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Group Parenting Intervention for the Treatment of Youth Disruptive Behavior in Academic Medical Settings

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Introduction

The oft-cited "research to practice gap" is glaringly apparent for treatment of disruptive behavior disorders. In the research world, parent-training is touted as an effective and scientifically-based treatment for disruptive behavior disorders and related problems (Eyberg, Nelson, & Boggs, 2008; Pelham & Fabiano, 2008). However, in many "real-world" settings, group parent-training is not reimbursable by the child's health insurance because parenting groups are not directly delivered to the identified patient (Roberts & Steele, 2010).

Furthermore, most evidence-based group parenting programs for children with disruptive behavior disorders have lengthy sessions, intense training and supervision protocols, and do not include children in the same room as the parents for sessions. These challenges provide a substantial barrier to providing group parenting programs in behavioral health settings.

The purpose of the current study is to identify an evidence-informed group parent-training program that is financially sustainable and fits within the current infrastructure of an academic medical setting.

Methods

First, we surveyed parents in the waiting rooms of our two outpatient clinics to determine the interest and need for a parenting group.

Next, we conducted a literature search to help us identify evidence-informed group parenting interventions for youth disruptive behavior. In order to narrow our list, we researched the availability and costs of training. Our preference was to choose programs with a train-the-trainer model to allow for the most flexibility in training future clinicians and disseminating the program to the community.

Once we identified available parenting programs, we had to determine the available billing options for the group parenting intervention. The most sustainable program in the Pediatric Behavior Health and Wellness (PBH&W) outpatient clinic would allow us to bill insurance without excess out-of-pocket costs for the patient or for the clinic. This was challenging as many of the parenting programs were at least 1 ½ hours long and required at least 4 staff split between the parent group and the accompanying child's group. We reached out to colleagues through a professional listserv to gather information on how others billed for parenting groups.

Acknowledgements: Thank you to the URMC Psychiatry Department Education Committee for making this poster possible.

Table 1. Results of Parent Survey

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Total
I feel stressed about parenting	18 (11.92%)	22 (14.57%)	33 (21.85%)	67(44.37%)	11 (7.28%)	151
I am interested in a group parenting program	22 (14.47%)	24 (15.79%)	49(32.24%)	44(28.95%)	13(8.55%)	152
I am able to participate	24 (15.79%)	27(17.76%)	38(25%)	52(34.21)	11(7.24)	152

Table 2. Group Schedule

Session # and Topic	Content
1. Welcome to Your Multiple Family Group	Introduction to the 4Rs (Rules, Responsibility, Relationships, & Respectful Communication) and 2Ss (Stress and Social Support)
2. Managing Family Stress	Sources of stress for both parents and children, stress management
3. Rules for Home and School	Making and evaluating rules
4. Respectful Communication	Listening and speaking in a respectful manner with family members.
5. Relationships	Building family closeness with family time
6. Responsibility at Home and at School	Understanding expectations for all family members
7. Building on Family Supports	Identifying sources of support in the community
8. Group Review and Celebration!	Barriers to utilizing strategies and problem-solving

Table 3. Outcome Measures

Measure	What does it measure?
1. IOWA Conners & Disruptive Behavior Disorders Rating Scale (ODD)	Symptoms of ADHD, ODD, and CD
2. Impairment Rating Scale	Severity of functional impairment
3. Alabama Parenting Questionnaire, Short Form	Positive parenting, inconsistent discipline, and supervision
4. McMaster Family Assessment Device	Roles and communication within the family
5. Center for Epidemiologic Studies Depression Scale	Parental Depression
6. Parenting Stress Index	Parenting stress
7. Multidimensional Scale of Perceived Social Support	Social support

Results

The results of parent survey are displayed in Table 1.
An informal survey to our colleagues revealed the following ways to bill for group parenting programs: 1) patients pay out-of-pocket, either entirely or partially 2) the clinic absorbs the cost 3) bill both the parent and child's insurance and 4) if the parent and child are in the same room for at least a portion of the session, bill as a multifamily group.

We determined that Options 1 and 2 were not economical. Option 3 was not possible in PBH&W as we are not able to bill adults since we are not licensed to provide services for adults. Finally, we determined that Option 4, billing as a multifamily group, was the only cost-effective option for the clinic.

We contacted our colleagues at New York University to gather more information on receiving training for the 4Rs and 2Ss Strengthening Families program. We were invited to join their ongoing NIMH funded implementation trial for Strengthening Families (for more detail see Acri et al., 2017). Table 2 displays topics for the 8-week Strengthening Families program. Table 3 lists the outcome measures used for the study at baseline, 8 weeks, 16 weeks, and 6 months. We are currently implementing the model in two sites.

Discussion

In our search for a sustainable parent-training model, we identified the 4Rs and 2Ss Strengthening Families program to be a good fit for our clinic. The 4Rs and 2Ss was developed by Mary McKay, Ph.D. and colleagues at NYU and takes a common elements approach to treatment of disruptive behavior disorders for families who have children ages 7-11. The program was developed in collaboration with urban families and clinicians and includes engagement techniques for enhancing retention (Gopalan et al., 2014).

A major advantage of the 4Rs and 2Ss is that we are able to bill insurance for treatment using the multiple family group CPT code because children take part in the session with their caregivers, which makes it a much more sustainable group-parenting option as the program will not need to rely on other sources of financial support. In addition, the program is also feasible logistically, as it requires only two facilitators, only one room (as parents and children are together), and no technology. Furthermore, the facilitator training for the Strengthening Families program was also a good fit for our busy clinic as we were only required to complete a 2 ½ hour internet module and 2 hours of a live web-based training. In addition, we receive 1 hour of phone/video supervision per month.

Future directions for research include expanding the model to include a wider age range, and implementing the model in other settings such as general pediatrics, community centers, and schools.