Responding to Voices Seeking Accessible Treatment for Children with Behavioral Disorders: Assessment of a Free Online Parenting Program

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Background

- Disruptive Behavior Disorders (DBDs) and Attention-Deficit/Hyperactivity Disorder (ADHD) are the most common reasons why youth are referred to clinical settings.
- First line of treatment for these disorders is often medication
- American Academy of Pediatrics recommends that children are given behavioral interventions before and in addition to other treatments (e.g., medication).
- Access (location, cost) to evidence-based behavioral interventions is limited in rural areas (e.g., Appalachia).

Goal

Lift the voices of families, children, and paraprofessionals across the U.S. by evaluating a low-cost, online program for MH providers, developed from evidence-based behavioral principles

FAMILY INTERACTION TRAINING
COURSE FOR TRAINERS

Participants and Procedure

- Home visitors recruited through Parents as Teachers, Head Start, Early Head Start, WVU Center for Excellence in Disabilities
- Four geographic locations in West Virginia
- 2 conditions:
  - In-person material review (n = 39)
  - Self-study (n=75)
- 3 time points
  - Baseline (n = 115)
  - Post (n = 94)
  - Follow-up (ongoing)

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CDC

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RESEARCH, EDUCATION, SERVICE

Program Content

- **Module 1**
  - **Lesson 1: Introduction and Module 1 Key Concepts**
  - **Lesson 2: Communication**
  - **Lesson 3: Using Attention Strategically**
  - **Lesson 4: Praise**
  - **Lesson 5: Scheduled Parent-Child Playtime**
- **Module 2**
  - **Lesson 6: Module 2 Key Concepts**
  - **Lesson 7: Establishing Routines and Family Rules**
  - **Lesson 8: Giving Clear Directions**
  - **Lesson 9: Anticipation Problems, Using Redirection, and Easing Transitions**
  - **Lesson 10: Helping Your Child Calm Down**
- **Module 3**
  - **Lesson 11: Module 3 Key Concepts**
  - **Lesson 12: Time Out**
  - **Lesson 13: Logical Consequences and Removal of Privileges**
  - **Lesson 14: Conclusion**

Analyses

Quantitative:
Changes in knowledge scores from baseline to post-assessment
Group differences in knowledge-change
Qualitative:
Written and verbal feedback provided during material review sessions
Feedback coded for themes related to likes and dislikes of each lesson

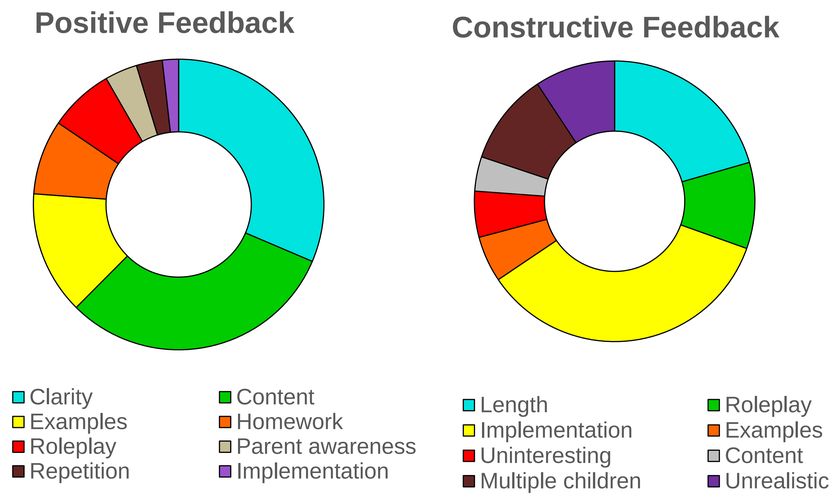
Quantitative Results

Participant Demographics	
Characteristic	**M (SD) or N (%)**
Age	40.35 (13.04)
Gender (female)	108 (97.3%)
Years experience with children and families	13.24 (9.17)
Years at current organization	6.44 (7.06)

Knowledge Comparisons		
Measure	**Pre M (SD)**	**Post M (SD)**
Knowledge of Behavior Principles	12.20 (3.97)	13.67 (3.62)***
FIT Module Quiz 1	2.61 (1.14)	3.85 (1.48)*
FIT Module Quiz 2	8.00 (1.96)	8.30 (1.69)$^{+}$
FIT Module Quiz 3	3.34 (0.84)	3.67 (0.58)**

Note: $^{+}p < .10$, $*p < .05$, $**p < .01$, $***p < .001$

Qualitative Results



Summary

- Paraprofessionals able to lift their voices by providing feedback on how to best serve the needs of children with ADHD/DBDs
- Generally positive reactions to FIT program
  - Participants believed it was clear and concise, easy to understand
  - Participants believed it would be helpful to use with their families
- Barriers and suggestions for changes were noted
  - Difficulty implementing in home rather than in clinic
  - Caregiver resistance to specific techniques and skills
- Appears to be a promising program, especially for providers in rural or underserved areas

Future Plans

- Evaluate the effectiveness of the FIT Program (skill acquisition, child behavior)
- Evaluate caregiver perspectives on the FIT Program
- Make training materials available for free on the CDC website

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