Implementing an Evidenced Based Treatment for Children in the Child Welfare System:

Parent-Child Interaction Therapy

July 18 & 19, 2008

Kim Pawley Helfgott
Melanie M. Nelson, Ph.D.
Robin H. Gurwitch, Ph.D.
Terry Mummery
Kirsten Brutzman-Livak
Overview of Agenda

- Evidence Based Practices in Systems of Care
- Overview of Parent-Child Interaction Therapy
- Hands on Practice—Let’s Play!
- Break Time (15 minutes)
- Family Experience with PCIT
- Research on PCIT Outcomes
- Implementing EBPs
- Implementing PCIT
- Cultural Considerations
- Dissemination of PCIT
- Other Resources on Evidence Based Practices
Importance of Evidence Based Practices

• The gap between routine mental health care practice and evidence based practice represents a significant public health problem. (US Surgeon General’s Report on Mental Health, 1999)

• Evidence-based practices are supported by scientific research as being effective in improving outcomes for children and families.
Requirements for System of Care Cooperative Agreements

• Key activities and concepts of service provision:
  “Delivery of effective clinical interventions, which as research has demonstrated, produce positive child and family outcomes”

• Delivery of clinical interventions:
  “Clinical interventions should be used that are effective within the cultural contexts of children, youth and families.”
Integrating Systems of Care, Individualized Care, and EBTs

Conceptual Mental Health Services Flow Chart

- Initial screening to meet eligibility for intake
- Child enters the system (Intake)
  - Comprehensive evaluation to determine the nature, severity, and complexity of the problem
  - Assigned a care coordinator who assembles a multi-disciplinary treatment team
  - Individualized treatment plan developed and continually modified allowing family informed choice of interventions
  - Specific treatments and providers selected (may or may not involve an evidence-based practice or program)

- Treatment successful but requiring continued (less intensive) services or supports or in need of significant change
- Treatment partially successful, or not at all successful
  - Discharge (can be re-opened if new need occurs)
  - Treatment successful

- Treatment initiated with continuous outcomes measurement
# Use of Evidence Based Practices in Systems of Care

<table>
<thead>
<tr>
<th>Practice</th>
<th>Number of Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wraparound services</td>
<td>8</td>
</tr>
<tr>
<td>Positive Behavioral Interventions and Support</td>
<td>7</td>
</tr>
<tr>
<td>Multisystemic Therapy</td>
<td>6</td>
</tr>
<tr>
<td>Trauma Focused CBT</td>
<td>4</td>
</tr>
<tr>
<td>Parent Child Interaction Therapy</td>
<td>4</td>
</tr>
<tr>
<td>Functional Family Therapy</td>
<td>3</td>
</tr>
<tr>
<td>Incredible Years</td>
<td>3</td>
</tr>
</tbody>
</table>
Lessons Learned in Implementing Evidence Based Practices

- Staff recruitment and selection
- Pre-service or in-service training
- Coaching, mentoring, and supervision
- Internal management support
- System-level partnerships
- Staff and program evaluation

("Implementing Evidence Based Practices: Six Drivers of Success" Allison Metz, Karen Blasé, Lillian Bowie. Child Trends, Research to Results Brief)
Experiences in Implementing Evidence Based Practices?

• What EBT services are being consideredimplemented in your community?
• What were the challenges in implementation?
• What were the successes?
Mental Health Needs of Children and Youth in Child Welfare

- 50% of children (ages 2-14) who had completed child welfare investigation had clinically significant emotional and behavioral programs
- 25% had received any behavioral health care in last 12 months

(National Survey of Child and Adolescent Well Being)
Components of parent training programs associated with better parent and child outcomes:

- Teaching parents to interact positively with their children and provide positive attention.
- Having parents practice with their own child during parent training.
Parent-Child Interaction Therapy

An Evidenced-Based Practice for Young Children with Behavior Problems
What is PCIT?

- Developed by Dr. Sheila Eyberg for families of children aged 2-7 with disruptive behavior disorders
  - Combines elements of attachment and learning theories, systems theory, and behavior modification
  - Short-term – avg. 14-16 weekly sessions
  - Direct coaching of parent with child
  - Empirically validated in over 80 studies
  - Gives parent responsibility, not blame
Overview of PCIT

• Key features
  – Emphasizes restructuring the parent-child interaction by teaching specific parenting skills
  – Based on principles of attachment and social learning theory
  – Implemented with parent and child together
  – Designed as a treatment for severe behavior problems in young children
Overview of PCIT

• Key features
  – Involves direct practice
  – and coaching of skills in sessions
  – Establishes daily positive parent-child interaction time
  – Teaches generalization of skills
Overview of PCIT

• Key features
  – Treatment manual used
  – Not time-limited
  – Assessment driven
Pre-post tapes
Balancing Two Factors…

1. Positive Interaction with the Child
   • Increase positive attention
   • Decrease negative attention
   • Addressed directly in the Child Directed Interaction (CDI)

2. Consistent Limit Setting
   • Consistency
   • Predictability
   • Follow-Through
   • Addressed in the Parent Directed Interaction (PDI)
   [also in CDI]
Goals of the Child Directed Interaction (CDI)

• Enhance relationship between parent and child
  – Reduce frustration/anger
  – Improve social skills
  – Improve self-esteem
  – Improve organization and attention

© OUHSC 2008
Features of CDI

- Special Time
- PRIDE skills
- Tactical Ignoring
- Coaching to Criteria
Special Time

5 minutes every day

-Avoid distractions
  - Find a way to have other children occupied so you can be one-on-one with the child
  - Don’t answer the phone
  - Planning 1:1 into your routine

- Follow the child’s lead
  - Allow child to choose the activity from 2-3 choices

- Encourage positive behavior by choosing positive activities at a time that is good for the parent and child

© OUHSC 2008
DON’T RULES
DON’T Give Commands

- Directs the play
- If the child doesn’t obey, the play becomes not fun
- Can make the play feel more like school
- Can be judgmental
- Examples:
  - “Give me the red one.”
  - “Let’s put these away”
DON’T ask Questions

• Often hidden commands
• Take over the lead of the conversation
• Suggest disapproval
• Suggest parent isn’t listening
• Examples
  – “What color is that?”
  – “Is that what you wanted?”
DON’T Be Critical

- Points out mistakes
- Lowers self-esteem
- Creates an unpleasant interaction
- Examples
  - “That doesn’t go there.”
  - “Stop hitting the table.”
Praise

- Increases behaviors that are praised
- Increases self-esteem
- Adds warmth to relationship
- Makes parent and child feel good
- Praise for spontaneous compliance
- Examples
  - “Thank you for sitting quietly”
  - “Good job making that piece fit”
  - “I like the way you made that basket”
Reflect

- Allows child to lead conversation
- Shows parent is really listening
- Shows acceptance
- Improves/increases child speech
- Children love it!
- Example
  - C: “I’m making a super-tall tower.”
  - P: “It is super-tall.”
Reflect
Imitate

• Lets the child lead
• Demonstrates approval
• Shows parent is involved
• Teaches appropriate social skills
Describe

• Lets the child lead
• Shows that parents are interested and paying attention
• Models speech and teaches vocabulary/concepts
• Holds child’s attention
• Examples
  – “You’re making a tower.”
  – “You’re rolling out the play-doh.”
Describe
Enthusiasm

• Expresses parent’s pleasure in spending time with child
• Increases warmth in play
What if the child doesn’t behave during one-to-one time?
Ignoring

- Avoiding all verbal and nonverbal reaction to inappropriate behavior
- Decreases attention-seeking behaviors
- Behavior tends to escalate before extinction begins
- Praise child immediately for appropriate behavior
- Not for aggressive/destructive behaviors
Ignoring
Stopping the play

- Aggressive or Destructive behaviors
  - Immediately stop the play and briefly explain to child why
  - Attempt one-to-one time again the next day
PRIDE skills in action!
Hands On Practice with PRIDE
Features of the Parent Directed Interaction (PDI)

- Command training—giving good instructions
- Contingent praise or consequence (time-out)
- Gradual generalization
- Planned responses to:
  - Refusing negative consequence
  - House Rules
  - Behavior disruptions in public settings

© OUHSC 2008
What do therapists do in PCIT?
What do parents do in PCIT?
What do therapists do in PCIT?
Coaching in action!
More coaching in action!
In-room coaching
Break Time

PLEASE RETURN IN 15 MINUTES

© OUHSC 2008
One Family’s Experience with PCIT

Terry Mummery: Grandfather/Foster Parent of a Child with Prenatal Substance Exposure
One Family’s Experience with PCIT
Access to Services and Supports

If the Mumry family was in your community, what services would be available to them?
Why did you feel treatment was necessary?
What were your first impressions of PCIT?
What made you continue treatment?
What did you do in PCIT?
What results did you see?
One Family’s Experience with PCIT

- What were your expectations when you started PCIT?
- Did your family face any obstacles in participating and completing treatment?
- What made the difference in your attitude toward PCIT?
- What changes did you see in your family as a result of PCIT?
- What words of wisdom do you have for others considering PCIT?
Empirical Support for PCIT
How effective is PCIT?

• National research findings:
  – Improvements in child behavior
  – Improvements in parenting skills and attitudes
  – Generalization to school
  – Generalization to untreated siblings
  – Reductions in the risk of child abuse
  – Benefits for parents and other caregivers

© OUHSC 2008
Mother Report of Child Behavior Problems—ECBI Intensity Score

ES = -3.41
n = 61
p < .0001

© OUHSC 2008
Parent rating of child disruptive behavior (CBCL Externalizing Scale T-score)

ES = -2.11

n = 61

p < .0001 for all pre-post comparisons

© OUHSC 2008
Observed Child Compliance

All subjects (n=62)

p < .001 for all comparisons

© OUHSC 2008
Mother report of parenting stress (PSI-SF)

Pre-post comparisons:
- Parental distress: ES = -1.62, p < .0001
- Parent-child dysf'n: ES = -0.86
- Difficult child: ES = -0.83

n = 60

© OUHSC 2008
Mother Report of Parenting Practices (Parenting Scale)

ES = -1.61

ES = -1.15

p < .0001 for all pre-post comparisons

n = 61

© OUHSC 2008
Mother Report of Depression (BDI)

Total Score

ES = -0.66

p < .0001 for pre-post comparison

n = 61

© OUHSC 2008
1- to 2-year follow-up

- Followed a sample of 13 PCIT completers at 1- and 2-year post-treatment
- Treatment was time-limited
- Demographic characteristics
  - 100% boys; 84% Caucasian
  - Mean age = 4.7
  - Median income = $15K
Parent rating of Child Disruptive Behavior (CBCL Externalizing)

T Scores

Pre: 76
Post: 61
1 Year: 63
2 Year: 64

Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood (2001)
Observed Compliance

Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood (2001)
Observed Child Negative Behavior

Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood (2001)
Observed Parent Negative Behaviors

4- to 6-Year Follow-up

- 23 families (out of 50 completers)
  - 70% boys
  - 83% Caucasian
  - Mean age at pre-treatment = 5.0
  - Mean Hollingshead Index = 40

Hood & Eyberg, 2002
© OUHSC 2008
Parent Rating of Child Behavior Problems—ECBI Intensity

6 children above the cutoff at long-term follow-up

Hood & Eyberg, 2003

© OUHSC 2008
PCIT in families with a history of abuse
Rationale for Applying PCIT to Physical Abuse

- Physical abuse usually occurs in the context of discipline.
- Physically abusive parents perceive their children as behaviorally disordered.
- Parent skills taught in PCIT are consistent with the intermediate goals for physical abuse treatment (ultimate goal is to stop abusive behavior).
Pre-treatment Scores

- Average 2 prior physical abuse reports
  - 39% had severely beaten a child
- Average 2 prior neglect reports
- Diagnostic Interview (DIS)
  - 32% drug or alcohol
  - 39% probably antisocial personality
- Beck Depression Inventory II
  - 22% moderate or higher depression score (>19)
- No differences between groups on demographic or test scores
PCIT with Abusive Parents

Re-Abuse Rate at 2.5 Year Follow-Up

- PCIT
- Parent Group
- Intensive Family Preservation
- Wrap-Around

© OUHSC 2008
Study Conclusions

- PCIT is effective in reducing future child physical abuse reports relative to standard services.
- PCIT outcomes can be obtained by therapists with a wide range of prior experience and training, if adequately trained in PCIT.
- PCIT is more expensive, but the cost to avert a single re-report is not unreasonable ($300-$1300).
Challenges

• Children may not be in the parent’s home
  – Limited opportunity to practice skills outside of session
  – Don’t want to discipline during session/visits

• Treatment tends to last longer
• Treatment is often mandated
• Parents may abuse drugs/alcohol
PCIT in families of children with prenatal substance exposure (PSE)
Rationale for Applying PCIT to families of children with PSE

- Increased risk for behavioral difficulties as secondary disabilities
- Increased risk for parenting stress
- Increased risk for failed foster care placement

OR

- Increased risk for substance abuse relapse
Rationale for Applying PCIT to families of children with PSE

- Parents perceive children as behaviorally disordered solely due to drug/alcohol exposure
- They are more receptive to an approach offering effective behavior management
- Needs of caretakers with children considered “at risk” are consistent with the skill training focus of PCIT
Population Studied

• Children (n=38)
  – Diagnosed with FAS/ARND or other substance exposure
  – Functioning at a minimum of 30 months of age in cognitive development
  – Between 2½ and 7 years of age

• Parent/Caregiver
  – >65 IQ based on KBIT
Rationale for Group Format

• Too many referrals, too few therapists
• Attrition
• Time efficiency
• Cost efficiency
• Vicarious learning opportunities
• Increased generalization opportunities
• Feedback and praise from others
• Support group for caregivers

© OUHSC 2008
Bi-variate Difference Score Model: Group PCIT ($n=92$)
Implementation of Evidence-Based Practices
Which EBT is right?

- **Core intervention components?**
  - Core values and philosophy
  - Relevance for population of focus
  - Service delivery activities- service duration, setting, staff skills, protocols

- **Core implementation components?**
  - Costs (implementation costs and ongoing costs)
  - Staff recruitment and selection criteria
  - Training and ongoing coaching for staff
  - Administrative structures necessary

- **Effectiveness of program?**
- **Plan for program consultation and TA?**
Organizational Readiness and Capacity Assessment

- Clients
- Leadership/clinicians /staff
- Supervision
- Internal and external stakeholders
- Program/culture /services
- Finance and administration
- Education
- Technology
Lessons Learned in Implementing Evidence Based Practices

- Staff recruitment and selection
- Pre-service or in-service training
- Coaching, mentoring, and supervision
- Internal management support
- System-level partnerships
- Staff and program evaluation

("Implementing Evidence Based Practices: Six Drivers of Success" Allison Metz, Karen Blasé, Lillian Bowie. Child Trends, Research to Results Brief)
Stages of Implementation

- Exploration
- Installation
- Initial Implementation 2-4 Years
- Full Implementation
- Innovation
- Sustainability

Fixsen, Naoom, Blasé, Friedman & Wallace 2005
What is Implementation?

“Methods to assure the use of evidence-based programs and other innovations with fidelity and benefit to consumers”.

(National Implementation Research Network website definition, 2008)
Implementation Model

Administrative Leadership and Support

Supervision

Expert Consultation

Training

Materials

Therapist

Use with appropriate clients

Client feedback

Stakeholder Engagement

(Wilson and Saunders, NCTSN Presentation, 2006)
Stages of Implementation

Moving from initial implementation to full implementation to sustainability
New York State Implementation Model

System & Policy Context
Financial policies, methods of reimbursement, state policies

Organizational Context
Culture
Climate
Structure

Engagement
Attitudes, Beliefs & Expectancies of Clinicians and Supervisors

Clinical Care Improvement
Training on EBP's, supervision, consultation and support

Empowerment
Attitudes, Beliefs & Expectancies of Families & Youth

Improved Implementation Efficiency & Effectiveness

Improved Child & Family Outcomes
Implementation of PCIT
Lessons Learned: Agency Commitment

- Memorandum of Understanding with Agency
- Room with observation room
- Sound equipment, assessment toys, etc
- Provide measures (ECBI), videotape capacity
- Staff time for initial training, ongoing consultation, co-therapy in early cases
Challenges to Maintaining a PCIT Program

- **Adequate Referrals** – new PCIT therapists should carry 4 or more cases for optimal learning.
- **Staff Turnover**
  - agencies are encouraged to train at least 2 staff members in PCIT for mutual support and so the program doesn’t end if one person leaves.
  - Rural agencies may have only 1 child/family therapist.
- **Supervisors in agency need to understand PCIT and support the theoretical basis and protocol adherence**.
- **Staff turnover requires ongoing training** – “within agency trainers.”

© OUHSC 2008
Requirements for Within Agency Trainers

• Licensed to provide therapy services to children and families
• Meet 10-10-10 criteria for PRIDE skills
• Demonstrate understanding of PCIT principles, protocol, and implementation
• Successful implementation of protocol
• Reliable DPICS coding
• Competent coaching
• Completion of 2 cases with weekly consultation from experts

© OUHSC 2008
Co-therapy model

- Traditional PCIT training model in graduate programs
- Involves seeing cases with trainees as a co-therapy team
- Trainer is lead for 2 completed cases, trainee is lead for 2 completed cases
- Trainers responsible for instructing trainees in theory, procedure, and implementation of PCIT
- Trainees responsible for collecting/scoring measures; maintaining client records

© OUHSC 2008
Factors Contributing to Success

- Ongoing training model
- $$$
- Administrative support
- Pre-existing data collection system
Successful Implementation of PCIT at the Organizational Level
Evidence Based Practice must:

- Have content that is welcoming to the host culture
- Be relevant to the host culture and not offensive
- Be validated and endorsed by the host culture
- Be individualized for your community
Latino Families are highly likely to benefit from PCIT, and to experience sustained behavioral change, because the core principles are in alignment with many value systems found in the Latino families.
PCIT: Culturally Relevant Evidence-Based Practice

Why is it important to understand the culturally specific elements of an Evidence Based Practice?

- **Strengthen and Grow** critical Protective Factors
- **Decrease Risk Factors**
PCIT can enhance Latino protective factors that break down during the immigration and acculturation process.

- Confianza
- Machismo
- Acculturation
- Language
- Familismo
- Compradazco
Dissemination of PCIT
PCIT Training Programs

- Graduate programs in clinical psychology
- University of Florida
  - 1 week, for academics and researchers
- University of Oklahoma (www.okpcit.org)
  - For community providers
  - 7 week-days, plus 6-months consultation
  - Also 1-year practicum placements and seminar
- University of California-Davis
  - For community agencies
  - 1-year program

© OUHSC 2008
Remote Live Consultation
Resources on Evidence Based Practices

- Child Welfare Information Gateway
  (www.childwelfare.gov/systemwide/serviceimprovement/systemsreform/improvingpractices)

- The California Evidence-Based Clearinghouse for Child Welfare
  (www.cachildwelfareclearinghouse.org)

- National Resource Center for Family Centered Practice and Permanency Planning
  (www.hunter.cuny.edu/socwork/nrcfcpp/info_services/evidence-based-practice.html)