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The CUIDAR Early Intervention Parent Training Program for Preschoolers at Risk for Behavioral Disorders:

An Innovative Practice for Reducing Disparities in Access to Service

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Abstract

Researchers report mental health disparities that indicate that children and families with the highest need for services often are less likely to use them. Only a few investigators have focused on service delivery models to address underuse of services. This study examines the Children's Hospital of Orange County (CHOC)/University of California, Irvine (UC Irvine) Initiative for the Development of Attention and Readiness (CUIDAR) model of service delivery in reducing disparities in access to and use of services and in decreasing child behavior problems in a community-based study with 169 self-referred, low-income, and predominantly minority families. The findings indicate that among minority families, CUIDAR is both more accessible and more equitably used than local, publicly funded mental health services. Among Latinos, attendance rates are higher when services are provided in Spanish. Parents report significant improvements in overall child difficulty and conduct problems. In addition, parents report high levels of satisfaction with the program.

Keywords

parent training; treatment access; intervention use; mental health disparities; preschool children; behavioral disorders

Children need nurturing, sensitively attuned, responsive caregiving environments for optimal development (e.g., Cassidy & Shaver, 1999). Parent–child emotional closeness, parental sensitivity to young children's emotions and needs, and the use of supportive adult guidance in place of punitive discipline yield more positive developmental outcomes for children (e.g., Teicher, 2002). Parent training programs are often used in early intervention to improve parenting skills and optimize child outcomes, especially in families with multiple risk factors, such as poverty and low parental educational attainment.

In a review of parent training studies, Barlow and Stewardt-Brown (2000) concluded that structured parent education programs are able to produce positive changes in parent perceptions and children's behavior. In the current study, we used the Community Parent Education (COPE) model, which has produced (a) improvements in parental problem-solving skills, (b) reductions in parent-reported child behavior problems, and (c) maintenance of those improvements at the 6-month follow-up with a community sample of 4-year-old children identified as having behavior problems in their homes (Cunningham, Bremner, & Boyle, 1995; Cunningham, Bremner, & Secord, 1998). A modified version of COPE for preschoolers also demonstrated promising findings, with parents reporting increased use of positive parenting skills, with concurrent reductions in child behavior problems and attention deficit–hyperactivity disorder (ADHD) symptoms in a community sample of families of 3- to 5-year-old children (Tamm et al., 2005). Other parent training models have shown similar, positive results (e.g., Webster-Stratton & Hammond, 1997; for a review see Barlow & Stewardt-Brown, 2000).

Challenges for researchers and clinicians who implement parent training programs have included promoting and sustaining parent participation (e.g., Tamm et al., 2005). Access to programs is often difficult, especially for low-income and minority families, who experience many disparities in access to most mental health interventions (U.S. Department of Health and Human Services, 1999).

Disparities in Access to Mental Health Services

Although the need for prevention and early intervention exists in all racial, ethnic, and socioeconomic groups, well-documented disparities indicate that many families have limited access to high-quality mental health services. In the United States, poverty and minority status have been associated with reduced access to mental health services, especially for Latinos (Alegria et al., 2002). According to the U.S. Department of Health and Human Services (1999), only 1 in 11 Latinos who have a mental health disorder have contacted a mental health specialist. Moreover, Latino children have entered mental health services at a later age and have received fewer services than African American or European American youths (Hough et al., 2002; Kataoka, Zhang, & Wells, 2002). Within particularly high-risk groups of children (e.g., children in foster care), the service use for European American children with relatively low needs has been equivalent to the service use for Latino children with higher needs (Garland, Landsverk, & Lau, 2003). Moreover, the U.S. Department of Health and Human Services reported that African Americans who need outpatient mental health services receive them at half the rate of non-Hispanic Whites. The report also indicated that African Americans are more likely to use emergency services and although underrepresented in outpatient treatment, they are overrepresented in inpatient treatment.

Vega and Lopez (2001) identified several potential barriers to service use for low–socioeconomic status and minority families, including (a) lack of insurance, (b) limited knowledge about mental health services, (c) administrative barriers (e.g., detection as undocumented immigrants), (d) distrust of and unfamiliarity with service providers, and (e) cultural and linguistic differences. Researchers from the U.S. Department of Health and

Human Services (1999) reported that about 40% of Latinos in the nation speak very limited English and there is a shortage of Spanish-speaking mental health providers. In addition, they noted that 37% of Latinos and 25% of African Americans are uninsured as compared with 16% of the general population. Vega and Lopez argued that research is needed to identify factors that improve access to appropriate mental health service use.

In this article, we describe the Children's Hospital of Orange County and University of California, Irvine Initiative for the Development of Attention and Readiness model (hereafter referred to as CUIDAR) of early intervention for children at risk for behavioral disorders. Our philosophy and approach has been to provide prevention and early intervention services prior to diagnosis and before expensive clinical evaluations with labeling of preschool children with psychiatric diagnoses (Tamm et al., 2005). We have used parent education to improve parent-child relationships and child outcomes in a culturally sensitive, community-based model of service delivery. The specific research questions about program implementation that we addressed in this study included the following:

1. Is the CUIDAR model accessed proportionally by Latino, African American, and European American families in San Bernardino County?
2. Do Latino parents who attend parent training groups provided in Spanish have better attendance than Latino parents who attend parent education groups provided in English?
3. Does the CUIDAR model of providing community-based intervention to self-referred parents serve children who can be categorized as at-risk for emotional and behavioral disorders?
4. Do the children of parents who complete the CUIDAR model report improvements in their behavior and parent-reported child problems? and
5. Are parents who attend the CUIDAR model satisfied with services and child and family outcomes?

Method

CUIDAR Model Components

The CUIDAR model consists of community-based services with two critical components: (a) the service delivery component and (b) the parent education component. We briefly describe the salient characteristics of each component and then provide evaluation information on the implementation of the CUIDAR model.

Service delivery model description—CUIDAR was designed to address the barriers to service noted previously (Vega & Lopez, 2001). Through funding provided by the Children and Families Commission of Orange County and First 5 San Bernardino, all services are provided free to local families with a child under the age of 5, and participants are not asked about insurance or residency status. We provide interventions in English and Spanish. During group sessions, we provide snacks or dinner and childcare, and we schedule interventions during daytime, evening, and weekend hours to increase access. We provide services in geographically convenient places where parents are comfortable (e.g., neighborhood preschools and churches) and enlist the cooperation and endorsement of persons (e.g., teachers, pastors) whom families know and trust, to help reduce the effects of distrust and unfamiliarity. Providing services in community sites, rather than mental health clinics, may reduce the stigma associated with seeking services. Each quarter groups are provided at new locations, allowing CUIDAR to cover a large geographical area.

To disperse information about mental health needs and the program, CUIDAR staff present at schools, churches, pediatric centers, and parent organizations throughout the regions. This strategy widely disperses information about mental health, young children, and available services—between July 2005 and June 2006, CUIDAR staff presented to more than 1,200 attendees in San Bernardino County alone. The *service before diagnosis* approach allows parents to self-refer and obtain services without labeling their children with a mental health diagnosis, which may be particularly important to parents of preschool children, and to families from diverse cultural backgrounds.

Parent education model description—CUIDAR modified the original COPE parent education model (Cunningham, Bremner, & Boyle, 1995) to be more appropriate for parents of preschoolers, and followed the authors' recommendations to provide a community-based, behaviorally oriented parent training curriculum with a child care component. The modified COPE curriculum consists of 10 weekly 2-hour sessions, including homework assignment and review, viewing videotaped parent–child interactions and identifying common parenting errors, discussing potential solutions to these errors, and modeling and role-playing strategies. A feature of the COPE model is the use of Socratic questioning to help facilitate increased feelings of self-efficacy for parents; for example, as parents view the videotaped parenting errors, they are encouraged within small groups to discuss and identify the errors, discuss the effect of the poor parenting practices on both the child's and parent's well-being, and generate more positive solutions. The topics for each session are summarized in Table 1. A more detailed description of the process by which COPE was modified for CUIDAR and results of a pilot study for COPE provided through CUIDAR in Orange County can be found in Tamm et al. (2005).

Participants

For most analyses, the participants included 169 children (117 Latino, 21 European American, 28 African American, and 3 Other). Due to missing data, some analyses used different numbers of children. Table 2 delineates the participants' demographics. Participants were identified by their parents or caregivers (hereafter referred to as parents), who voluntarily enrolled in CUIDAR. Enrolled children were between 3 and 5 years of age. In 82% of all cases, the participating parent or caregiver was an enrolled child's biological mother. Twenty-eight percent of the parents attended parent education classes provided in Spanish.

Procedures

This study was approved by the Internal Review Board of California State University, San Bernardino, and informed consent was obtained from all participants in accordance with human subjects research guidelines. All participants were from CUIDAR San Bernardino and were enrolled in either Spanish or English parenting groups, based on their preference of language. Parents were self-referred and learned of the groups via flyers distributed through preschools, churches, and community agencies. During enrollment, they were invited to participate in the research study and signed written consent forms. Interventionists described the protocol in either English or Spanish, depending on the preferred language of the parents. A demographic questionnaire (DQ) and the Strengths and Difficulties Questionnaire (SDQ) were administered during the first parent group session. To measure attendance, we documented parents' attendance on weekly sign-in logs that were verified by the group facilitator. Participants also completed the SDQ and Parent Satisfaction Questionnaire (PSQ) at the end of their 10-week intervention protocol.

Demographic questionnaire—Participants completed a demographic questionnaire that included questions about race and ethnicity, country of origin, family income, and parent

education level. The DQ was translated into Spanish by program personnel with professional translation experience. The DQ was developed, pilot tested, and revised in both English and Spanish for the CUIDAR model. CUIDAR personnel remained in the room while parents completed the measures and answered questions as they arose.

Strengths and Difficulties Questionnaire—The SDQ–Parent Version is a parent informant rating scale that was designed to measure child behavior across several domains: (a) emotional symptoms, (b) conduct problems, (c) peer relationship problems, (d) hyperactivity–inattention, and (e) prosocial behavior. Subscale scores except for the prosocial behavior subscale are added to yield a Total Difficulty Score. In this sample, Cronbach's alpha reliability coefficients were .62 (emotional difficulties), .68 (conduct problems), .67 (hyperactivity–inattention), .47 (peer problems), and .69 (prosocial behavior). In previous research, the SDQ subscales were found to correlate highly with the Child Behavior Checklist (CBCL; Goodman & Scott, 1999). In an effort to establish the SDQ as a screening measure for use in the United States, Bourdon, Goodman, Rae, Simpson, and Koretz (2005) published normative data for the SDQ gathered in the 2001 National Health Interview Survey with 9,878 racially and ethnically diverse children between 4 and 17 years of age. The Spanish version of the questionnaire that was used for this study is available at www.sdqinfo.org.

Parent Satisfaction Questionnaire—The PSQ is a social validity measure developed by CUIDAR personnel to evaluate the program and was administered in the final session of the intervention protocol. The PSQ was also translated into Spanish by CUIDAR personnel and pilot tested and then revised with more than 1,500 families in Orange County. Sample questions included “My relationship with my child has improved as a result of this class,” “I feel more confident as a parent,” and “My child's behavior has improved.” Parents respond using a 6-point Likert-type scale (1 = *strongly disagree*, 6 = *strongly agree*).

Results

With respect to Question 1 concerning equitable access and use of community-based mental health services, CUIDAR participants compared favorably with local county demographics. Specifically, we performed a chi-square analysis to determine differences between the observed CUIDAR and expected county demographics and the comparison showed no statistically significant difference between CUIDAR participants and local demographics, $\chi^2(3) = 6.215$, $p = .10$ (see Table 3). We also conducted a chi-square analysis comparing service use between the CUIDAR model and publicly funded mental health services and found reliable differences. Specifically, CUIDAR participation rates for minority families were higher when compared to publicly funded mental health services, especially for Latino families, $\chi^2(3) = 63.706$, $p = .000$ (see Table 4).

Concerning Question 2 about Latino parents' attendance in parent education training in their preferred language of Spanish, they attended more often than Latinos who attended courses provided only in English. We performed an independent samples t test to evaluate whether the Latinos in courses provided in Spanish attended at a higher rate than Latinos in classes provided in English. The comparison indicated a significant difference in attendance patterns, $t(115) = -3.92$, $p < .05$. Specifically, Latinos in parent training groups conducted in Spanish attended at a higher rate ($M = .77$, $SD = .30$) than did Latinos in English only classes ($M = .54$, $SD = .33$). The 95% confidence interval for the difference between the means ranged from .11 to .34; the eta-square effect size estimate indicated that language of instruction accounted for 12% of the variance in attendance rate.

With respect to Question 3 about the risk status of children who participated in the CUIDAR model, given their resultant parental SDQ ratings, they appeared to be at risk for behavioral disorders when compared to the U.S. SDQ standardization sample for 4- to 7-year-olds (see Table 5). Hence, SDQ ratings indicated that the CUIDAR model effectively enrolled self-referred parents of children who appeared to be at risk for behavioral disorders.

Concerning Question 4 about parental ratings of child difficulty and the level of parent-rated child conduct problems, children improved following intervention in a pre- to posttest only design. We performed a paired samples *t* test to determine whether Total Child Difficulty on the SDQ decreased from the pretest to the posttest following the CUIDAR program. The results indicated that the mean score for Total Child Difficulty was significantly higher at the pretest ($M = 13.30$, $SD = 6.22$) than on the posttest ($M = 11.27$, $SD = 5.89$), $t(101) = 3.61$, $p < .05$. The standardized effect size, Cohen's *d*, was .36. The 95% confidence interval for the mean difference between the pre- and posttest score was .91 to 3.14. We also conducted a paired samples *t* test to determine whether the average child's score for conduct problems on the SDQ decreased from the pre- to the posttest following interventions. The results indicated that the mean score for conduct problems was significantly higher at the pretest ($M = 13.30$, $SD = 6.22$) than on the posttest ($M = 3.62$, $SD = 2.35$), $t(118) = 3.59$, $p < .05$. The standardized effect size, Cohen's *d*, was .33. The 95% confidence interval for the mean difference between the pretest and posttest scores was .31 to 1.08.

With respect to Question 5 concerning parental satisfaction with services, parents reported high levels of satisfaction with the CUIDAR model. Specifically, on the PSQ they indicated that the intervention (a) enhanced their parenting skills (98% of respondents), (b) improved their sense of parent efficacy and confidence (98% of respondents), (c) enhanced their parent-child relationships (96% of respondents), and (d) improved their child's behavior (97% of respondents).

Discussion

The CUIDAR model was designed to deliver responsive prevention and early intervention services to underserved preschool children who are at risk for behavioral disorders and their families. Our results indicated that CUIDAR services were successful in recruiting parents of children at risk for emotional and behavioral disorders and improving intervention access and participation for many underserved families (e.g., low-income, Latino). Our other primary finding was that the CUIDAR model appears to be effective in reducing both the parent-rated level of child difficulty and child conduct problems as indicated by parental reports.

Reducing Disparities in Access to and Use of Services

We found no differences in access or participation rates based on race or ethnicity in our local area (i.e., no significant difference between the racial or ethnic breakdown of CUIDAR participants and county demographics). This is in contrast with the other local mental health service use rates, and our findings indicated that the disparities evident in the county's publicly funded mental health services were not evident in the CUIDAR model. Thus, CUIDAR community-based services may serve as an exemplary model to decrease disparities in access to and use of preventive mental health services.

Identification of Children at Risk

The descriptive data for the CUIDAR participating families demonstrates that the children were at high risk for emotional and behavioral disorders, or a psychiatric diagnosis, as demonstrated by Goodman, Ford, Richards, Gatward, and Meltzer (2000). In the absence of

a systematic community screening system to identify children at risk for emotional and behavioral disorders, the CUIDAR model increases community awareness and results in parents of high-risk children self-referring to the program. These findings have important implications for policy makers and others interested in prevention and early intervention efforts with young children. Systematic, comprehensive efforts to universally screen children under 5 years of age are currently being discussed in California and elsewhere. Many challenges may arise for such efforts, including locating children for screening, especially those in high-risk families, and sustaining the necessary funds for the associated costs for universal screening. Some children in high-risk communities do not receive routine medical care and often are not enrolled in preschool, making it difficult to identify them for any needed screening or services. Although developing a comprehensive screening system likely holds the best promise for early identification of children at risk for behavioral and other developmental problems, in most communities, it may well take years for a screening system to become effective. The CUIDAR model has promise as a prevention and early intervention approach that can recruit and serve underserved parents of children at risk for emotional and behavioral disorders. Moreover, the services include using a flexible, community outreach screening approach, whereby participants may enter the program through multiple avenues (e.g., screening and subsequent referral from medical practitioners, screening and referral by preschool teachers, and parent self-selection through community awareness presentations that encourage parents to be the “screeners” for their child).

We also addressed differences in intervention participation for Latino families attending English versus Spanish parent training groups. We found that participation was greater for Latinos attending parent education groups in Spanish than Latinos attending groups only in English. This finding is consistent with previous research indicating that mental health consumers prefer to receive services in their native languages (e.g., Aguilar-Gaxiola et al., 2002).

Limitations

There were a number of limitations in our study that should be addressed in the future. First, the sample was fairly homogenous, as the majority of participants were Latino and low-income. As a result, the numbers of European American and African American participants were relatively small, and we did not have the statistical power to include ethnicity as a factor in some of the analyses. The sample is, however, highly representative of many underserved communities in southern California and other regions of the United States.

Second, in the current study we focused on service delivery and program access rather than specific intervention outcomes. Future investigators should examine the efficacy of the model with other populations in other locales. Although the approach has been studied previously with positive results (Tamm et al., 2005), the intervention procedures have not yet been evaluated in a well-designed and performed randomized clinical trial with pre-school-age children and with multiple measures of children's difficulties and abilities. Our pre- to posttest analyses of a local population with only the single parent-rating scale to assess child behavior is simply not sufficient to determine the efficacy or effectiveness of the CUIDAR model. Third, we had limited information on the English proficiency, residency status, or time in the United States of our Latino families. Although we ask for country of origin for grandparents, parents, and children, we have not included questions on our demographics questionnaire asking directly about amount of time the family was in U.S. residence or their residency status because we are concerned that that this might restrict families' participation in the program. Fourth, similar to most educational and psychological interventions, we acknowledge that participants who voluntarily enroll in the CUIDAR model may be a different population from those who do not enroll, and therefore results may

not generalize to extremely high-risk families who often do not seek services. Finally, we did not directly measure the parents' perceived barriers to participation in the CUIDAR model.

Implications for Practitioners

Based on the evidence presented, CUIDAR, as a service delivery model, has implications for practitioners concerned with reducing disparities in access to early intervention. Some of these are summarized below:

1. Consider lack of insurance or poor insurance coverage as a potential barrier and work with policy makers and donors to obtain funding sources that allow families to participate in early intervention at no or little cost to the families.
2. Provide community education about child development and mental health to increase knowledge and appropriate referral to early intervention.
3. Consider the location of services and whenever possible provide mobile services or services in varying community locations easily accessed by families.
4. Reduce administrative barriers such as requiring extensive personal information or documentation of residence status.
5. Reduce the effects of distrust and unfamiliarity by engaging community leaders (particularly "unofficial" leaders) to support and disperse information about early intervention.
6. Reduce the effects of stigmatizing young children by providing services before making diagnoses.
7. Provide services in the primary language of the family.
8. And make efforts to improve the accessibility of early intervention. This may include providing services during hours (e.g., evening, weekend) convenient to working families. In addition, providing childcare, food, and other incentives may help improve participation.

Conclusion

Community-based service delivery models such as the CUIDAR program may result in recruitment of parents of children at risk for emotional and behavioral problems. Moreover, the approach may improve access and intervention participation among underserved participants (e.g., low-socioeconomic status, ethnic-minority groups). A CUIDAR follow-up study is currently underway to evaluate the degree to which positive outcomes are maintained over time. In addition, the follow-up study included questions addressing barriers to participation that may provide some insight into which barriers are most critical to address to improve access for underserved families of children with severe emotional and behavioral problems. In summary, racial, ethnic, and socioeconomic disparities in access to prevention and early intervention ought to be given high priority in enhancing mental health services across the nation (Arons, Katz-Leavy, Wittig, & Holden, 2002).

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Table 1

Description of Community Parent Education (COPE) Modification for CUIDAR

Session	Title	Description
1	Introduction	Discussing goals and expected outcomes
2	Attending & Rewards	Praising and providing social rewards
3	Planned Ignoring	Anger management and conflict resolution, ignoring comments that may escalate arguments
4	Transitional Warnings & When–Then Statements	Helping children manage transitions, pairing parental demands with rewards to increase compliance
5	Planning Ahead	Anticipating and planning for situations that may be difficult for children
6	Point Systems	Using simple, developmentally appropriate point systems to encourage positive behaviors
7	Time Out	Using time-out as a last resort strategy
8	Response Cost: Time Out From Privileges	Taking away a privilege and developing realistic consequences. Discussing punishment options (positive and negative) and the short- and long-term probable consequences of each
9	Problem Solving	Using PASTE: Pick a problem, consider alternative solutions, select the best strategy, try it out, and evaluate it
10	Closing	Reviewing and celebrating completion of COPE

Table 2

Demographics of the Full Sample by Ethnicity

	Latinos	European Americans	African Americans	Other	Total
Household income					
<\$4,999	16	3	3	0	22
\$5,000-9,999	7	2	5	0	14
\$10,000-14,999	13	1	3	1	18
\$15,000-24,999	24	5	4	1	34
\$25,000-40,000	23	2	6	1	32
>\$40,000	34	8	7	0	49
Parent education					
More than high school	1	0	0	0	1
High school	42	2	6	0	42
Some college or vocational	35	5	4	0	35
Bachelor's degree	24	10	13	2	24
Advanced degree	4	2	3	1	4
Total	117	21	28	3	169

Table 3
CUIDAR Participant Race or Ethnicity Compared to SBC Population Demographics

CUIDAR Target Child					SBC Population Under 18			$\chi^2(3)$
Latino	European American	African American	Other Race or Ethnicity	Latino	European American	African American	Other Race or Ethnicity	
69%	12.4%	16.6%	2%	61%	18.4%	11.9%	8.6%	6.215

Note: SBC = San Bernardino County, California. SBC population demographics are based on data reported by the Children's Network (2006).

Table 4
CUIDAR Participant Race or Ethnicity Compared to SBC Publicly Funded Mental Health Services Participant Demographics

CUIDAR Target Child		SBC Publicly Funded Mental Health Services Participants (Ages 0-18)				$\chi^2(3)$
Latino	European American	African American	Other Race or Ethnicity	Latino	European American	
69%	12.4%	16.6%	2%	32%	40%	20%
						8%
						63.706***

Note: SBC = San Bernardino County, California. SBC service participant demographics are based on data reported by the Children's Network (2006).

 $p < .001$.

Table 5

SDQ Results for CUIDAR Participants Based on U.S. Normative Data for Children Ages 4 to 7

SDQ Subscales	<i>M</i>	<i>SD</i>	Percentile	Normative Band
Emotional symptoms	3	2.6	89.0%	Medium difficulties
Conduct problems	5	2.6	97.5%	High difficulties
Hyperactivity/inattention	5	2.0	82.9%	Low difficulties
Peer problems	5	1.9	98.4%	High difficulties
Total difficulties	16	4.6	93.7%	High difficulties

Note: SDQ = Strengths and Difficulties Questionnaire. Mean scores are rounded to the nearest number. Normative banding includes three bands: low, medium, and high. Percentiles show what percentage of the U.S. normative sample had scores falling below the CUIDAR mean.