Evidence-Based Behavioral Parenting Models in Child Welfare

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Family of PMTO & Hanf Interventions
Originally Developed as Parent-Mediated Treatments for O.D.D.
What They Have in Common

• Based on similar theory of change—Parent mediated behavioral model
  – Parent mediated. Change child behavior by changing parenting
  – Skill focused. *Parenting as it is behaviorally delivered, not as it is talked about.*
  – Techniques are: Modeling, behavioral practice, feedback.
  – Focused—*Depth and intensity over breadth and "comprehensiveness"*

• Three main themes
  – Consistency
  – Relationship enhancement. Increasing pleasant positive parent-child interactions and warmth
  – Structured behavior management system

• Related home-based models: SafeCare
Parent-Child Interaction Therapy (PCIT)

• Dyadic (parent and child together) behavioral parenting model
• Well established EBT for early behavior problems
• ~ 14 sessions
• Effect size in 13 RCT’s .61 – 1.45
• Benefits generalize to school and to siblings
• Scale-ups in several states. NCTSN
Structure of PCIT

• Two Phases
  – Child Direction Interaction (CDI)—teaches relationship enhancement skills, use of positive reinforcement, and ignoring minor misbehavior
    • Praise
    • Reflection
    • Imitation
    • Description
    • Enthusiasm
  – Avoid commands, criticisms, questioning, etc.
Structure of PCIT

• Two Phases
  – Parent-Direction Interaction (PDI)—teaches discipline skills, minding
    • How to give specific instructions
    • Following step-by-step sequence for non-compliance
    • Consistency
    • Time-out and backups
    • Strategies for managing challenging situations (e.g., tantrum in grocery store)
PDI Phase Behavior Management Protocol

Discipline procedure

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Why Adapt a Treatment for ODD to Child Welfare?

• Parenting programs are the most common service in Child Welfare service plans (NSCAW).
  – However, few “parenting groups” utilized by Child Welfare use evidence-based models and have not taken advantage of the substantial progress made in other parent training domains

• Child behavior problems and harsh, disengaged or distressed parenting share reciprocal etiological developmental pathways in families under stress (e.g. coercive cycles) and deteriorating parent-child relationships are common
  – These are the behavior patterns the behavioral parenting EBTs can alter
  – Parenting stress, parenting satisfaction, and improved parent-child closeness are known benefits of behavioral parenting EBTs

Parent-Child Interaction Therapy: An Intensive Dyadic Intervention for Physically Abusive Families

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West Virginia University

A designated priority in the field of child maltreatment is the development of empirical approaches for treating abusive families. This article describes parent-child interaction therapy (PCIT), an intervention that has been shown to be effective for helping parents manage young children with severe behavioral problems. The potential application of this treatment program to the child maltreatment field is examined by: (a) providing a social learning perspective to explain the development and stability of some physically abusive parent-child relationships, (b) outlining the effectiveness of PCIT with similar populations, and (c) discussing the unique benefits that PCIT may offer the field of child maltreatment. The limitations of PCIT with physically abusive families are also discussed.
Adapting PCIT for Parents and Children in Child Welfare

- Major change of intervention purpose and primary goals
- No longer a “parent mediated treatment” for child behavior problems. The parent, not the child, is often the primary focus of the treatment.

- The main goals in adapted PCIT are:
  - IMPROVED PARENTING
  - REDUCTION IN CHILD WELFARE RECIDIVISM
  - BETTER PARENT-CHILD RELATIONSHIP
  - LESS HARSH OR DISENGAGED PARENTING

- Reduced child behavior problems is a bonus
Example of Disrupted Parent-Child Sequential Interaction Patterns Among Parents in Child Welfare

![Bar chart showing interaction patterns among parents in child welfare](chart.png)
Adaptations Made to Standard PCIT for Child Welfare Cases

- Motivational Interviewing Pre-treatment
  - In treatment for child behavior problems, parents are help-seeking.
  - Parents in Child Welfare are usually coerced into services
Adaptations to Standard PCIT for Child Welfare Cases

- Parent affect modulation steps added to discipline protocol
- No use of physical “back-ups”
- Extended protocol for children up to age 12 (elements similar to Barkley and other PMTO family protocols)
Initial RCT of PCIT in Child Welfare

Survival for Future Physical Abuse Reports to Child Welfare

- Randomized Treatment Group
  - PCIT
  - Parenting Group
### Section 3: Benefits and Costs

<table>
<thead>
<tr>
<th>Washington State Institute for Public Policy Estimates as of May 2008</th>
<th>Total Benefit-to-Cost Ratio (per participant)</th>
<th>Total Benefits Minus Costs (per participant)</th>
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</thead>
<tbody>
<tr>
<td><strong>Prevention Programs</strong></td>
<td></td>
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<tr>
<td>Chicago Child Parent Centers</td>
<td>$4.82</td>
<td>$31,036</td>
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<tr>
<td>Nurse Family Partnership for Low-Income Families</td>
<td>$3.02</td>
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<td>Parents as Teachers</td>
<td>$1.39</td>
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<td>Iowa Family Development and Self Sufficiency Program</td>
<td>Not computed</td>
<td>$448</td>
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<tr>
<td>Healthy Families America</td>
<td>$0.57</td>
<td>$1,830 (negative)</td>
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<tr>
<td>Other Home Visiting for At-Risk Mothers and Children</td>
<td>$0.56</td>
<td>$2,359 (negative)</td>
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<tr>
<td><strong>Intervention Programs</strong></td>
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<tr>
<td>Intensive Family Preservation Service Programs (Homebuilders® model)*</td>
<td>$2.54</td>
<td>$4,775</td>
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<tr>
<td>Parent-Child Interaction Therapy (Oklahoma)</td>
<td>$5.93</td>
<td>$4,962</td>
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<td>Dependency (or Family Treatment) Drug Court (CA, NV, NY)</td>
<td>$0.74</td>
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<td>Intensive Case Management for Emotionally Disturbed Youth</td>
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<td>Other Family Preservation Services (non-Homebuilders®)</td>
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<td>SAFE Homes (Connecticut)</td>
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<td><strong>Administrative Policies</strong></td>
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<td>Subsidized Guardianship (Illinois)</td>
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<td>Family Assessment Response (Minnesota)</td>
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<td>Flexible Funding (Title IV-E Waivers in North Carolina and Oregon)</td>
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</table>
Other Findings: “Less-Is-More?”

• Well, probably not always, but clearly sometimes it is. And parenting programs (the staple of any child welfare service plan) may be one place where it is.
  – Randomized assignment to tailored “comprehensive services” in addition to PCIT actually increased child welfare recidivism rates and lowered skill acquisition (Chaffin, et al., 2004)

• This is NOT an unusual finding. For example, in a review of 77 published parent training studies
  – “…..Also as predicted, providing parents with other ancillary services as part of the parent training program was associated with smaller program effects on parent behaviors and skills outcomes, a result that has been found in [three] other meta-analyses….” (Kaminski, Valle, Filene and Boyle, 2008).
“Less is More” is becoming a cross-cutting theme in the contrast between EBTs and Usual Care

<table>
<thead>
<tr>
<th><strong>EBTs</strong></th>
<th><strong>Usual Care</strong></th>
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<tbody>
<tr>
<td>• Brief. Gets down to business quickly. Gets done quickly. Most change occurs in first few sessions</td>
<td>• Often unspecified duration. Lots of relationship building. Always “more issues to deal with…..”</td>
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<tr>
<td>• Focused—fewer things, but greater depth and intensity</td>
<td>• Comprehensive—breadth, but very little depth on any one thing</td>
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<tr>
<td>• Less “information gathering,” more action and doing</td>
<td>• Modal activity is “information gathering” and</td>
</tr>
<tr>
<td>• Skills and behaviors—parenting as it is behaviorally delivered</td>
<td>• Parenting as it is talked about or conceptualized</td>
</tr>
<tr>
<td>• A session-by-session plan</td>
<td>• More free-flowing. Plans, even if present, are rarely actualized. Crisis chasing.</td>
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<td></td>
<td>• A program for every problem—polytherapy with multiple providers.</td>
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(see Garland, et al., 2010)
Early Response is Common
Second PCIT RCT

**Implementation Questions**

- Does the motivational adaptation improve engagement?

- Can the Adapted PCIT model work with the most severe chronic abuse/neglect Child Welfare cases (mean of 6 prior referrals, all children removed to foster care, most facing termination of rights)?

- Can results be replicated in an entirely front-line, real-world service setting?

**Dismantling Questions**

- What are the relative contributions of the the Motivational pre-treatment and PCIT and their synergistic combination?

- 2 X 2 double-randomized design

- Accounting for risk-deprivation in recidivism outcomes
Dismantling Design Recidivism at 900 days follow-up

Motivation + PCIT cell of 2X2 RCT design had much better retention and completion

85% retention vs. 65% retention

About 15% recidivism for PCIT + Motivation compared to 55% for standard. Replicating initial RCT.
Third PCIT Trial—Quality Control and Two-State Scale Up Project

Main question is how whether live real-time video consultation, after training, is necessary for producing provider competency development (defined by client improvement).

Two conditions—post-hoc telephone video Live real-time video consultation.

Cluster randomized sequential or “roll-out” type design.

* Indicates an agency that began with video consultation, without prior phone consultation. Others had phone consultation beginning at baseline and continuing until the start of video consultation. All agencies received follow-up phone consultation after video consultation ended.
Live Video Consolation
Impact of Live-Consultation Quality Control vs. Phone Consultations

The net cost difference (incremental cost of delivering live video supervision) – cost of saved sessions defining “recovery” is a wash.

However, the fewer number of sessions requires suggests greater impact due to potentially greater numbers of clients served.
Plus Collateral Benefits

Benefits on parental depression, and child trauma symptoms, even though these are not directly targeted.

Treatment Effects: Pre- & Post-PCIT Means on TSCYC Scales by Trauma Group
Future Directions

• Integrating PCIT elements and other PMTO family elements into home-based delivery models
  – Current model developed for SafeCare, delivered by paraprofessionals
  – Preliminary data shows effect sizes comparable to clinic-based PCIT
  – Main advantage is compliance (virtually 100% vs. often low compliance with clinic referrals).