Strategy for the Evidence-Based Aspects of the Family First Service Continuum

Models Recommended for the Mental Health Services Array

Spotlight on

child first

&

PCIT INTERNATIONAL

Presenters

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Facilitators

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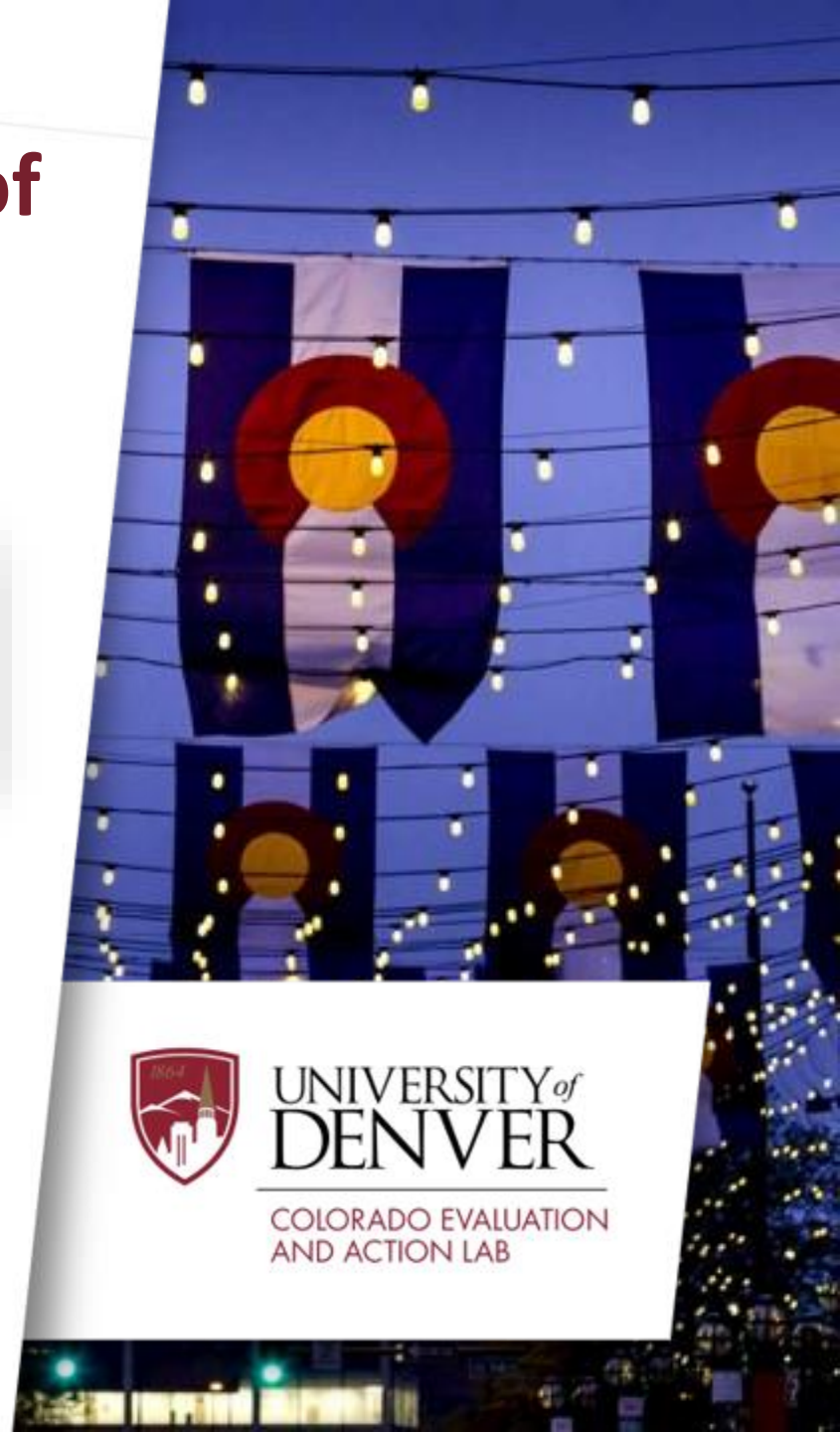

Welcome!

Please drop your name/agency in the chatbox

- Framing from the Colorado Lab and CDHS
- Spotlight on PCIT and Child First
- Time for Q&A at end
  - Submit questions in chatbox along the way!
- Wrap-up

Project Purpose

Develop a short-, medium-, and long-term strategy for expanding Family First-eligible prevention services in Colorado

- Generate recommendations:
  1. for the **creation of an evidence-based service continuum** matched to needs.
  2. to **maximize federal drawdown**, including which services on the continuum should and should not be funded through Title IV-E prevention dollars.

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Partnership Between

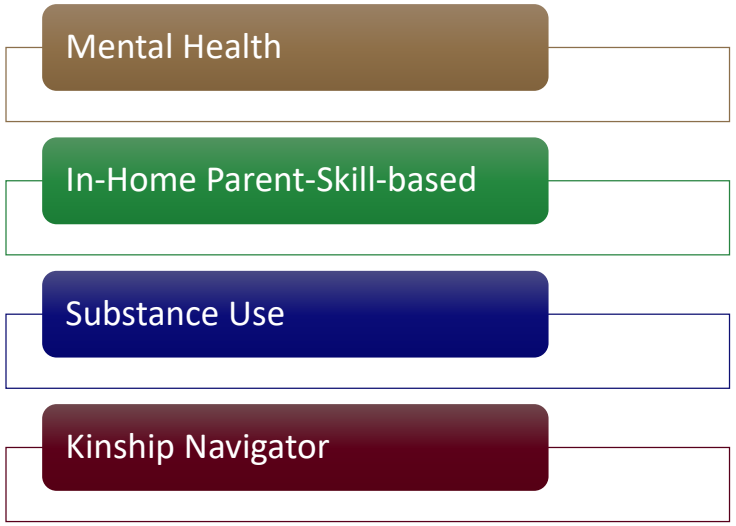
COLORADO
Office of Children, Youth & Families
Department of Human Services

www.ColoradoLab.org

Step 1: Initial Approach to Defining a Strategy

Goal: Synthesize existing information to identify alignment between documented needs within Colorado and evidence-based services rated by the Title IV-E Clearinghouse. To do this, we:

- Gathered needs assessment data/reports
- Identified ***"anchor"*** program within each domain
- Identified "***complementary"*** *services* to create a more comprehensive array



Purpose of These Info Sessions

- To provide a foundational orientation to recommended models for the mental health services array
- Guiding Question: Is this a service you want to bring to your communities and/or scale?

Opening Remarks

- Yumiko Dougherty, Director of Strategic Planning & Implementation, CDHS

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Mental Health Services

1. Mental health needs of children and youth
2. Family functioning

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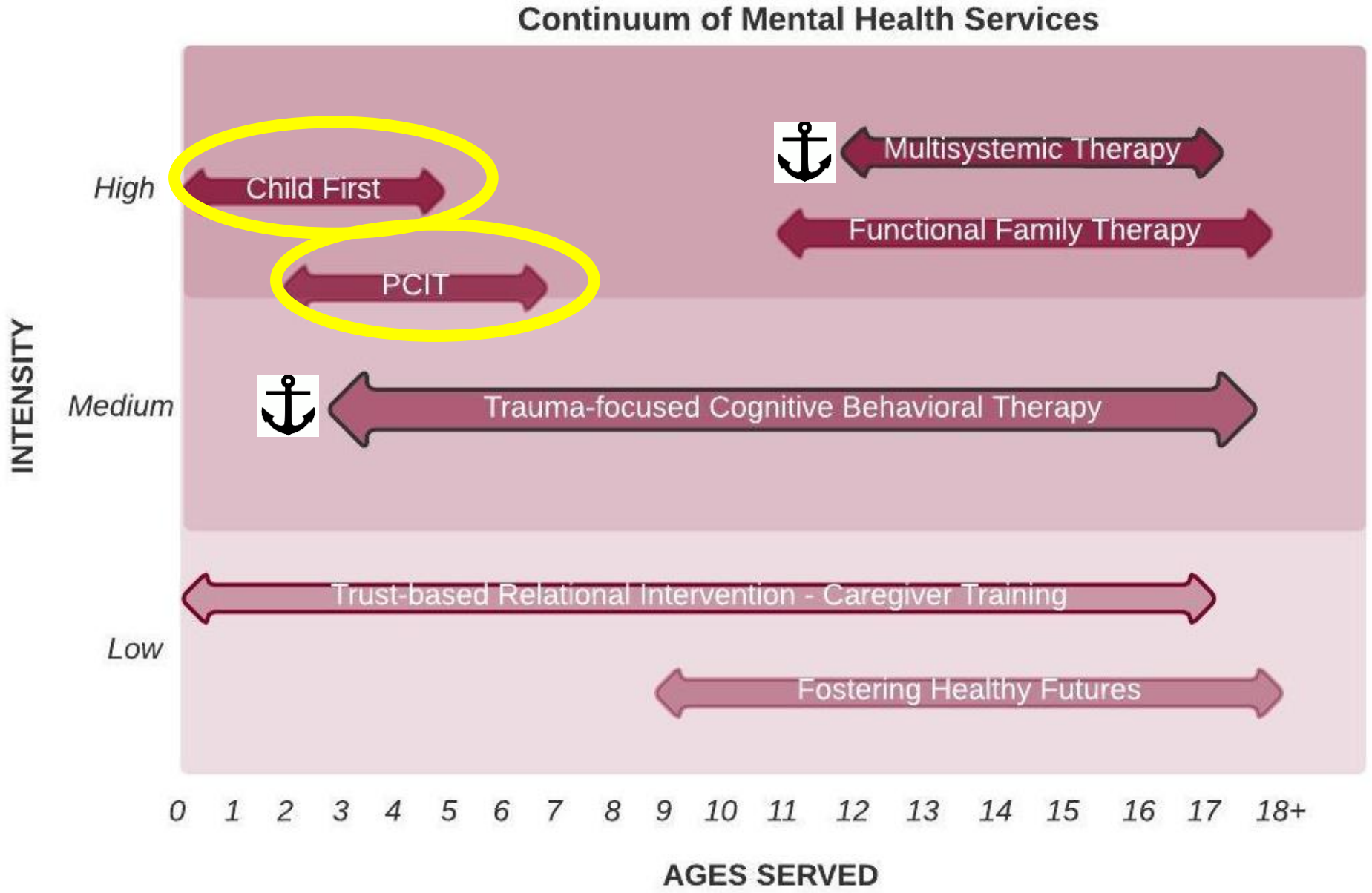
Mental Health Services

Anchor Services:

TF-CBT: Mental Heath of Youth

MST: Family Functioning Needs



PCIT & Child First Evidence Ratings

PCIT: **Well-Supported**

- According to the Title IV-E Prevention Services Clearinghouse

Child First: **Supported**

- According to the Colorado's Independent Systematic Review (ISR) Process to Claim Transitional Payments

	☑ to Verify
There is *NOT* sufficient evidence of risk of harm such that the overall weight of evidence does not support the benefits of the program or service.	
	☑ the Designation and Provide a Response to the Questions Relevant to that Designation
Well-Supported	
• Does the program or service have at least two eligible, well-designed and well-executed studies with non-overlapping samples[3] that were carried out in a usual care or practice setting?	
• Does one of the studies demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome?	
Supported	
• Does the program or service have at least one eligible, well-designed and well-executed study that was carried out in a usual care or practice setting and demonstrate a sustained favorable effect of at least 6 months beyond the end of treatment on at least one target outcome?	
Promising	
• Does the program or service have at least one eligible, well-designed and well-executed study and demonstrate a favorable effect on at least one 'target outcome'?	

OR -- Does not meet criteria at this time

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& Now…the main show!

Parent-Child Interaction Therapy

Family First Presentation

May 6, 2021

Dr. Amanda N'zi

Regional Trainer, PCIT International

Executive Director, Growing Together Child and Family Therapy

Parent Child Interaction Therapy

Well-supported, evidence-based , dyadic treatment for children ages 2 – 7 and their caregiver(s)

Developed for children with challenging behaviors and conflict in the caregiver-child relationships

Improves attachment in the caregiver-child relationship and improves child behavioral functioning

Structure of the two-phases of PCIT

- **Child Directed Interaction (CDI)**
  - Didactic, "Teach," sessions
  - Coach sessions
  - Play therapy skills

- **Parent Child Interaction (PDI)**
  - Didactic, "Teach," sessions
  - Coach sessions
  - Consistent and predictable discipline

Treatment Length:

12-20 sessions

Child Directed Interaction Skills

Follow the Child's Lead

PRIDE

- Praise, Reflect, Imitate, Describe, Enjoy
- Avoid Questions, Commands, Criticisms

Differential Attention

Goals of CDI

Child Directed Interaction (CDI)

- Decreased frequency, severity, and/or duration of tantrums
- Decreased activity levels
- Decreased negative attention-seeking behaviors (such as whining and bossiness)
- Decreased parental frustration
- Increased feelings of security, safety, and attachment to the primary caregiver
- Increased attention span
- Increased self-esteem
- Increased pro-social behaviors (such as sharing and taking turns)
- Improve parent and child emotion regulation

Parent Directed Interaction Skills

- Structured, consistent, predictable discipline
- Clear, effective commands
- Timeout procedure
- House Rules
- Public Behavior
- Siblings

Goals of PDI

Parent Directed Interaction PDI

- Decreased frequency, severity, and/or duration of aggressive behavior
- Decreased frequency of destructive behavior (such as breaking toys on purpose)
- Decreased defiance
- Increased compliance with adult requests
- Increased respect for house rules
- Improved behavior in public
- Increased parental calmness and confidence during discipline
- Improve parent and child emotion regulation

Essential Program Components

- Dyadic
- Coaching-based
- Assessment Driven
- Goal based
- Modular driven

Target Population

Families and children that benefit from PCIT:

Child Focused Referrals

Children ages 2-7 with frequent temper tantrums, aggressive behavior, or oppositional behavior that impacts caregiver-child functioning and/or school functioning

Children with challenging behaviors related to a placement change or attachment disruptions

Children with co-morbid diagnoses of Intellectual Disability, Autism Spectrum Disorder, ADHD, Callous and Unemotional Traits*, Anxiety Disorders* and/or Depressive Disorders*

Children can have open cases with child welfare. More than one caregiver can be involved

Families and children that benefit from PCIT:

Parent/ Caregiver Focused Referrals

- Foster caregivers, kinship caregivers, and biological parents are appropriate referrals.
- Parents or caregivers at-risk or with histories of physical abuse towards a child or coercive parenting interactions
- Parents preparing for reunification with visitation at least three times per week
- Parents that need help with behavior management

Cultural Research with PCIT

Families from diverse cultural backgrounds

- Mexican-American (McCabe et al., 2009, 2011)
- African-American (Fernandez, 2001)
- Puerto Rican (Matos et al., 2006, 2009)
- Australian (Nixon, 2003; Phillips, Morgan, et al., 2008)
- Dutch (Abrahamse et al., 2012)
- Chinese (Leung, 2009; Yu, et al., 2011)
- Ongoing PCIT in Norway, Germany, Korea, Japan, etc.

Child welfare caseworkers

Pediatricians

Self-referral

Case managers

Psychological assessment

Referral Resources

Safety

Child/
Family
Well-being

Demonstrated Changes in PCIT Research

Outcomes in PCIT

Demonstrated in clinical, foster care, and parent involved with child welfare

Parenting

- Improves praise and decreased criticism

Child Specific

- Increases compliance
- Decreases oppositional and conduct problems,
- Improves child emotion regulation and lability

Parent/Caregiver Specific

- Improves parental stress and depression
- Improves recidivism rates
- Improves parent emotional regulation and ability to use cognitive reappraisal

PCIT and Other Diagnoses

Developmental Delay and Autism Spectrum Disorders

- Increases child compliance, reduces child disruptive behavior, and improves parenting skills

ADHD

- Improved hyperactive, inattentive, aggression and oppositional behaviors as well as parental stress

Prevention in early identified children with high stressors (toddlers)

- Improved parental warmth and sensitivity. Improves language development

PCIT and Internalizing Disorders

with adaptation

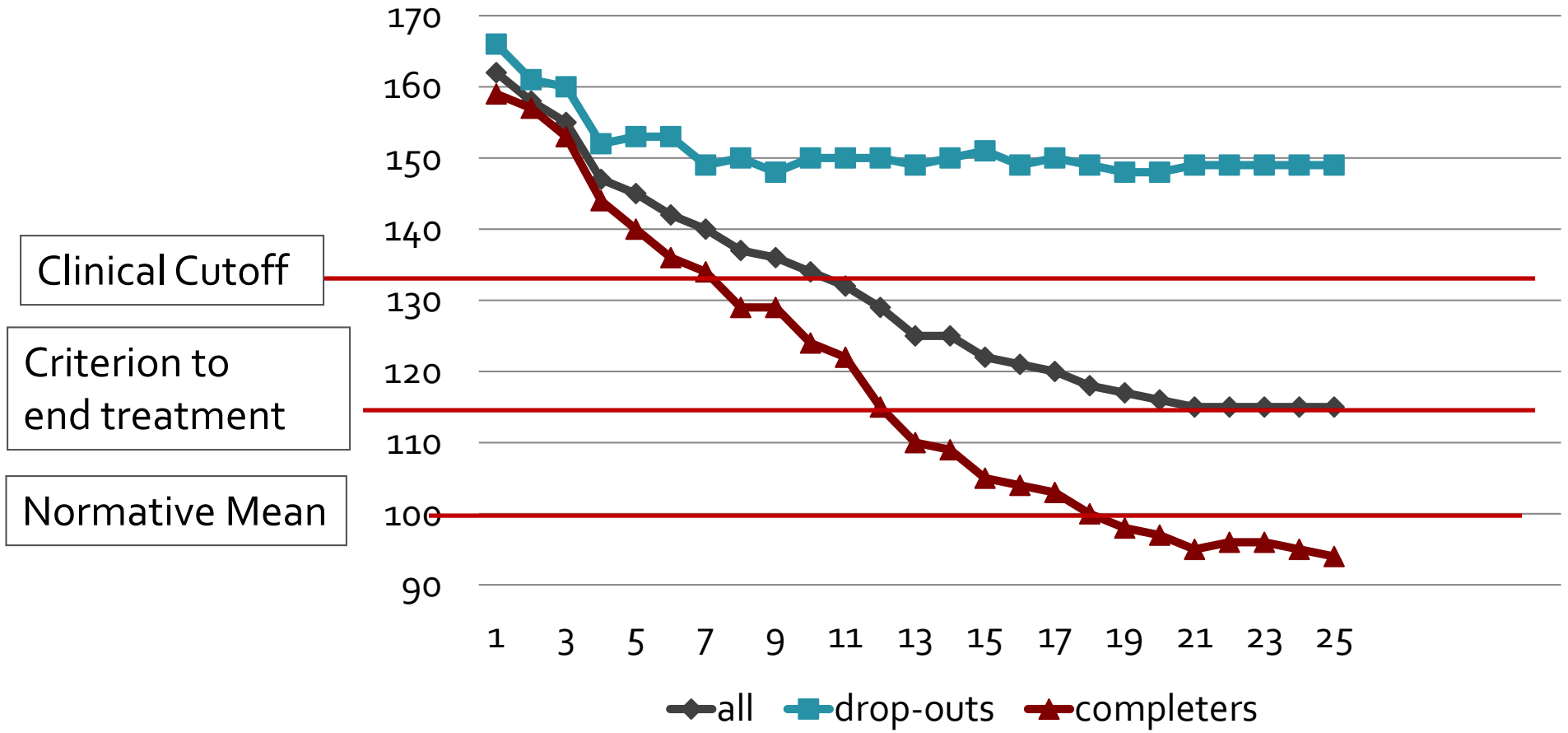
Anxiety Disorders

- Improvement in separation anxiety and anxiety disorders
- *Bravery Directed Interaction or CALM*

Depression

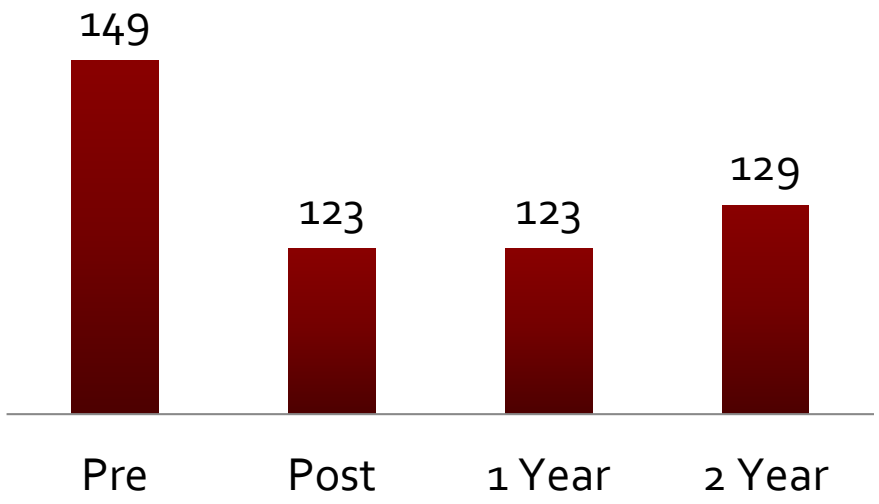
- Improved depressive symptoms in child and caregiver
- *Emotion Development*

ECBI Weekly Intensity Score

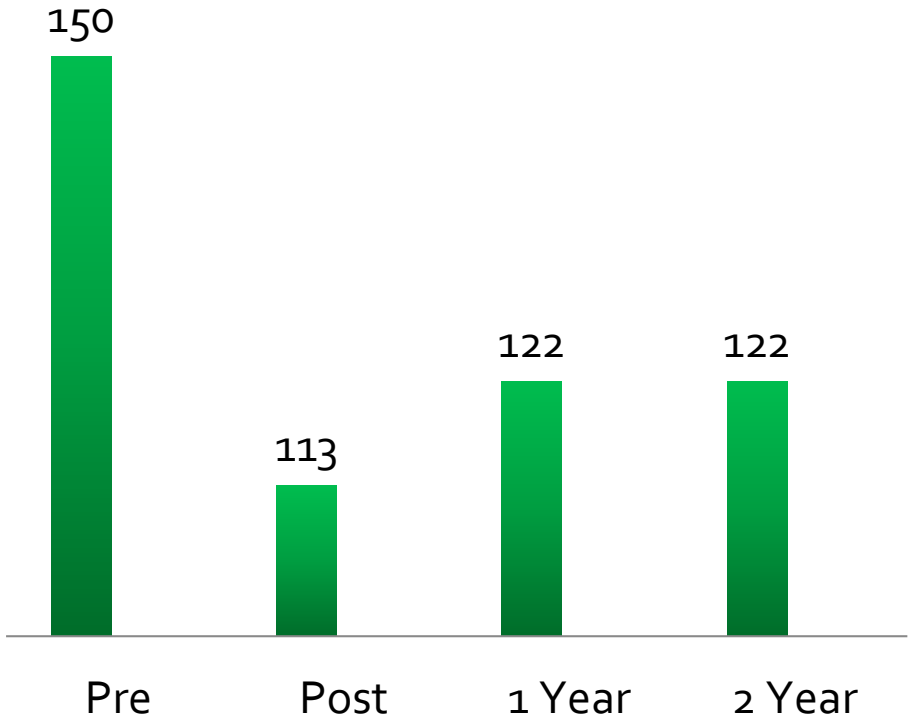


Parenting Stress Index

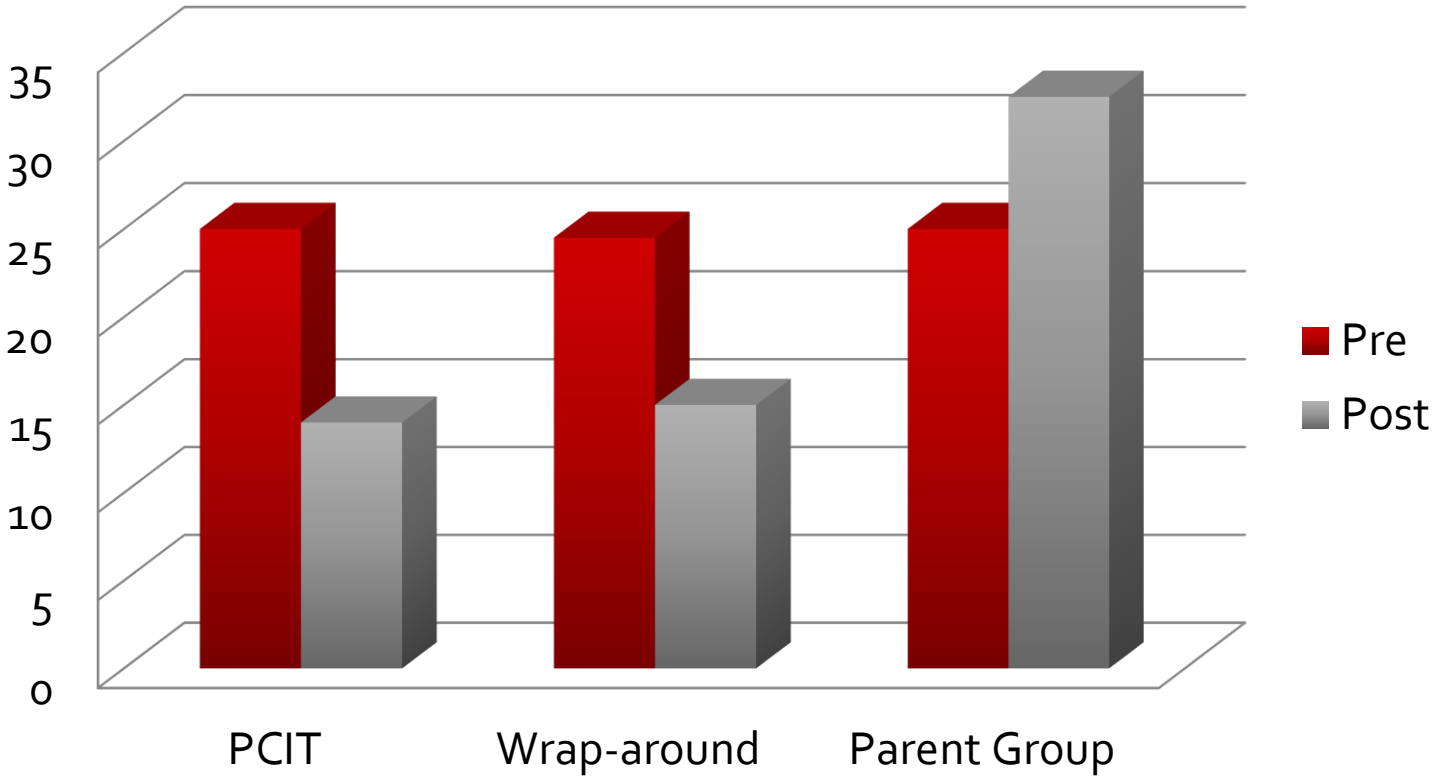
Parent Domain
2-year Effect Size = .70



Child Domain
2-year ES = 1.71

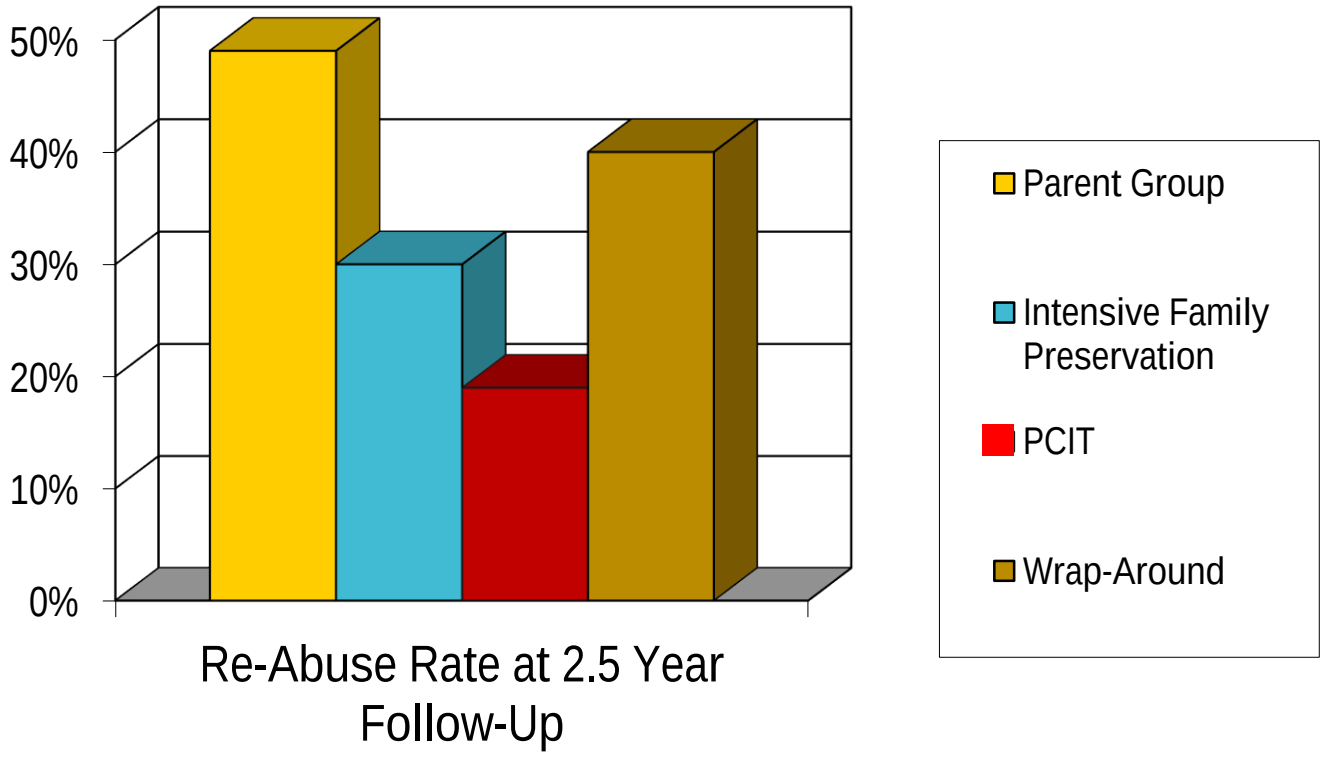


Abusive and Neglectful Parents
DPICS Parent Negative Behavior
(30 min observation)



Chaffin, M. et.al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, 72, 500–510.

Abusive and Neglectful Parents
Re-abuse Rate at 2½ year follow-up



Chaffin, M. et.al. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, 72, 500–510.

Dosage and Frequency

- **Recommended Intensity:**
- Weekly 1-hour sessions
- *Can be delivered in more intensive models or with longer sessions

- **Recommended Duration:**
- 14 session on average; 10 to 20 sessions.
- Treatment continues until the parent meet goals for the interaction skills and the child's behavior has improved to within normal limits.

Location

- Outpatient Clinic
- Community-based Agency/ Provider
- Telehealth
- In-Home

PCIT International Therapist Certification

- **Education**: Equivalent of a Master's degree or higher in a mental health field; licensed or under supervision as a mental health professional
- **Training:**
  - 40 hours of skills training
  - Complete 2 cases under consultation
  - Competency check-offs in live session or video review
  - Twice monthly consultation for a minimum of 12 months
- Certification
  - Renew every 2 years with application and 3 hours of PCIT CEUs
- http://www.pcit.org/therapist-requirements.html

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WWW.PCIT.ORG

PCIT International Within Agency Trainer Certification

- **Education**: Equivalent of a Master's degree or higher in a mental health field; licensed as a mental health professional
- **Training:**
  - 8 hours of skills training
  - Complete 4 cases
  - Competency check-offs in live session or video review
  - Monthly consultation for a minimum of 12 months
  - Train one provider to PCIT Therapist requirements
- Certification
  - Renew every 2 years with application and 6 hours of PCIT CEUs
- http://www.pcit.org/trainer-requirements.html

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WWW.PCIT.ORG

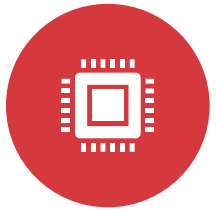
Pre-agency Readiness

SERVE FAMILIES BETWEEN THE AGES OF 2-7 YEARS OLD

ESTABLISH REFERRAL PATHWAYS FOR PCIT

OBTAIN AGENCY LEVEL COMMITMENT TO MANUALIZED INTERVENTION

THERAPISTS CAN PROVIDE WEEKLY SESSION



PCIT EQUIPMENT (VARIES FOR IN-CLINIC VERSUS IN-HOME VS TELEHEALTH)

Sustainability

- Within Agency Trainer Model
- In-house quality monitoring
- Integration of treatment into agency
- Ongoing financial support

PCIT in Colorado

PCIT International Certified Therapists

- 13 agencies (3 additional in training)
- 21 providers (4 additional in training)

PCIT International Within Agency Trainers

- 6 trainers (2 additional in training)

PCIT International Regional Trainers

- 1 trainer

Language/ Resources

- Treatment materials are available in:
  - English
  - Traditional Chinese
  - Japanese
  - Korean
  - Spanish
  - Dutch
  - German

Questions??

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www.pcit.org

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WWW.PCIT.ORG

Growing Together
CHILD AND FAMILY THERAPY

Invest in Kids and Child First in Colorado

INVEST IN KIDS

Since 1998, we have been investing in and ensuring the success of evidence-based programs to improve the health and well-being of Colorado's young children and families experiencing economic vulnerability.

INVEST IN KIDS

Invest in Kids' Approach

- **Identify** research-based, proven programs with methodologies for success
- **Introduce** these programs to Colorado communities and constituencies to determine potential for impact
- **Implement** programs through agency partnership and community collaboration
- **Ensure** ongoing program success through measurement of results

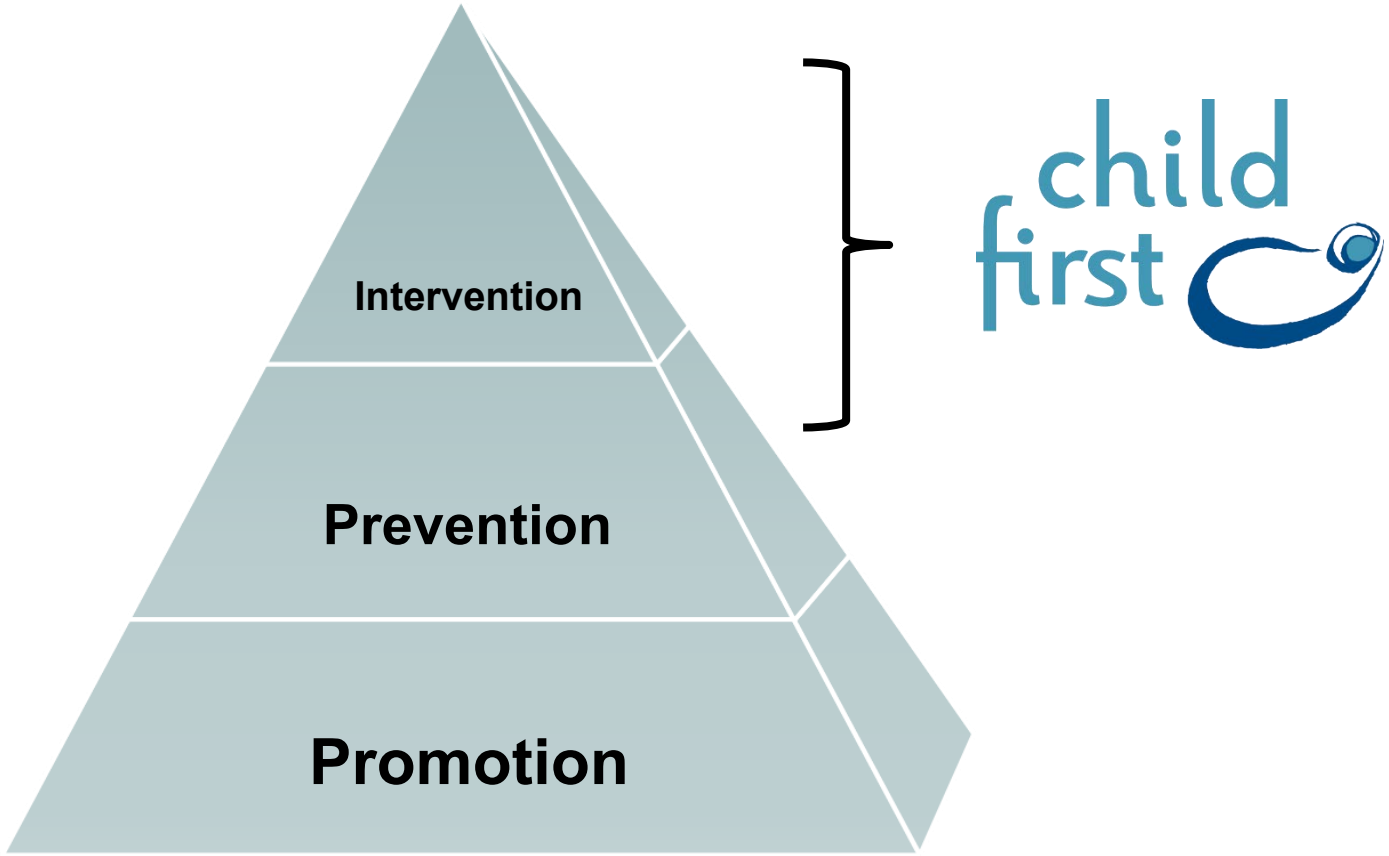
Child First is an evidence-based, two generation, home-based mental health intervention that serves young children and their families most impacted by systemic and structural inequities.

Goals of Child First:

(1) Promote child and parent emotional health,
(2) Promote child development and learning,
(3) Enhance parent and child executive capacity, and
(4) Prevent child abuse and neglect.

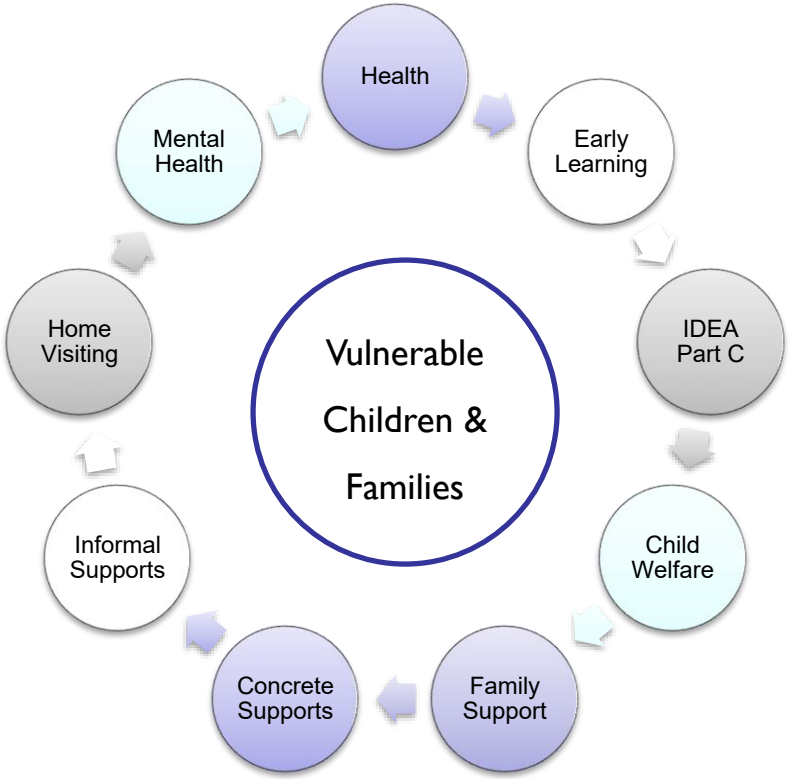
FILLING A CRITICAL GAP

in the continuum of care



INVEST IN KIDS

Early Childhood System of Care



INVEST IN KIDS

Child First – Target Population

Any child who is prenatal through five years of age may be referred to Child First. The service is intended for parent and child whose secure attachment has been disrupted due to the following referral behaviors:

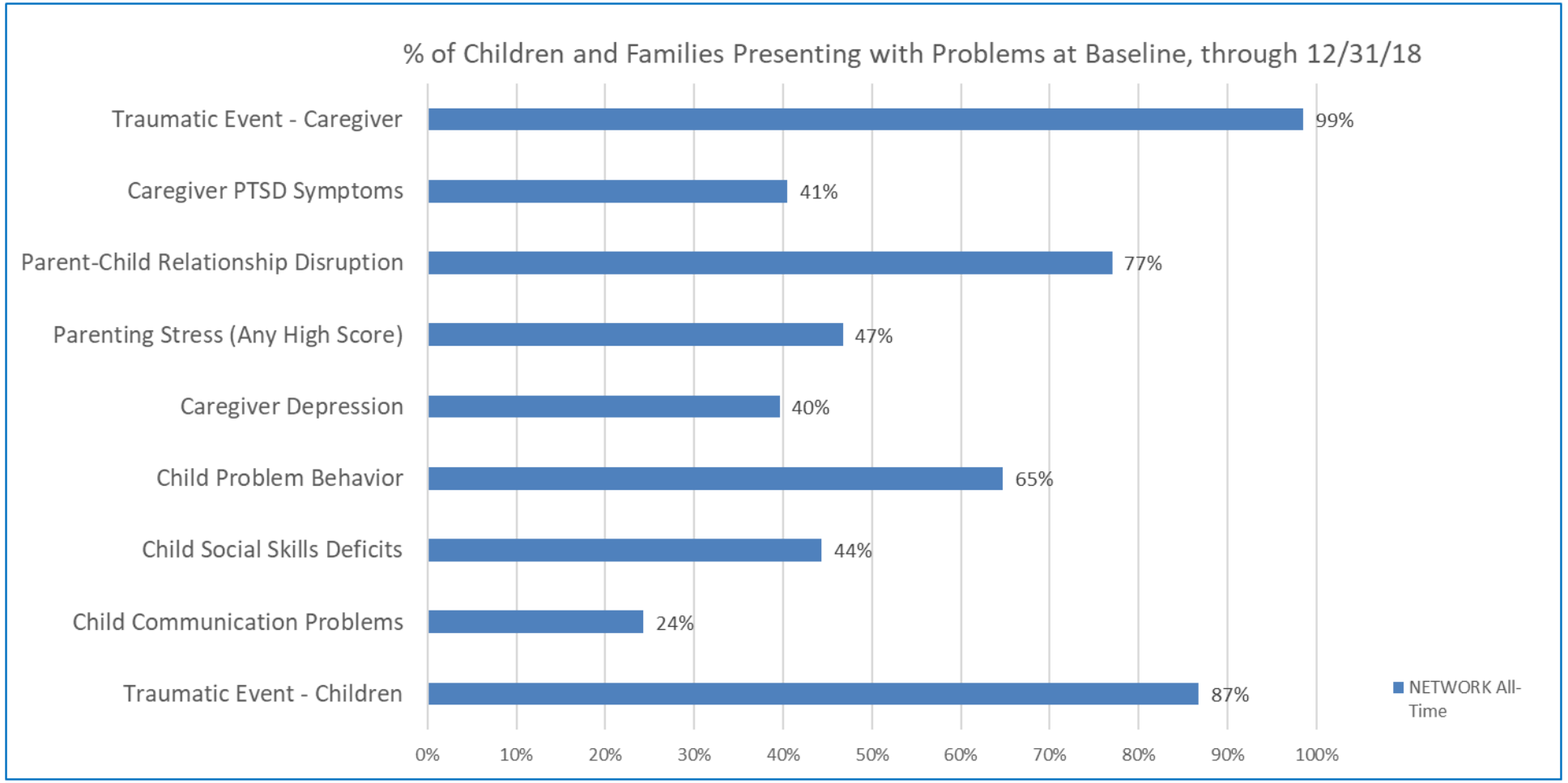
Children:

- emotional or behavioral problems,
- developmental or learning problems, or
- come from environments in which there is considerable risk to their health and development.

Caregiver:

- parental mental illness,
- substance abuse,
- incarceration,
- intimate partner violence,
- living in shelters, being homeless or having undocumented status.

Who Child First Serves



Data drawn from all Child First sites in CT, FL, NC

INVEST IN KIDS

Child First's Clinical Team Approach

Home Visiting Team

- Family Support Partner
  - Stabilize family, connect to services and supports, provide growth enhancing opportunities for child and family
- Licensed Mental Health Clinician
  - Trained to work with the family and child to facilitate responsive, nurturing parent-child relationships. Promotes attachment, emotional regulation, and behavioral health

Child First Intervention Process

- **Visit Frequency**
  - 2x's per week during 1st month with CF Team
  - Minimum of 1x per week as needed
  - May increase based on unique needs of family
- **Length of Service**
  - Average 6-12 months
  - May increase to 18 months (or longer) is clinically necessary
- **Caseload**
  - Average of 10-16 cases, based on family complexity, travel time
- **Number of Home Visits** per week per Clinical Team
  - Average of 12 per week.

Components of Child First

- Screening and referral
- Family engagement – trust and respect
- **Family stabilization and care coordination**
- Comprehensive assessment of child and family
- Child and Family Plan of Care (Treatment Plan)
- **Child-Parent Psychotherapy** – 2-generation intervention
- Executive functioning in child and caregivers
- Mental health classroom consultation

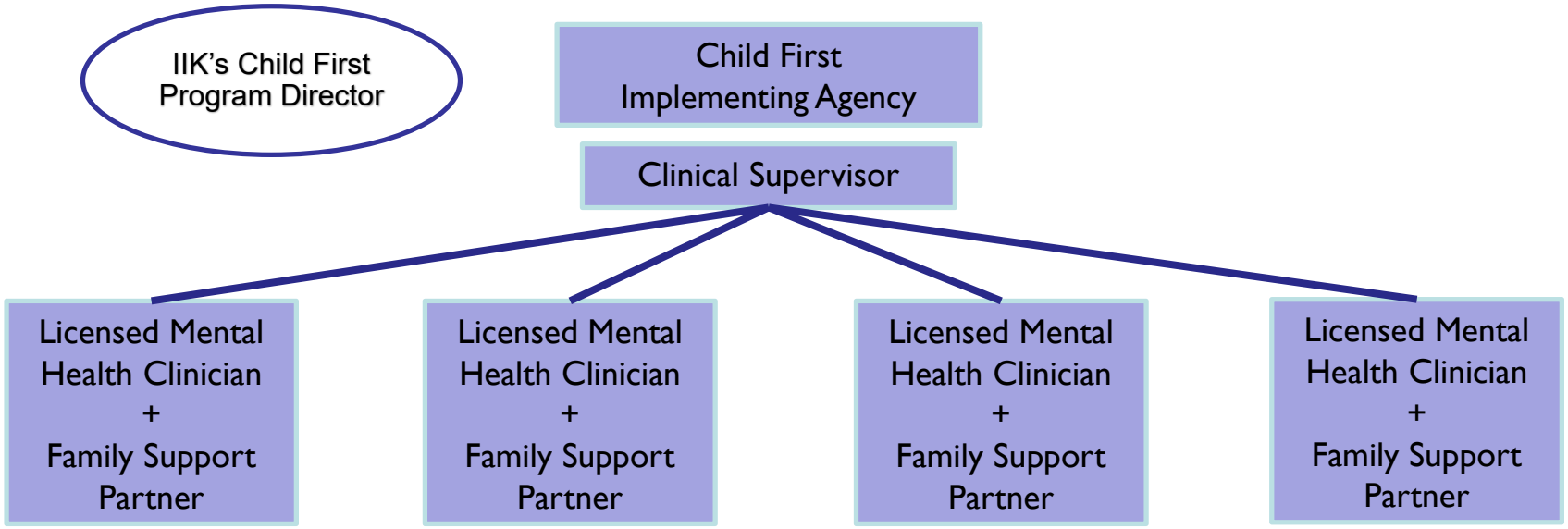
Current Child First Partners in Colorado

IIK is supporting the launch of Child First services in 2021 alongside the following engaged partners:

<u>Cohort One Implementing Agencies</u>

- San Luis Valley Behavioral Health Group – serving the San Luis Valley
- Tennyson Center for Children – serving Boulder, Broomfield, and Jefferson Counties
- Aurora Mental Health Center – serving the city of Aurora
- Savio House – serving El Paso County and Adams County

Structure of the Child First Agency



Each Implementing Agency has 1 Supervisor that oversees 4 clinical teams of two people – 9 FTE

Each Implementing Agency will see ~80 families/year

Rigorous Training

Training extends over several months:

- Child First Learning Collaborative: 4 training sessions, a 6-7-month process
- Child-Parent Psychotherapy (CPP) Learning Collaborative: 3 training sessions and 18 months of biweekly consultation groups
- Child First Online Distance Learning, combining guided web-based modules, teleconferencing, & readings
- Specialty trainings:
  - DC: 0-5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood)
  - Circle of Security (Practices to promote secure attachment between caregiver and child)

Ongoing Reflective Supervision

Support to ensure high quality program delivery and prevent staff burnout:

- Reflective clinical consultation from the IIK Statewide Clinical Director for site Clinical Supervisors
    - Weekly to Biweekly
- Reflective clinical supervision from site Clinical Supervisor for all Child First staff
    - Each individual staff member received 3.5 hours/week of reflective supervision (individually, as a clinical team, and as a whole group)
- Administrative Group Supervision monthly to review Benchmarks and Outcomes.

Major Impacts Across All Outcomes

Children's mental health: 42% less likely to have externalizing symptoms at 12-month follow-up.

Maternal mental health: 64% less likely to have scores in the clinical range for mental health issues at 12-month follow-up. Significantly lower depressive symptoms at 12-month follow-up.

Language delays: At 12-month follow up, language delays were 68% less likely for children. Among those with baseline language problems, competent language was observed in 80% of children in Child First compared with 36.4% of Usual Care children.

Access to services: The Child First Intervention group had 91% of service needs met at 12-month follow-up, compared with only 33% in Usual Care group (with a large effect size).

Involvement in Child Protective Services: 39% less likely to be involved with protective services during the 12-month follow-up period (parental self-report), and 33% less likely to be involved with protective services (based on child protection records) 3 years later.

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Areas of Articulation – Complements and Overlaps

	PCIT	CHILD FIRST
POPULATION	Children ages 2 to 7 (& caregivers) – dyad	Children ages 0 to 5 (& caregivers) – dyad
GOAL	Children w/challenging behaviors; children w/comorbid disorders; conflict in dyad relationship	Children w/challenging, emotional, behavioral, development, or learning issues; caregiver w/trauma, life stressors, or mental health issues that can disrupt the relationship
DOSAGE	16 weeks (12 to 20 sessions total)	6 to 12 months (1- 2x/week)
DELIVERY SETTING	Outpatient, tele-health, community, in-home	In-home
PROVIDER EDUCATION	Master's degree or equivalence, licensed or under supervision as mental health professional	Mental Health Clinician is licensed or license eligible. Family Support partner typically has a Bachelor's degree or a HS diploma/GED w/early childhood experience
PROVIDER TRAINING	40 hours of training + 1 year consultation; additional 8 hours +1 year consultation to become in-house trainer	Initial trainings lasts ~7 months plus ongoing specialty trainings
DELIVERY MODEL	Individual therapist	Team-based approach
IMPLEMENTATION CONSIDERATIONS	Can be done at individual provider level; equipment varies based on delivery setting	Site level training for launch and ongoing support
SUPERVISION	CEUs and renewals every 2 years	Reflexive supervision weekly

Next Steps

- Conversations will continue as we invest in capacity-building for Family First, together

- Recording and slides will be posted
- Save the Date! Next Session will be:
  - Wednesday, May 19th 11:30am – 1pm on FFT and MST
- Help us advertise these sessions far and wide!

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Many thanks!

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