thing. (P7, +PC)

Parents also noted downsides of addressing behavioral concerns during routine visits, including that medical visits can feel rushed and overwhelming, so adding more content may be exacerbating. Some parents expressed interest in longer visits to address behavioral topics, but others preferred to limit duration to avoid the chaos of managing children while interfacing with providers. "Having both my kids sit in the room with me and trying to focus and get my thoughts across to the doctor is difficult." (P10).

Separate visits While parents generally preferred to avoid multiple visits, they also noted some benefits of scheduling separate encounters to address behavioral topics. Contrasting the jam-packed nature of medical visits, parents felt separate visits would allow for adequate time and focus on behavioral issues. "I like the idea of having two separate [visits]. That way, neither component of a person [physical or mental] is neglected." (P14).

Telehealth and patient portals Parents talked favorably about distance-based methods of interacting with providers, including telehealth services and patient portals, and noted these methods allow for convenient, in-the-moment access to trusted sources of information. Several parents noted positive experiences receiving medical advice through these methods, particularly through nursing telephone services, and suggested the possibility of equivalent behavioral services:

> If there was some kind of parent support line pediatricians could recommend that they could call. Like a suicide line, but like an "I'm losing my shit as a parent" line where you could have someone calm you down or give you some kind of idea to deal with what you're dealing with." (P9, +ECBI-P, +PC)

Groups Parents identified the opportunity to learn from others with similar experiences as a strength of group formats. "I think that would be a good idea as far as building community, because then you could have parents that have maybe the same situation with their kids coming together and finding answers with each other." (P3, + ECBI-I). Parents raised the potential logistical difficulty of attending multiple meetings as a concern, particularly if group attendance requires securing childcare.

Multimedia resources Parents' attitudes toward media-based delivery methods (e.g., books, handouts, digital resources) varied and were driven by congruence with their broader media-consumption habits. Consistent with the overarching theme of convenience, *accessibility* and *organization* of information were major determinants of parents' preferences for different mediums. For instance, parents who were accustomed to using computers or mobile devices for other purposes perceived digital methods as more navigable. One parent said, "Mobile technology… that's easy access compared to books. With books, we don't know which page, and then every time we have to carry the book." (P15) Parents noted the helpfulness of being able to access the same information repeatedly. Some parents preferred hard copy formats for this purpose and cited the utility of storing them in conspicuous places (e.g., handouts posted on the refrigerator, book in a purse), but others noted that materials like paper handouts are easily lost. Parents preferred methods of delivery that incorporate into existing routines and allow for *multitasking*. "You're listening at the same time. You're cooking and listening… or looking after kids, but the audio is on. You can at least listen to what's happening. That helps a lot." (P8, + ECBI-both).

Implications for Behavioral Health

This study identifies several important factors that underlie parents' attitudes toward behavioral services in pediatric care. The desire for personalized care was especially prominent across domains of inquiry, in that parents were most desirous of services that pertain specifically to their child, are consistent with their goals and values, and are delivered in a manner compatible with their individual life circumstances. This attitude is highly congruent with emphases on family-centered and shared decision-making processes,[25, 26] and underscores the importance of incorporating family preferences into treatment plans. Importantly, different attitudes and experiences emerged based on reported household income, level of child behavior problems, and use of corporal punishment.

Consistent with previous findings, parents conveyed high interest in receiving behavioral guidance as part of pediatric care, further validating universal behavioral guidance strategies. However, the results also revealed the limitations of blanket approaches, as parents commonly perceived general information to be insufficient, inapplicable, or impractical. This may partially explain why some prevention parenting programs struggle to attract and retain high levels of participation.[10] Parents

who do not perceive an immediate behavioral problem, or who perceive a mismatch between their particular problem and the offered service, may be less likely to participate. Importantly, while personalization of information was most prominent among parents who reported significant behavioral problems, even parents who described normative child-rearing challenges voiced a need for a more tailored approach. Use of tools that allow parents to identify their priorities for well-visits (e.g., the Well-Visit Planner[27]) may help customize the provision of behavioral information, but it is important these priorities are not neglected once assessed. Stepped-care models of behavioral guidance, in which some broadly applicable information (e.g., use of positive praise) is available as a first step, but more detailed and personalized information is available for those who require it, may also provide for more personalized care. However, parents who encounter behavioral interventions they deem insufficient or inapplicable (i.e., the first step in a stepped model) may form negative attitudes toward those interventions, making them less likely to pursue additional services. For example, a parent who receives a cursory description of time-out as discipline strategy may implement it suboptimally and experience it as ineffective.[28] Subsequently, that parent might be hesitant to follow recommendations to use time-out, even if it is likely to be effective when delivered with fidelity or in the context of a more comprehensive intervention. Ideally, parents could be referred to types and intensities of interventions that are likely to be sufficient, but not excessive, for their needs. Comparative effectiveness research to determine which integrated care strategies are most likely to benefit which individuals is needed to inform more precise behavioral counseling.

The results indicate parents balance the perceived adequacy of information sources to meet their behavioral needs with relationship factors like trust and familiarity. Parents generally have an established relationship with their child's PCP, so when behavioral needs are minimal (e.g., preparing for toilet training), PCPs are usually the most desirable source. However, as parenting needs increase (e.g. toileting training in the context of persistent child resistance), expertise is more highly valued. This balance of trusted environment and behavioral expertise is foundational to the rationale of integrated primary care and has implications for the features of some integration models. For example, some evidence indicates that warm-handoffs increase follow-up engagement with behavioral services.[29] This process may facilitate a transfer of trust and familiarity from PCPs to behavioral providers, thereby increasing parents' comfort with services. Alternatively, some integrated programs (e.g., Healthy Steps[30]) consistently integrate behavioral providers into well-child care beginning early in life, allowing for trust and relationship building.

Attention to relationship factors may be especially important for parents who use corporal punishment, as this group expressed more dissatisfaction with previous services, fear of judgment from providers, and wariness of behavioral services. Pidano et al. recently found that parents' comfort in discussing mental health topics is inversely related to PCPs' dismissal of those concerns.[17] It may be that those parents who are most in need of behavioral services are the most likely to have interactions with providers that make them less likely to pursue those services. Use of an inviting and non-judgmental clinical style that normalizes and appreciates parents' behavioral concerns may help to attenuate this dynamic. Incorporating elements of motivational interviewing into behavioral counseling may also be helpful,[31] as more directive approaches may push ambivalent parents away from change.

Overall, parents want behavioral guidance delivery methods that convey sufficient information to meet their needs, can be received with minimal inconvenience to their daily lives, and normalize the care experience. Delivery of behavioral services during routine medical care may best strike this balance for most families. Evidence for single-session child behavioral health interventions concerns is growing,[32] and such interventions merit more study when implemented in the context of well-child care. Ideally, primary care could offer a spectrum of behavioral intervention delivery modalities (e.g., educational materials, consultation during medical care, co-located therapy, telehealth) across clinical content areas. Many families will likely require

more intervention than can feasibly be delivered in the context of medical visits, so determining whether briefly intervening to partially address presenting concerns or engaging in efforts to boost likelihood of engagement in follow-up care is a better use of time during medical visits is an important clinical decision. These alternatives are not necessarily mutually exclusive, and our results suggest that provision of tailored, actionable behavioral guidance may result in greater openness to continuing care. Allowing parents to choose their preferred method of receiving behavioral care through a shared decision-making process may increase engagement with available services, and our results indicate flexible delivery options may be especially important for families with lower SES, as they face more logistical barriers to engaging with office-based services.

In order to provide a spectrum of services, integrated behavioral health practitioners need access to a spectrum of payment and reimbursement mechanisms. As Miller et al.[33] discussed, different payment models support different models of behavioral health integration. For example, fee-for-service payment models tend to incentivize more traditional (i.e., separate from medical care) delivery of behavioral services, whereas global payment models allow for more flexibility in delivery modality and may incentivize more preventative care. As the field of integrated primary care evolves and evidence for different modalities of intervention accumulates, it is likely that new and alternative payment mechanisms will be needed to incentivize shifts in clinical practice.

Limitations

This study's limitations should be taken into account when considering the implications of the findings. The study was conducted in a single geographic region with parents of young children from five pediatric primary care practices. The representativeness of the participants' experiences and attitudes beyond those settings and age groups is unclear. Data saturation was reached for RQs 1–3, but larger subsamples of parents of varying parenting styles and income levels may have yielded more information about RQ4. In particular, as no parents with annual household incomes below $25,000 agreed to participate in the study, these results may be less generalizable for families living in poverty. Furthermore, the underrepresentation of fathers in this study precluded analysis of any comparison of the attitudes of mothers and fathers. It is possible that fathers' attitudes toward primary care behavioral services differ considerably, or that other factors interact with parent gender; however, our previous quantitative analyses did not identify any significant parent gender effects on priorities and preferences for behavioral primary care.[13] Finally, while the racial/ethnic characteristics of participants were proportionally more diverse than the surrounding region, Black parents were underrepresented (one multiracial parent identified as Black). This is an important limitation given racial/ethnic and cultural differences have significant implications for how parents seek out child-rearing information.[34] Understanding the role of these factors is critically important for designing and implementing accessible and equitable behavioral health services.

Declarations

Disclaimer **The content is solely the responsibility of the authors and does not necessarily represent the official views of the funders.**

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