Project Name: Evaluation of a Technology-Based Parenting Intervention for Young Children Behavioral Health Challenges Identified in Pediatric Primary Care
Date: 4.6.2026
Narrative

Background

Children's behavioral health challenges are an under-treated public health threat and include, but are not limited to, defiance, noncompliance, aggression and hyperactive-impulsive behavior. In preschool-aged children, Oppositional Defiant Disorder and Attention-Deficit Hyperactivity Disorder affect approximately 10% of children (Lavigne et al., 2009). "Early starter" models of children's problem behaviors suggest that parenting in early childhood plays a role in developing behavior problems that are severe and persistent (Cyr et al., 2022; Moffitt, 1990; Patterson et al., 1992; Shaw et al., 2000). Serious behavior problems can emerge as early as age two as children make gains in mobility and independence (Shaw et al., 2000). These newly challenging behaviors can bring about patterns of coercive behavior in the parent-child relationship, which often solidify around ages 3-6 years old (Chang & Shaw, 2016; Shaw et al., 2000). Early childhood behavioral health challenges can persist into adolescence and adulthood and increase the likelihood of negative outcomes such as school dropout, substance use and criminality (Moffitt et al.,1996; Shaw & Taraban, 2017; Trentacosta et al., 2013).

Multiple existing programs promote young children's behavioral health by teaching parents behavioral parenting skills. These efficacious treatment approaches promote young children's behavioral health (e.g., Eyberg et al., 2008; Webster-Stratton et al., 2013). While there are multiple evidence-based behavioral parenting programs, many of these programs have overlapping content and share the broad goal of ending the emerging pattern of coercive behavior in the parent-child relationship and building a strong, positive parent-child bond. Key content in behavioral parenting programs includes showing parents how to reinforce children's positive behavior (e.g., using praise), teaching ways to promote child compliance to parents' requests (e.g., using effective commands), encouraging parents to ignore minor misbehavior, and teaching parents a time-out procedure (Kaminski et al. 2008; Sanders, 2023). While there is ample evidence that parenting programs promote children's behavioral health, there is also a clear need for programs that expand the reach of parenting programs as only 3% of young children in need of behavioral health treatment receive it (Lavigne et al., 2009).

The Parenting Young Children Check-up (PYCC) is a technology-based solution designed to overcome barriers to accessing behavioral parenting programs and was designed with underserved populations in mind. The PYCC has three components (see Figure 1 in additional attachment): 1) the initial check-up, 2) text messages, and 3) the parenting program website. Parents who report child behavioral health challenges on a screener then complete the initial check-up, a brief, tablet-based program, while waiting at a pediatric visit. The initial check-up introduces parents to the PYCC and provides information about parenting children who are "strong willed" (a term preferred by study participants in early program development; McGoron et al., 2023a). The program offers parents feedback about their child's behavioral health and motivational content that encourages parenting changes. The program encourages parents to talk to their child's doctor about their child's behavioral health and use the PYCC online

modules. At the end of the brief program, parents enter their phone number and then begin receiving text messages that contain links to the PYCC program website to connect parents to behavioral parenting content. The website teaches parenting skills through interactive modules with video-based content derived from common elements in evidence-based behavioral parenting programs that are organized into two categories: preventing and responding to children's challenging behavior (see Figure 1 in additional attachment for specific content).

PYCC development and evaluation is guided by the ORBIT model, a human-centered translational intervention development approach (Czajkowski et al., 2015). The ORBIT model specifies two early intervention development phases, which have already been completed for the PYCC, that should be completed before moving on to a randomized clinical trial to establish intervention efficacy. In fulfilling these early intervention steps, we first gathered qualitative and quantitative data from 17 Detroit parents, all of whom had a young child with behavioral health challenges, and 17 Detroit area pediatricians and family medicine doctors who see children. Early versions of PYCC intervention materials were refined and modified based on input and suggestions from parents and physicians. Next, at the New Center One Henry Ford pediatric clinic in Detroit, which serves predominately low-income families, we conducted a proof-of-concept trial to assess parents' response to engaging in the PYCC as part of a pediatric visit and to ensure that the initial check-up prompted parents' interest in using the PYCC website (McGoron et al., 2023b). This phase also allowed us to collect additional feedback and suggestions about the PYCC before moving on to a randomized clinical trial. Parents (n = 30) completed a screener; 9 parents reported elevated DBPs, and 6 completed the proof-of-concept trial. After going through the initial check-up, all parents reported interest in using the PYCC website and rated the PYCC program elements highly. Feedback from parents was incorporated into the PYCC. After incorporating these changes into the PYCC, two pilot investigations were completed to initially examine the impact of the PYCC. These investigations serve as preliminary data for the proposed investigation. In these early investigations, which did not randomize the participants to intervention or control conditions (i.e., results regarding the impact of the program were using a pre-post design), we found that there was a statistically significant reduction in child behavior problems from baseline to follow up in two small samples of parents (n = 38 and n = 68, respectively). These early investigations suggest there is potential for the PYCC to have a meaningful impact on children's behavioral health and support moving onto randomized clinical trial, which is the goal of the proposed project.

The PYCC program is delivered through the Computerized Intervention Authoring System (CIAS). CIAS is a highly secure, online software that allows researchers and clinicians to create and deliver technology-based interventions without a need for programming experience. CIAS resides on a HIPAA-compliant AWS cloud server with multiple compliance and security controls that are managed by MSU IT and www.HealthcareBlocks.com. Key security measures include access controls and multi-factor authentication using the principle of least privilege (PoLP); audit trails and configuration tracking, along with constant monitoring of uptime and resource utilization; monitoring to ensure use of the latest database servers; encryption in transit and at rest using AES 256-bit keys, provisioned and rotated through the AWS Key Management Service (KMS); TLS encryption of transmission of data between internal services; encryption of public traffic all the way to containers and virtual machines; automated

failover; a scalable service layer; application load balancing that is integrated with the AWS firewall; systems redundancy across multiple data centers; daily database backups; intrusion detection and protection that analyzes traffic in real-time, blocking unwanted bots and intrusion attempts; ongoing threat detection that continuously monitors for malicious activity; security-hardened virtual machines based on the CIS Benchmark for Ubuntu Linux, enhanced with security features including file integrity monitoring, malware detection, automated software security patching, and continuous vulnerability scans. The AWS HIPAA risk management program is aligned with FedRAMP and NIST 800-53, and AWS data centers also feature multiple layers of physical security and redundant power systems.

In the proposed project, we will recruit 40 parents of young children at pediatric healthcare visits. Since the original application, Dr. Johnson has moved her practice from The Detroit New Center One pediatric practice to the Harbortown practice (both of these practices are in Detroit). While Harbortown is a family medicine practice, there are two pediatricians that have their practice there and the family medicine doctors also see children in the target age range for this project. Given Dr. Johnson is still closely affiliated with the New Center One clinic, additional recruitment can also take place in this location. Recruited parents will be randomized to intervention (i.e., going through the PYCC initial check-up, receiving text messages, and having full access to parenting program modules on the PYCC website) or control (assessment only). We will conduct follow-up assessments to examine the impact of the program.

Hypothesis(es)

First, we hypothesize that randomization to the PYCC intervention group, as compared to the control group, will be related to reduced child behavioral health challenges. **Second,** we hypothesize that randomization to the PYCC intervention group, as compared to control, will be related to improved positive parenting and reduced parenting stress. **Third**, for parents in the intervention group, we hypothesize there will be high rates of module use on the PYCC website (i.e., >50%). **Finally**, for parents in the intervention group, we also hypothesize that there will be high rates of satisfaction with the PYCC overall and with each PYCC module.

Significance of research

McGoron and Ondersma (2015) identified that there are substantial barriers to parents engaging in and completing evidence-based behavioral parenting programs. These barriers range from failing to recognize their child's behavior as problematic, taking a "wait and see" approach to the problem, or stigma preventing help seeking. For families that do want help with their child's challenging behavior, waitlists, unavailability of behavioral health care, provider shortages, and negative perceptions of behavioral health care can impede receiving services. Even for families that begin a behavioral parenting program, challenges, stressors, and obstacles (e.g., lack of childcare or transportation) can lead to early dropout. These findings highlight the need for innovative behavioral parenting programs to overcome barriers.

McGoron & Ondersma (2015) also identified emerging solutions to overcoming barriers to parents connecting with and completing behavioral parenting programs. First, pediatric primary care was

identified as an ideal setting for screening for and responding to behavioral health challenges in early childhood. Pediatricians have regular contact with children and parents through well-child visits that are recommended at ages 2, 2 ½, 3, 4 and 5 (Foy, 2010; Hagan et al., 2008). Additionally, current pediatric guidelines encourage incorporating behavioral health screening into pediatrics (American Academy of Pediatrics, 2022; Foy et al., 2019). Pediatric delivery of behavioral health interventions is also ideal for reaching young children at well-child visits. The PYCC proactively engages parents in pediatrics through screening for behavioral health challenges and delivering the PYCC initial check-up.

Second, technology-based delivery is a promising approach to increase access to behavioral parenting programs. Technology-based programs allow parents to access behavioral parenting program content on their own time, circumventing practical barriers such as lack of childcare or transportation, and can include sophisticated features such as interactivity, tailoring, use of multimedia, and reminders. Importantly, McGoron et al. (2018) demonstrated that access to the Internet is becoming ubiquitous for parents through Smartphone ownership and that many parents already use the Internet to gain parenting information. A more recent 2021 report by the PEW research institute demonstrated that 85% of participants in a large, nationally representative sample of U.S. adults own a Smartphone, including 95% of people under age 50 (Perrin, 2021). Over the past decade, research has emerged showing that online behavioral parenting programs are a promising approach as they lead to gains in children's behavioral health and promote positive parenting practices (e.g., Sanders et al., 2012; Spencer et al., 2020). The PYCC uses technology, specifically Smartphones, to deliver parenting program content at a time and place that is convenient for parents. The entire PYCC program can be accessed at www.parentingcheckup.org.

Innovation of research

The PYCC has multiple innovative features that align with the overarching goal of developing, evaluating and implementing an evidence-based, high-reach program with real-world application. Specific areas of innovation include:

1. The PYCC uses a proactive approach to engaging parents in the behavioral parenting program. Traditional parenting program models wait for parents to seek help for children's challenging behavior. This approach misses a large portion of the population of parents that could benefit from behavioral parenting programs. While the PYCC can benefit parents actively seeking help, it is designed to also engage non-treatment-seeking parents in a setting they already use – pediatric primary care.

2. The PYCC was developed with input from parents and physicians (pediatricians and family medicine doctors). The qualitative input of parents and physicians led to refinements to intervention materials and informed the creation of the full PYCC intervention. Modifications to the intervention were made in subsequent phases of intervention development based on input from end users.

3. Made with accessibility in mind. The PYCC was designed specifically to be a high-reach resource for parents and pediatric practices. Thus, it is an open-source resource that parents do not have to pay to use. PYCC modules are intentionally brief (i.e., 15 minutes or less) to increase the likelihood of successful use by parents. The program is completely accessible through Smartphones, including both text

messages and online videos on a program website. This is important as Smartphone ownership is becoming ubiquitous and for many, particularly people from under-resourced communities, is the primary or only way they access the internet. Parents can use the program modules at any time and at their own pace.

4. Randomized clinical trial conducted in a real-world clinic/clinics to inform future implementation. This trial will take place in a pediatric clinic/clinics. While other approaches could be used to recruit large samples of parents to use the PYCC (e.g., recruiting parents online), this intervention must be tested in the setting it was designed for to inform real-world applicability.

Research design and methods

To test the impact of the PYCC, this project will use a randomized clinical trial design with 40 parents of two- to five-year-olds with behavioral health challenges; randomization will be determined by a randomization sheet (i.e., a form to determine what group participants are in with groups assigned through random order). Members of the research team will be present at the Henry Ford Health clinic(s) daily and work closely with pediatric staff to recruit parents of young children with behavioral health challenges to accomplish all project aims. A research team member will attend all meetings and clinical staff huddles at the clinic(s) to ensure they are integrated into the office flow. Research team members will meet with parents who are interested in participating (see information about consent below)—participation will take no more than 20 minutes and will include answering questionnaires (in secure, online systems) and randomization to the intervention (n = 20) or control condition (n = 20). All project questionnaires will be complete through the RedCap system. The project team will have read-only access to the office Electronic Medical Records (i.e., the practice[s] use Epic) to know what times potential participants will be seen and see if they completed the screener for the project (see more information below) and if they qualify to participate (see more below). Follow-up assessments will take place by phone and online questionnaires 1 month and 3 months after baseline participation.

The Henry Ford Harbortown family medicine clinic and the New Center One pediatric primary clinic are busy, thriving practices that serves children in Detroit. At both practices, most patients identify as Black/African American and receive Medicaid. Patients check in at a front desk and sit in a waiting area until a medical assistant moves them to a private patient room. The Preschool Pediatric Symptoms Checklist (PPSC; Sheldrick et al., 2012), which is part of the Survey of Wellbeing of Young Children, will serve as the screener for this project and is already used as a screener at both practices.

Parent participants will be those bringing their child (ages 2-5 years old) to a healthcare visit. The research team will ensure that all parents of children in the target age range complete the PPSC and that the PPSC is scored. Parents who report elevated scores on the PPSC (i.e., a total score of 9 or more; Sheldrick et al., 2012) will be invited to participate in the PYCC project by a member of the pediatric staff along with a member of the research team. We will work closely with clinic staff to develop a streamlined, effective process that works within the flow of the practice. Parents in both the control and intervention conditions will be paid $30 through Tango cards (i.e., an online system that allows participants to pick a specific gift card they would like) for their participation.

Parents will be randomized into either the intervention group (*n* = 20) or the control group (*n* = 20). Randomization will be automatically generated. Parents randomized to the control condition will complete the evaluation measures (see Table 1 in additional attachment) but will not engage in the PYCC; at the end of the project period (i.e., after the 3-month follow-up), a research assistant will work with parents who were randomized to the control condition to get them access to the full PYCC if they are interested. Parents randomized to the intervention condition will complete baseline questionnaires (see Table 1 in additional attachment), go through the full initial check-up, and then begin receiving PYCC text messages that have embedded links to access the parenting program modules on the PYCC website (all content is online at www.parentingcheckup.org). These parents can use the PYCC website as much, or as little, as they choose during the study period. Parents will receive three text messages a week for four weeks to prompt use of the PYCC website. Then, to test project hypotheses, parents in both the intervention and control group will complete follow-up assessments one and three months after baseline and complete each of the questionnaires (all questionnaires are enclosed).

Given data from baseline, one-month follow-up, and three-month follow-up are needed to test project hypotheses, high study retention will be an important goal of this work. We will take multiple steps to ensure strong retention rates. At baseline, at the clinic(s), parents will be given a reminder card with the dates of their 1-month and 3-month follow-up appointments with the research team. Parents will be encouraged to take a picture of this reminder card and put these dates in their Smartphone calendar. A reminder about follow-up calls will also be included in text messages. On the day of each follow-up assessment, the research assistant will then contact participants in both the intervention and control condition through a phone call, with additional text messages and emails, if needed. The research assistant will ask them questions over the phone. Parents will then receive a link to complete additional questionnaires through an online survey. Parents will be paid $30 for the 1-month follow-up and $30 for the 3-month follow-up through Tango Cards.

Expected outcomes

The outcomes of focus for this project will allow us to test the four project hypotheses—all questionnaires are enclosed in this submission. These outcomes are commonly measured in parenting program research and will allow us to determine if the PYCC has had a meaningful impact on parent and child well-being. How each outcome is measured is listed in Table 1 and outlined below:

1) *Children's behavior health.* To test hypothesis 1, we will use scores from two parent-report questionnaires measuring children's behavioral health collected at baseline, 1-month follow-up, and 3-month follow-up. The first questionnaire is the PPSC, which is a brief measure of children's behavioral health. We will also collect the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) the ECBI includes 36 items in which caregivers rate the frequency of specific challenging child behavior (e.g., "does not obey") on a 7-point Likert scale (ranging from 1 = Never to 7 = Always). After data is collected, data analyses, including t-tests and Repeated Measures ANOVAs, will allow us to test if randomization to the intervention group impacts scores on the PPSC and ECBI over the three-month study period. We expect reductions in scores on the PPSC and the ECBI for the intervention group, but not the control group.

2) *Parenting and Parenting Stress*. To test hypothesis 2, at each time point, we will measure parenting practices with the Alabama Parenting Questionnaire—Preschool Revision (APQ-PR; Clerkin et al., 2007). The APQ-PR stems from the widely used Alabama Parenting Questionnaire (Frick et al., 1999) and asks parents to rate how frequently specific parenting behaviors occur (e.g., "You let your child know when he/she is doing a good job with something") on a 5-point scale ranging from 1= Never to 5 = Always. To measure parenting stress, we will collect the Parenting Stress Index—Short Form (PSI-SF; Taubman–Ben-Ari, Findler, & Shlomo, 2012). The PSI-SF includes 36 items (e.g., "Sometimes I feel my child doesn't like me and doesn't want to be close to me") rated by parents on a 5-point scale raining from 1 = Strongly Agree to 5 = Strongly Disagree. Like with children's behavioral health, data analyses, including t-tests and Repeated Measures ANOVAs, will allow us to test if randomization to the intervention group impacts scores on the PPSC and ECBI over the three-month study period. We expect gains in scores on the APQ-PR and reductions in the PSI-SF for the intervention group, but not the control group.
3) *Use of the PYCC Parenting Program Modules.* To test hypothesis 3, will track participants' use of the modules on the PYCC website. Parents enter their phone numbers when entering a PYCC module, which serves as a way to track their program use. This approach has been used successfully in the two previous evaluations of the PYCC. Members of the research team can log into CIAS with a username and password and view question responses, including the response for parents' phone numbers. We expect the majority of the parents in the intervention group to use the PYCC modules on the program website. Parents enter their phone number in CIAS, which allows us to track which makes use the program and how much.
4) *Satisfaction with the PYCC program.* To test hypothesis 4, satisfaction with each part of the PYCC will be measured with questions made for evaluating the PYCC, which will be adaptations of questions used in past investigations (e.g., McGoron et al., 2023a; McGoron et al. 2023b). Item creation is guided by the Technology Acceptance Model (Davis, 1989), which posits that ease of use and perceived usefulness are important components that motivate the use of technology. How much parents like each component will also be assessed. Five questions tapping into satisfaction will be asked after parents complete the Initial Check-up and after they complete each PYCC module. Parents will complete 10 questions about overall satisfaction with the PYCC at the 1-month and 3-month follow-up assessments, and there will be several open-ended questions in which parents can record their feedback and suggestions about the program. We expect parents to report high levels of satisfaction.

Inclusion and Exclusion Criteria

The following inclusion criteria will be used: 1) Reporting a score of 9 or higher on the Preschool Pediatrics Symptoms Checklist (part of the SWYC), 2) Having a child ages 2-5 years old

The following exclusion criteria will be used: 1) Not speaking/reading English, 2) Not owning a Smartphone, 3) Being under 18 years of age

Informed Consent and Baseline Participation

A research assistant will recruit parents that report elevated child behavioral health challenges on the Preschool Pediatric Symptoms Checklist (the PPSC is part of the Survey of Well being of Young Children, which is routinely used in pediatric primary care as a screener). Eligible parents will be invited to participate in the project. If they express interest in participating, a research assistant will meet with them in a private setting. To best meet the needs of busy parents (i.e., at this time, there have been parents that wanted to participate but were too tired to or needed to leave right after the office visit), if a parent expresses an interest in participating but it is not possible for them to participate in the clinic at that time (e.g., they have to get to work and cannot stay at the clinic any longer), they will be given the opportunity to schedule an appointment with the research assistant (RA) remotely. The RA will stress the importance of needing to participate at home at a time/place that allows for privacy. With this in mind, the RA will schedule a time to meet with the parents remotely. If the parent elects to participate in person, they will do so right after the office visit.

All parents will complete the informed consent in person. If parents elect to participate remotely instead of at the clinic, they will still do the informed consent in-person before they leave. For all parent participants, the research assistant will go over the informed consent with them (please see enclosed consent script), allow them time to read it, and answer all their questions. Parents will sign the consent if they choose to participate. Parents will be given a copy of the consent for their records.

The next step of baseline participation, done either remotely or at the clinic, will be answering the baseline questionnaires and, for those in the intervention group, going through the initial check-up of the PYCC. For parents participating remotely, this will be done on their own devise (owning a Smartphone is necessary for participation).

Data Analysis Plan

We will compute descriptive analyses for children's behavioral health challenges, disruptive behavior problems, positive parenting, and parenting stress. We will also determine what percentage of parents in the intervention group used the PYCC website and the number of PYCC modules they access. Finally, we will look for changes from pre-post in reports of children's behavioral health, parenting, and parenting stress. We will use ANOVAs to compare the rate of change in key outcomes between the intervention and control groups over the course of the project**.**

Sample Size

A sample size of 20-60 participants is generally recommended for this phase of intervention development and evaluation and is consistent with a pilot randomized clinical trial.

Anticipated Risks and Benefits

There are two possible areas of risk. First, there is an emotional risks (e.g., feelings of sadness or anxiety) as parent may feel uncomfortable answering some of the questions. Second, there is a possible social risks (e.g., possible loss of confidentiality, possible effect to employment status) as parents are providing their name and contact information. While protections are in place to keep this information secure, there is the risk of participation becoming known to others.

To minimize these risks, participants will be able to skip questions if they choose not to respond and can discontinue participation at any point. Discounting participation will have no impact on their child's care at HFH. All data will be collected through two secure, HIPAA-compliant system: RedCap and the Computerized Intervention Authoring System (CIAS). Using these systems has resulted in secure data across multiple projects conducted by Dr. McGoron. When data is downloaded, all identifying information will be replaced with a Participant ID number in the file.

There are two benefits. First, parents will learn parenting strategies that other parents have previously reported as being helpful. Second, results will begin to lay the foundation for the evidence-based of the PYCC, which could be used as a tool for more parents in the future.

Cost

There is no cost associated with participating in this research.

Alternatives

There are no alternatives to participating in this research. Participants are free to not participate. Participants are able to withdrawal from participating at any time.

Withdrawal of Subjects

Participants are free to withdraw at any time. At baseline participation, participants are free to skip questions or discontinue participation at any time. For those in the intervention group, parents can stop text messages at any time by texting “STOP,” and they can use the PYCC website as much, or as little, as they choose. Parents can decide not complete follow up assessments for any reason.

Privacy and Confidentiality

Data will be collect through secure, online systems. Questionnaire results will be downloaded and stored without identifiers in a secure drive. Parents will be able to decline participation and discontinue participation at any time.

Identifying information will be collected only in secure, online systems (i.e., RedCap and CIAS). The data, after being downloaded from secure online system, will be stripped of any PHI and be deidentified when stored. Only members of the study team will have access to the full dataset—logging into both online systems requires a username and password and an invention from the study PI to access the data.

The screener that will determine if parents are eligible will be the only records from the EMR reviewed. If parents consent, responses will be entered into a secure, online system. When downloaded, the data file will be deidentified and merged with other responses to the online surveys and, like all data, stored without identifiers.

Addressing health equity and social determinants of health

Children from minoritized groups and those from families experiencing economic adversity face disparities in accessing behavioral health care (Hoffmann et al., 2022). Cobb (2023) highlights these

points: children's behavioral health needs are increasing, parents are vital agents of change in promoting their child's behavioral health, disparities exist for minoritized and low-income parents in access to behavioral health, and technology-based programs delivered to parents have the potential to reduce these disparities. Given that access to the internet is becoming ubiquitous, technology-based programs, such as the PYCC, are a logical approach to disrupting existing disparities. In our investigation of 160 predominantly low-income and Black/African American mothers of toddlers and preschoolers in Detroit, Michigan (McGoron et al., 2018), we found high levels of access, openness and comfort with the Internet; these outcomes were not impacted by participants' reported race or income.

Programs that are accessible by Smartphone are particularly important to promote health equity. With 15% of people being smartphone-dependent, Smartphones are their only way of accessing the internet (Perrin, 2021). A relatively high portion of people living in low-income communities are Smartphone-dependent compared to people living in higher-income communities—thus, Smartphones are an important gateway to resources on the internet, including internet-based parenting programs, such as the PYCC, for low-income parents. Cobb (2023) also points out that there needs to be a stronger evidence base for technology-based parenting-focused interventions to promote youth behavioral health and that programs have not yet been developed to meet the needs of diverse populations. The PYCC was created specifically to promote health equity for underserved families. Before creating the full PYCC program, extensive time was spent reviewing the literature and surveying low-income parents to understand if a technology-based program would meet their needs. Testing the efficacy of the PYCC in a sample of predominately low-income families will further our understanding of whether the program meets the needs of those facing health disparities.

Addressing how this work is valuable to the population, increases the quality of care, and improves the access to healthcare

There is a severe shortage of behavioral health care providers nationwide. Our discussions with our local community partner in Detroit, pediatricians at Henry Ford Health, suggest that these shortages impact their ability to refer children to behavioral health care. For the behavioral healthcare services that are available in Detroit, waitlists are commonplace and barriers, such as lack of transportation or childcare for other children, impede parents from accessing behavioral healthcare services even when they are available. The PYCC brings content from evidence-based parenting programs to parents who could benefit from such information (i.e., they have a child with behavioral health challenges) in a highly feasible way; thus, the PYCC aims to improve access to behavioral health care. Parents can access the program from the comfort of their own homes at a time of their convenience—they will not need transportation or childcare to use the program as much as they choose. Given that many of the families we anticipate participating in the proposed project will be low-income and facing disparities in access to health care, the PYCC aims to be highly accessible, even for low-income families, and easy to use.

Conclusion

This investigation is designed to build on the initial evidence base of the PYCC. Evaluating the intervention through a randomized clinical trial within pediatric care is critically important to understand

the real-world application of this unique program. Furthermore, recruiting from a site/sites that predominately serves low-income families will allow for further understanding of whether the program meets the needs of this population. The results of this investigation, depending on the findings, could lead to multiple subsequent investigations and future program implementation in pediatric care. Based on the results of this RCT, and in line with the ORBIT model (Czajkowski et al., 2015), the next steps will be to further evaluate the program in an effectiveness trial with the program implemented in pediatric care and delivered by pediatric staff. Ultimately, this project is an important step toward understanding the impact of this unique and innovative approach to delivering evidence-based parenting practices to promote young children's behavioral health.

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