Published in final edited form as:

Vulnerable Child Youth Stud. 2017 ; 12(3): 215–225. doi:10.1080/17450128.2017.1282069.

Pilot and feasibility study of a parenting intervention delivered by parent peers

Ashley M. Butler and Courtney Titus

Department of Pediatrics, Baylor College of Medicine, Houston, TX, USA

Abstract

Preventive parenting interventions delivered by parent peer specialists may be a viable alternative to professional-led interventions and offer an advantage of increasing access in medically underserved areas. The objective of this pilot study was to assess the feasibility and preliminary outcomes of a 10-session, peer specialist-delivered preventive parenting intervention (*Smart and Secure Children*) for child disruptive behavior. The intervention was evaluated among a small sample of parents ($N = 15$) of preschoolers (2–5 years) residing in medically underserved communities. Pediatricians referred families to the intervention, which was delivered in primary care practices within medically underserved communities. To determine feasibility, we calculated percentages of pediatricians who referred parents to the intervention, parent peer specialists who completed 40-h interventionist and leadership training, and the average number of sessions attended by parents. Enrolled parents completed questionnaires assessing child disruptive behavior, parenting stress and parenting competence at pre- and post-intervention. Descriptive statistics demonstrated the majority of pediatricians within the clinics referred families, and all parent peer specialists completed training to deliver the intervention. On average, 60% of sessions were attended by parents. Pairwise t -tests showed pre-to-post-intervention improvements in number of child disruptive behaviors perceived as a problem by parents, parenting stress and parenting competence. No significant change was found in parent-reported frequency of child disruptive behaviors. Results suggest adequate feasibility of the Smart and Secure Children Intervention, and that it holds promise for improving parenting stress and competence, and decreasing the number of child behaviors that are perceived as a problem by parents. Future directions for research are discussed.

Keywords

Child disruptive behavior; parent training; peer; support specialist

Disruptive behaviors include oppositional, aggressive, defiant and hyperactive behavior, and represent a common classification of mental health problems in childhood (Cosgrove et al., 2011). The public health outcomes of disruptive behavior problems can be costly, given their worsening or persistence without adequate intervention. Indeed, the annual cost of disruptive

Contact: Ashley M. Butler, ambutler@bcm.edu, Department of Pediatrics, Baylor College of Medicine, 1102, Bates St., Suite 940, Houston, TX 77030, USA.

Disclosure statement: No potential conflict of interest was reported by the authors.

behavior disorders across childhood is \$2753–\$5625 per child (Foster & Jones, 2005). Preventing the escalation of disruptive behavior during the preschool-age years is important to reduce these costs and to avert later child, family and public health burden during adolescence such as school failure and juvenile justice involvement (Ezpeleta, Keeler, Erkanli, Costello, & Angold, 2001; Fite, Wynn, & Pardini, 2009).

A large body of literature shows parenting interventions are effective for preventing escalations in preschool-age disruptive behavior (Fernandez, Butler, & Eyberg, 2011; Reid, Webster-Stratton, & Beauchaine, 2001). However, there is a significant workforce shortage for delivering preventive interventions that significantly restricts reach, especially in *medically underserved communities* in the United States (Institute of Medicine, 2006). Medically underserved communities consist of areas with few primary care providers and high levels of high poverty. Provider shortages in these areas exist for psychologists, nurses, social workers and other clinicians to deliver preventive interventions. Given these professional provider shortages, there is a need to identify novel intervention delivery approaches that successfully prevent escalating disruptive behavior problems among children in medically underserved areas.

Preventive parenting interventions delivered by *parent peer support specialists* are a viable alternative to professionally led interventions. Parent peer support specialists are primary caregivers of children who have personal experiences in successfully addressing childhood disruptive behavior problems, and have received training to support other parents raising young children (Cavaleri, Olin, Kim, Hoagwood, & Burns, 2011; Hoagwood et al., 2010). Parent peer support specialists can uniquely serve as trustworthy and credible sources for other parents as they share their own experiences and solutions in addressing children's disruptive behavior (Gyamfi, Burns, Stephens, Geng, & Stambaugh, 2010; Robbins et al., 2008). Another advantage of interventions led by peer support specialists is the increasing availability of reimbursement for peer-delivered interventions, given some states in the United States have endorsed Medicaid reimbursement for parent peer support services (Center for Health Care Strategies, 2012). Peer-delivered interventions are effective for improving physical health outcomes among children (Eggleston et al., 2005; Flores et al., 2009; Parker et al., 2008; Williams et al., 2006). Preventing parenting interventions led by peer support specialists may also be effective for addressing young children's disruptive behavior (Salzer, Schwenk, & Brusilovskiy, 2010); yet no study has examined the feasibility or preliminary outcomes of such preventive interventions (Cavaleri et al., 2011).

The focus of this study is the *Smart and Secure Children* (SSC) intervention. The SSC intervention is a 10-week manualized intervention that was developed using community-based participatory research in collaboration with community members residing in neighborhoods within the United States that are characterized by high rates of poverty (Okafor, Sarpong, Ferguson, & Satcher, 2014). The SSC intervention was designed to increase parenting knowledge, parenting skills and parental mental well-being as parental protective factors to reduce the negative impact of poverty and related risk factors affecting children's mental health. The SSC intervention is group-based and conducted by parent peer specialists (titled *Parent Leaders*) using a conversational learning process. Parent Leaders facilitate conversations on the SSC intervention content by sharing their own real-life

applications, experiences and solutions to children's disruptive behaviors. Parent Leaders receive training in leadership skills and in the intervention content prior to delivering the SSC intervention.

The purpose of this study was to evaluate the feasibility, fidelity and preliminary outcomes of child disruptive behavior, parental stress and parental competence of the SSC intervention delivered in primary care practices located within medically underserved communities. We hypothesized that results would indicate (a) the intervention is feasible as evidenced by a high percentage of pediatricians referring parents to the intervention, a high percentage of Parent Leaders completing training to deliver the SSC intervention and a high percentage of average intervention session attendance; (b) the intervention can be delivered with high fidelity; and (c) medium-to-large effect sizes for the preliminary outcomes.

Method

Setting

The study was conducted in two pediatric primary care clinics located in zip codes that are designated as medically underserved areas by the United States Health Resources and Services Administration (HRSA). HRSA uses an index comprised of the following to determine medically underserved areas: the ratio of primary medical care physicians per 1000 population, infant mortality rate, percentage of the population with incomes below the poverty level and percentage of the population aged 65 or over (Department of Health and Human Services, 2016). The population of children served within the two primary care clinics in this study are predominantly from minority backgrounds (approximately 70% African-American and 30% Latino) and have public insurance (80%).

SSC intervention

The theoretical basis for and content of the SSC intervention are described in detail elsewhere (Okafor et al., 2014). Briefly, session content is detailed in an interventionist manual that specifies the objectives and content of each session, order of presentation and sample dialogues. Parents who receive the intervention are provided with a workbook to support reflective activities and goal-setting during each session. During each of the 10 sessions, parents are provided with time to reflect on their current parenting practices and write goals related to the content that was presented. The first session consisted of information on factors that contribute to children's healthy brain development (e.g. healthy nutrition, stimulating and enriched home environments). The second session consisted of information on behavioral skills related to promoting healthy nutrition in order to prevent obesity and related diseases. The third session addressed adequate sleep and physical activity for children, as well as age-appropriate learning activities. In the fourth session, Parent Leaders addressed key areas of child development (e.g. cognitive, social-emotional). During the fifth session, parents focused on how to pose questions to children during television time to promote learning. The sixth session introduced parenting strategies to support positive social-emotional development. The seventh session included information about promoting empathy, as well as challenges and potential opportunities in blended families. The eighth session covered positive discipline. In the ninth session, parents learned

and practiced cognitive-behavioral strategies to manage stressors in their life. In the final session, parents engaged in role-play activities involving effective discipline strategies. The SSC intervention sessions were conducted with a maximum group of five parents. Each of the group sessions was led by two Parent Leaders who received in-person supervision by a licensed clinical psychologist.

Parent Leaders

Five Parent Leaders were recruited to deliver the SSC intervention. Minimum qualifications of the Parent Leaders included the following: being 18 years or older, completed the General Educational Development test/obtained a high school diploma, being the primary caregiver of a young child (8 years and below), lived within a medically underserved area of a clinic, being able to articulate challenges in their lived experiences related to addressing children's disruptive behavior and able to discuss successful experiences of participation in a parent-based intervention for their child's health/development (e.g. Home Visiting program). Table 1 shows the demographic characteristics of the Parent Leaders. They received financial incentives for delivering each session of the intervention.

Participant enrollment

Institutional Review Board approval was obtained for the study. We informed the seven pediatricians from the two primary care practices of the purpose of the research, and requested that they provide referrals to the study. Inclusion criteria were being the parent of a child between the ages of 2 and 5 years and English as the primary household language. The exclusion criterion was the child having a pervasive developmental disorder capable of affecting behavior (e.g. autism spectrum disorder). Thirty parents of children were referred to the study by their child's pediatrician. Fifty percent of these parents ($n = 15$) were able to be contacted by the research team and signed informed consent for the study. Demographic information of the 15 parents and their children at pre-intervention are included in Table 2. The majority of caregivers who consented to participate were the biological parent (73%), had obtained a high school diploma as their highest level of educational attainment (73%), were never married or divorced/separated (60%) and had a household income of less than \$40,000 per year (80%).

Measures

Feasibility—To determine intervention feasibility, we calculated the percentages of pediatricians in the primary care practices ($N = 7$) who referred families to the intervention, recruited parents ($N = 5$) who completed training activities for the parent peer leader role and average number of sessions attended.

Fidelity—Intervention fidelity was determined using audiotaped sessions and an observer-rated 20-item checklist created by the SSC program developers. The 20 items are rated on a dichotomous scale (yes vs. no). Sample items included the following: 'Completed all activities/discussions as described for this session' and 'Provided balance between "lecture" and "facilitated" discussion among participants'. A random sample of 50% of the intervention sessions ($n = 15$) was reviewed and rated by a research staff member.

Eyberg Child Behavior Inventory—The 36-item Eyberg Child Behavior Inventory is a parent-report measure of disruptive behavior (Eyberg, 1999). The instrument is comprised of two scales: the Intensity Scale and Problem Scale. The Intensity Scale reflects the frequency of specific disruptive behaviors. Items are rated on a 7-point scale ranging from never to always. The Problem Scale reflects the number of disruptive behaviors that are perceived as a problem by parents. Items are rated on a dichotomous yes/no scale. The internal consistencies for the Intensity and Problem Scales are .93 and .98, respectively (Eyberg, 1999). Adequate internal consistencies have been reported for African-American and Latino children (Butler, 2013; Gross et al., 2007).

The Parenting Stress Index – Fourth Edition—The Parenting Stress Index – Fourth Edition (PSI-4) is a 120-item self-report measure (Abidin, 2012). The Child Domain scale was used, which assesses parents' level of stress related to characteristics displayed by children that make them difficult to parent. Items are rated on a 5-point scale ranging from strongly agree to strongly disagree. Internal consistency of the Child Domain scale is .90 (Abidin, 2012).

The Parenting Sense of Competence Scale—The Parenting Sense of Competence Scale is a 16-item questionnaire that assesses parents' level of parenting self-efficacy (Gilmore & Cuskelly, 2009). Items are rated on a 6-point scale ranging from strongly agree to strongly disagree. Internal consistency has reported at .75–.88 (Gilmore & Cuskelly, 2009).

Procedure

Study authors sent letters that described the study to parents of young children who had participated in a previous study on preschool-age disruptive behavior to recruit Parent Leaders. Letters were mailed to six parents. Letters were followed up with a phone call from study investigators to determine interest. Five parents were recruited to be Parent Leaders. A 1-week, 40-h training with Parent Leaders was conducted by two trainers who had received instruction for training others in the curriculum and in leadership skills. Parent Leaders received compensation for completing the 40-h training and delivering each intervention session.

Pediatricians referred 30 parents of young children during the enrollment period. Investigators reached 15 (50%) parents who provided consent. Parents who consented to participate in the study completed pre-intervention questionnaires assessing child disruptive behavior, parenting stress and parenting competence with research staff. After five parents provided consent, they were selected to form a group to receive the intervention. The second group of five participants who provided written consent formed a second group to participate in the intervention, and so on for the third group. Research staff reminded parents of each upcoming session, and light snacks were provided at each session to facilitate retention. Immediately after participation in the intervention, parents completed post-intervention questionnaires. Parents received financial compensation for completing questionnaires.

Attrition

Fifteen parents met the inclusion criteria for the study and signed an informed consent form. Of the 15 parents, 6 completed post-intervention questionnaires (40%), 4 parents attended at least one session but did not complete post-intervention questionnaires (27%) and 5 parents did not attend any sessions or complete post-intervention questionnaires (33%). Thus, two of the groups were begun with three parents, and one group was begun with four parents. Chi-square statistics indicated parents who completed post-questionnaires, and those who did not were not different with regard to their level of education, income, marital status or race/ethnicity. Similarly, independent samples *t*-test indicated no differences in children's mean age. Table 2 indicates that parents who completed post-intervention questionnaires were biological parents and African-American. Most were never married/divorced or separated (67%) and had a yearly household income of less than \$40,000 (67%). Half of the parents' (50%) highest level of education was obtaining a high school diploma.

Overview of analyses

To determine feasibility, we calculated percentages of pediatricians ($N = 7$) who referred families to the intervention program, recruited Parent Leaders who completed the 40-h training, and average sessions attended by parents who attended at least one session ($N = 10$). To determine fidelity, we calculated the average percentage of 'yes' responses to 20 items for each randomly reviewed session and then calculated the average across the 15 reviewed sessions. Pairwise *t*-tests were conducted to evaluate pre- to post-intervention changes in the frequency of child disruptive behaviors, number of disruptive behaviors perceived as a problem by parents, levels of parenting stress and levels of parenting self-efficacy. Cohen's *d* estimates were calculated to determine the effect sizes of pre- to post-intervention changes.

Results

Intervention feasibility

Eighty-six percent ($n = 6$) of the seven pediatricians within the clinics referred families, and all five parents who were recruited to be Parent Leaders (100%) completed interventionist and leadership training. The average percentage of sessions attended was 60%.

Intervention fidelity

Fifteen of the 30 intervention sessions were reviewed. Calculations indicated that fidelity was 78%.

Preliminary outcomes

Pairwise *t*-tests and Cohen's *d* calculations indicated statistically significant and large improvements from pre- to post-intervention in number of child disruptive behaviors perceived as a problem ($t = 2.62$, $p = .04$, $d = 1.1$), parenting stress ($t = 3.50$, $p = .02$, $d = 1.5$) and parenting competence ($t = 3.36$, $p = .02$, $d = 1.5$). No significant changes were found in the frequency of child disruptive behaviors, but the results indicated a medium effect size ($d = .50$). See Table 3 for means and standard deviations.

Discussion

The purpose of this study was to evaluate the feasibility, fidelity and preliminary short-term outcomes of an innovative preventive parenting intervention delivered by peer support specialists in medically underserved communities. The results of this pilot feasibility study of the SSC intervention are promising. The findings suggested that the peer specialist-delivered intervention is practical to implement in primary care practices serving primarily racial/ethnic minority families living in medically under-served communities, and that the intervention may improve parent psychological functioning and decrease child disruptive behavior. Importantly, the results also indicated that peer specialists from medically underserved communities can deliver the intervention with fidelity. While a small number of studies have demonstrated the effectiveness of peer-delivered services for parents (Hoagwood et al., 2010), this study is one of the few focused on a preventive intervention (Cavaleri et al., 2011). The results of this study have several implications for future research on the SSC intervention in medically underserved areas.

First, previous research has demonstrated that some providers view peer-led interventions less favorably than professionally led interventions, which may result in decreased referrals to peer-led programs (Alberta, Ploski, & Carlson, 2012; Kutash et al., 2014). In the current study, the majority of providers referred families to the intervention. Pediatricians were informed that the peer support specialists would receive comprehensive training to deliver the intervention, as well as ongoing supervision by a psychologist. It is possible that this may have facilitated referrals to the program. Future research that examines pediatrician referrals to interventions led by peer specialists with a larger sample of providers is needed to confirm the findings and determine factors that facilitate referral rates.

Second, the parent peer specialists in this study received a 40-h training prior to their implementation of the intervention, and this initial training was followed by group-based, in-person supervision throughout the implementation of the intervention. Yet, our review of the literature indicates there is wide variation in the length of training for peer support specialists across research studies (Dyken, Fisher, Taylor, Lambert, & Miodrag, 2014). Future research that examines associations between training dosage, training format and intervention fidelity is needed to inform best training practices for parent peer specialists.

Third, previous studies have demonstrated modest enrollment and attendance rates in preventive parenting interventions. Enrollment rates in previous studies have ranged from 45% to 60% (August, Lee, Bloomquist, Realmuto, & Hektner, 2003; Begle, Lopez, Cappa, Dumas, & de Arellano, 2012; Brotman et al., 2005), and average attendance has ranged from 45% to 55% of sessions (Begle et al., 2012; Linares, Montalto, Li, & Oza, 2006). Results from the current study are in line with this previous research. This study included pediatrician referrals, incentives, snacks at each session and frequent contact with participants to facilitate recruitment, attendance and retention. Future research would benefit from evaluation of (a) recruitment through parent-focused community-based organizations and (b) fewer in-person sessions combined with alternative intervention delivery formats, such as telephone-based support, or technology-delivered components (i.e. Internet). Additionally, research studies in medically underserved low- and middle-income countries

have indicated that conditional cash transfer programs increase preventive services use (Lagarde, Haines, & Palmer, 2007). These programs provide income to families for using preventive services (Lagarde, Haines, & Palmer, 2009). A promising direction for future research is evaluating whether conditional cash transfer programs implemented in medically underserved communities increase enrollment and attendance in preventive parenting interventions such as SSC.

A limitation of this pilot and feasibility study is the lack of a control group to ensure preliminary changes were due to the intervention instead of extraneous factors. Additionally, as noted earlier, enrollment and average intervention attendance rates were modest but consistent with previous research. Overall, this research contributes to the growing body of literature documenting benefits of trained parent peers specialists in delivering interventions to parents of young children, and is one of the few studies focused on a preventive intervention.

Acknowledgments

Funding: Research reported in this manuscript was supported by the National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health under award number [K12DK097696] and by the National Institute on Minority Health and Health Disparities of the National Institutes of Health under award number [U54MD008173].

References

- Abidin, RR. Parenting stress index. 4th. Lutz, FL: PAR; 2012.
- Alberta AJ, Ploski RR, Carlson SL. Addressing challenges to providing peer-based recovery support. *The Journal of Behavioral Health Services & Research*. 2012; 39(4):481–491. DOI: 10.1007/s11414-012-9286-y [PubMed: 22828975]
- August GJ, Lee SS, Bloomquist ML, Realmuto GM, Hektner JM. Dissemination of an evidence-based prevention innovation for aggressive children living in culturally diverse, urban neighborhoods: The Early Risers effectiveness study. *Prevention Science : The Official Journal of the Society for Prevention Research*. 2003; 4(4):271–286. DOI: 10.1023/A:1026072316380 [PubMed: 14598999]
- Begle AM, Lopez C, Cappa K, Dumas JE, de Arellano MA. Ethnicity differences in child and parental outcomes following involvement the PACE program. *Behaviour Research and Therapy*. 2012; 50(1): 56–64. DOI: 10.1016/j.brat.2011.09.009 [PubMed: 22041087]
- Brotman LM, Gouley KK, Chesir-Teran D, Dennis T, Klein RG, Shrout P. Prevention for preschoolers at high risk for conduct problems: Immediate outcomes on parenting practices and child social competence. *Journal of Clinical Child and Adolescent Psychology : The Official Journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*. 2005; 34(4):724–734. DOI: 10.1207/s15374424jccp3404_14
- Butler AM. Cross-racial measurement equivalence of the Eyberg Child Behavior Inventory factors among low-income young African American and non-Latino White children. *Assessment*. 2013; 20(4):484–495. DOI: 10.1177/1073191111431341 [PubMed: 22186637]
- Cavaleri MA, Olin SS, Kim A, Hoagwood KE, Burns BJ. Family support in prevention programs for children at risk for emotional/behavioral problems. *Clinical Child and Family Psychology Review*. 2011; 14(4):399–412. DOI: 10.1007/s10567-011-0100-9 [PubMed: 22080305]
- Center for Health Care Strategies. Medicaid financing for family and youth peer support: A scan of state programs. 2012. Retrieved from http://www.chcs.org/usr_doc/Family_Youth_Peer_Support_Matrix_052512.pdf
- Cosgrove VE, Rhee SH, Gelhorn HL, Boeldt D, Corley RC, Ehringer MA, et al. Hewitt JK. Structure and etiology of co-occurring internalizing and externalizing disorders in adolescents. *Journal of*

- Abnormal Child Psychology. 2011; 39(1):109–123. DOI: 10.1007/s10802-010-9444-8 [PubMed: 20683651]
- Department of Health and Human Services. Medically underserved areas. 2016. Retrieved June 7, 2016, from <http://www.hrsa.gov/shortage/mua>
- Dykens EM, Fisher MH, Taylor JL, Lambert W, Miodrag N. Reducing distress in mothers of children with autism and other disabilities: A randomized trial. *Pediatrics*. 2014; 134(2):e454–e463. DOI: 10.1542/peds.2013-3164 [PubMed: 25049350]
- Eggleston PA, Butz A, Rand C, Curtin-Brosnan J, Kanchanaraksa S, Swartz L, et al. Krishnan JA. Home environmental intervention in inner-city asthma: A randomized controlled clinical trial. *Annals of Allergy, Asthma & Immunology: Official Publication of the American College of Allergy, Asthma, & Immunology*. 2005; 95(6):518–524. DOI: 10.1016/S1081-1206(10)61012-5
- Eyberg, SM. Eyberg child behavior inventory. Lutz, FL: PAR; 1999.
- Ezpeleta L, Keeler G, Erkanli A, Costello EJ, Angold A. Epidemiology of psychiatric disability in childhood and adolescence. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*. 2001; 42(7):901–914. DOI: 10.1111/1469-7610.00786
- Fernandez MA, Butler AM, Eyberg SM. Treatment outcomes for low socio-economic status African American families in parent-child interaction therapy: A pilot study. *Child and Family Behavior Therapy*. 2011; 33(1):32–48. DOI: 10.1080/07317107.2011.545011
- Fite PJ, Wynn P, Pardini DA. Explaining discrepancies in arrest rates between Black and White male juveniles. *Journal of Consulting and Clinical Psychology*. 2009; 77(5):916–927. DOI: 10.1037/a0016626 [PubMed: 19803571]
- Flores G, Bridon C, Torres S, Perez R, Walter T, Brotanek J, et al. Tomany-Korman S. Improving asthma outcomes in minority children: A randomized, controlled trial of parent mentors. *Pediatrics*. 2009; 124(6):1522–1532. DOI: 10.1542/peds.2009-0230 [PubMed: 19948624]
- Foster EM, Jones DE. The high costs of aggression: Public expenditures resulting from conduct disorder. *American Journal of Public Health*. 2005; 95(10):1767–1772. DOI: 10.2105/AJPH.2004.061424 [PubMed: 16131639]
- Gilmore L, Cuskelly M. Factor structure of the Parenting Sense of Competence Scale using a normative sample. *Child: Care Health and Development*. 2009; 35(1):48–55. DOI: 10.1111/j.1365-2214.2008.00867.x
- Gross D, Fogg L, Young M, Ridge A, Cowell J, Sivan A, Richardson R. Reliability and validity of the Eyberg Child Behavior Inventory with African-American and Latino parents of young children. *Research in Nursing & Health*. 2007; 30(2):213–223. DOI: 10.1002/nur.20181 [PubMed: 17380522]
- Gyamfi PWC, Burns BJ, Stephens RL, Geng Y, Stambaugh L. Family education and support services in systems of care. *Journal of Emotional and Behavioral Disorders*. 2010; 18(1):14–26. DOI: 10.1177/1063426609333891
- Hoagwood KE, Cavaleri MA, Serene Olin S, Burns BJ, Slaton E, Gruttadaro D, Hughes R. Family support in children's mental health: A review and synthesis. *Clinical Child and Family Psychology Review*. 2010; 13(1):1–45. DOI: 10.1007/s10567-009-0060-5 [PubMed: 20012893]
- Institute of Medicine. Improving the quality of health care for mental and substance use conditions. Washington, DC: National Academies Press; 2006.
- Kutash K, Acri M, Pollock M, Armusewicz K, Serene Olin SC, Hoagwood KE. Quality indicators for multidisciplinary team functioning in community-based children's mental health services. *Administration and Policy in Mental Health*. 2014; 41(1):55–68. DOI: 10.1007/s10488-013-0508-2 [PubMed: 23873037]
- Lagarde M, Haines A, Palmer N. Conditional cash transfers for improving uptake of health interventions in low- and middle-income countries: A systematic review. *JAMA*. 2007; 298(16):1900–1910. DOI: 10.1001/jama.298.16.1900 [PubMed: 17954541]
- Lagarde M, Haines A, Palmer N. The impact of conditional cash transfers on health outcomes and use of health services in low and middle income countries. *Cochrane Database Systems Review*. 2009; 4(CD008137)doi: 10.1002/14651858.CD008137

- Linares LO, Montalto D, Li M, Oza VS. A promising parenting intervention in foster care. *Journal of Consulting and Clinical Psychology*. 2006; 74(1):32–41. DOI: 10.1037/0022-006X.74.1.32 [PubMed: 16551141]
- Okafor M, Sarpong DF, Ferguson A, Satcher D. Improving health outcomes of children through effective parenting: Model and methods. *International Journal of Environmental Research and Public Health*. 2014; 11(1):296–311. DOI: 10.3390/ijerph110100296
- Parker EA, Israel BA, Robins TG, Mentz G, Xihong L, Brakefield-Caldwell W, et al. Lewis TC. Evaluation of Community Action Against Asthma: A community health worker intervention to improve children's asthma-related health by reducing household environmental triggers for asthma. *Health Education & Behavior : The Official Publication of the Society for Public Health Education*. 2008; 35(3):376–395. DOI: 10.1177/1090198106290622 [PubMed: 17761540]
- Reid MJ, Webster-Stratton C, Beauchaine TP. Parent training in head start: A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science : The Official Journal of the Society for Prevention Research*. 2001; 2(4):209–227. DOI: 10.1023/A:1013618309070 [PubMed: 11833925]
- Robbins, V., Johnston, J., Barnett, H., Hobstetter, W., Kutash, K., Duchnowski, AJ., Annis, S. Parent to parent: A synthesis of the emerging literature. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute Department of Child & Family Studies; 2008.
- Salzer MS, Schwenk E, Brusilovskiy E. Certified peer specialist roles and activities: Results from a national survey. *Psychiatric Services (Washington, D C)*, 61. 2010; (5):520–523. DOI: 10.1176/appi.ps.61.5.520
- Williams SG, Brown CM, Falter KH, Alverson CJ, Gotway-Crawford C, Homa D, et al. Redd SC. Does a multifaceted environmental intervention alter the impact of asthma on inner-city children? *Journal of the National Medical Association*. 2006; 98(2):249–260. [PubMed: 16708511]

Table 1

Demographic characteristics of the five Parent Leaders.

Characteristic	<i>n</i>
Race/ethnicity	
African-American	5
Marital status	
Married	3
Divorced/separated/widowed	2
Parent's highest educational attainment	
High school diploma	3
Specialized trade/technical degree	2
Yearly household income	
<\$40,000	3
>\$40,000	2

Table 2

Parental characteristics at each time point.

Characteristic	Pre-intervention (N = 15)	Post-intervention (N = 6)
Relationship to child		
Biological (%)	73	100
Other (%)	27	0
Race/ethnicity		
African-America (%)	80	100
Latino(a)	20	0
Child gender		
Female (%)	53	50
Male (%)	47	50
Child age (M, years)	3.1	3.6
Marital status		
Never marriage(%)	47	50
Married (%)	40	33
Divorced/separated(%)	13	17
Parent's highest educational attainment		
High school diploma (%)	73	50
Specialized trade/technical degree (%)	7	17
College degree(%)	20	33
Yearly household income		
<\$40,000 (%)	80	67
>\$40,000 (%)	20	33

Table 3

Parent-reported child behavior, parenting stress and parenting competence at pre- to post-intervention.

Measure	Pre M (SD)	Post M (SD)
Frequency of child disruptive behaviors	121.00 (43.75)	105.83 (35.26)
Child disruptive behaviors perceived as a problem	13.33 ^a (9.69)	9.33 ^a (9.5)
Parenting stress	120.5 ^b (20.86)	107.00 ^b (22.30)
Parenting competence	66.33 ^c (11.40)	75.83 ^c (9.28)

M: mean; SD: standard deviation. Means with the same superscript are statistically different at $p < .05$.