The Development of

Parent-Child Interaction Therapy in Pennsylvania

Introduction

Since the 1990s, Pennsylvania has been increasing the use of research-based prevention and intervention programs as part of a comprehensive system of treatments and services for children and adolescents with emotional and behavioral problems. These programs are generally referred to as Evidence-Based Treatments (EBTs).

At the same time, the children's behavioral health system, not only in Pennsylvania but in other parts of the country, has seen an increase in the number of families of young children and providers who work with them requesting intervention services for externalizing behaviors. If left untreated, these externalizing behaviors (sometimes diagnosed as Disruptive Behavior Disorders or DBDs) are likely to have lifelong implications, and may cause young children to be excluded or expelled from early care and learning programs and suspended from primary grade classrooms.

In Pennsylvania, Early Childhood Mental Health consultants working in child care programs were finding it very difficult to locate appropriate mental health services for children under the age of four. In 2009, the former statewide Early Childhood Mental Health Advisory Committee made recommendations to the secretary of the Department of Public Welfare (now the Department of Human Services) for improving the service system for young children. Among the recommendations were ones to identify and promote evidence-based and best practice emotional coaching programs and to ensure the availability of well-coordinated and age-appropriate interventions for young children and their caregivers who need more intensive supports. Parent-Child Interaction Therapy (PCIT) has been identified as one intervention program that accomplishes these recommendations.

With over 20 years of research support, the evidence demonstrates that PCIT decreases child behavior problems, improves the parent-child relationship, decreases parental stress while increasing their sense of control, and decreases the re-occurrence of child physical abuse (Borrego et al., 1999; Chaffin et al., 2004; Chaffin et al., 2011; McNeil et al, 2005; Thomas & Zimmer-Gembeck, 2007, 2011, 2012; Timmer et al., 2005; Timmer, Urquiza, & Zebell, 2006). PCIT adds a much-needed therapeutic component to the community-based mental health system, and supports state and local efforts to increase the effectiveness of services to families with very young children who are experiencing emotional and behavioral disturbances, developmental disabilities, and the effects of trauma exposure.

This narrative provides an overview of Parent-Child Interaction Therapy, documents its implementation across Pennsylvania, and highlights several strategic years prior to a dedicated five-year NIMH grant to compare three training models for implementing an EBT (PCIT) statewide.

Overview of Parent-Child Interaction Therapy

PCIT is a nationally-recognized, evidence-based parent training program for families of young children (ages 2.5 to 7 years) with externalizing behavior problems. The program is unique in that it involves live coaching of parents as they interact with their child in structured play sessions. There are two phases to PCIT: Child Directed Interaction (CDI) and Parent Directed (PDI). At the onset of each phase, parents attend one teaching session without their child present during which the PCIT therapist reviews with the parent specific skills that will be "coached" in subsequent sessions. This teach session is used to build rapport as well as to provide detailed descriptions and rationales for each skill. In fact, each skill is modeled for and role-played with parents to facilitate their learning. Following the initial teach session, parents attend weekly sessions with their child, during which they are coached in how to apply the skills taught as they interact with their child in a structured play scenario. This coaching by the PCIT therapist is typically done from behind a one way mirror using a bug-in-the-ear system, in order to preserve the natural interaction between parent and child.

During CDI parents are encouraged to follow their child's lead while using the PRIDE (Praise, Reflection, Imitation, Description, and Enjoyment) Skills. Parents are coached in how to apply these positive parenting skills so that they can increase appropriate child behaviors (e.g., sharing, using good manners,) and decrease challenging child behaviors (e.g., grabbing, being bossy or rude) by providing attention to appropriate and ignoring mildly inappropriate behaviors. Once parents' skill level meets a predetermined level, typically in six or seven sessions, the second phase of PCIT begins. During PDI parents are taught to provide clear, direct commands, assess compliance versus noncompliance, and to provide consistent consequences for both compliance (labeled phrase) and noncompliance (time-out). In response to noncompliance, parents are taught a sophisticated time-out procedure that emphasizes shaping and teaching appropriate behavior. Critical clinical components of PCIT have been identified and include involving the child and parents together in treatment, establishing the parent as the central figure within the family, live coaching of parents, using assessment to guide treatment, and tailoring treatment to the child's developmental level (Herschell, Calzada, Eyberg, & McNeil, 2002a). For most families, the full course of treatment is conducted in 12-20 weekly, one-hour, clinic-based sessions.

The Evidence Base

Consistent with a scientist-practitioner approach, studies of PCIT have sought to answer clinically-meaningful questions: How is PCIT helpful for parents and their children? Do the results generalize to untreated settings and children? How long do treatment benefits last? Can the model be adapted to help other families? A significant body of literature is now available to support that PCIT is an effective intervention for increasing parenting skills and improving child behavior.

Treatment outcome studies demonstrate improvements in parent skill and child behavior (for reviews see Gallagher, 2003: Herschell, Calzada, Eyberg, & McNeil, 2002b). More specifically, behavior observations of parent-child interactions indicate pre-post changes in parent behavior such as increased rates of praise, descriptions, reflections, and physical proximity as well as decreased rated of criticism and sarcasm (e.g., Eisenstadt et al., 1993). Additionally, parents report lower parenting stress, more internal (rather than external) locus of control, and increased confidence in parenting skills after completing PCIT. Similarly, observations of child behavior have demonstrated decreases in disruptive behavior and overactivity as well as increases in compliance (Herschell & McNeil, 2005). Parents report their child's behavior to improve from the clinical range to within normal limits (McNeil, Clemens-

Mowrer, Gurwitch, & Funderburk, 1994; Schuhmann, et al., 1998: Eisenstadt, et al., 1993). In addition to being highly satisfied with the outcome of treatment, parents also report high satisfaction with the process of PCIT (e.g., Schuhmann, et al., 1998).

Studies have also indicated that the treatment results of PCIT generalize to untreated siblings (Brestan, Eyberg, Boggs, & Algina, 1997) as well as home and school settings (McNeil, Eyberg, Eisenstadt, NBewcomb, & funderburk, 1991). Children who experience behavioral difficulties at home often experience these same difficulties at school. Some have suggested that school problems have to be directly addressed in order to successfully reduce them (Breiner & Forehand, 1981); however, McNeil, et al., (1991) found that preschool children who completed PCIT demonstrated behavioral improvements at school without any direct classroom intervention. In a follow-up study, Funderburk, Eyberg, Newcomb, McNeil, Hembree-Kilgin, and Capage (1998) found that these school gains maintained up to 12-months post-treatment; however, at 18-months post-treatment, only compliance (rather than attentional) gains maintained.

PCIT in Pennsylvania

Implementing PCIT in Pennsylvania formally began in 2009, in Philadelphia and Allegheny Counties.

In Philadelphia in 2009, the Annie E. Casey Foundation provided a grant to researchers at the Children's Hospital of Philadelphia (CHOP) in collaboration with city leadership from the Departments of Human Services (DHS) and Behavioral Health (DBH) to pilot a collocated model of PCIT within two foster care agencies within Philadelphia. This investigation was in response to earlier findings from a longitudinal cohort study of children in child welfare in Philadelphia that demonstrated that young children newly entering foster care experienced considerable placement instability and associated poor outcomes. One of the primary reasons cited for the reported displacements was behavioral concerns. The PCIT program was introduced to try to manage this instability and increase positive parenting skills to mitigate some of these behavioral concerns. Initially two psychologists from the CHOP research team were trained to assist with sustainable program development. In 2010, two clinicians from the Children's Crisis Treatment Center (CCTC) were trained to provide PCIT to families in the two foster care agencies involved in the pilot grant. In 2013 an additional seven clinicians from three behavioral health agencies in Philadelphia were trained as part of a dissemination effort from this initial pilot. In addition, in 2013, one of the originally trained PCIT therapists from CCTC completed training to become a level 1 PCIT trainer, with capacity to train additional therapists under her supervision at CCTC.

Meanwhile in 2009 in Allegheny County, the Clinical Translational Science Institute at the University of Pittsburgh trained seven clinicians from a behavioral health agency and a domestic violence shelter in PCIT. The goal of this pilot project was to translate PCIT into community practice with a domestic violence population. PCIT had not yet been implemented in a real world setting for children and their parents who had been exposed to domestic violence. The pilot project studied the feasibility of delivering PCIT in a group format at a domestic violence shelter, as well as individually at a domestic violence shelter and as mobile therapy.

In 2010, the Staunton Farms Foundation in Allegheny County provided funding to help train 11 clinicians through a collaboration among Allegheny Children's Initiative, Milestone Centers Inc., and the

University of Pittsburgh. This second training was an effort to increase capacity in this densely populated county and involve additional providers.

Also in 2010, The Heinz Endowments awarded a grant to the Department of Public Welfare (now Department of Human Services) to assist in increasing the number of mental health therapists trained to provide PCIT. Participation was open to all licensed mental health outpatient facilities across the state. Agencies were selected through a Request for Proposal process. Consideration was given to agencies that demonstrated previous experience implementing evidence-based practices and a commitment to sustaining PCIT in the agency. Finally, agencies were selected to represent diverse geographic areas of the Commonwealth.

The goals of this grant were to establish a training initiative to implement PCIT across the Commonwealth to serve young children and their families; to develop a system to grow and sustain the number of clinicians certified in PCIT; to improve access to evidenced-based mental health intervention for young children and their families; and to implement structural changes to establish multi-system, multi -funding streams, including Medicaid and Child Welfare, for on-going use of the PCIT model. Sixteen clinicians from eight mental health centers in the following counties were trained: Allegheny, Bradford, Butler, Chester, Delaware, Lackawanna, Lancaster, Luzerne, and Montgomery Counties.

The grant project was implemented over a two-year period. During the grant period, a nationally recognized PCIT trainer provided intensive training, ongoing supervision, coaching and support to 20 master's level clinicians in 10 licensed mental health agencies across the Commonwealth. The therapists who were trained were able to train an additional clinician in their agency. The grant also funded two Commonwealth-wide PCIT Network meetings held in the Fall 2011 and 2012. These PCIT Network meetings brought together state policy makers from Department of Public Welfare program offices, representatives of managed care organizations, licensed mental health outpatient facility administrators, mental health clinicians, and the PCIT researchers and training team.

In 2011, the Starting Early Together (a grant-funded System of Care project) in Allegheny County assisted with the selection of sites to locate PCIT playrooms that were representative of the community of Allegheny County, and to assist with the final selection of agencies to invite to PCIT training. Six agencies were selected to participate in training: Allegheny Children's Initiative (Southside), Glade Run Lutheran Services (Friendship), Laughlin Children's Center (Sewickley), Matilda Theiss Child Development Center, Western Psychiatric Institute and Clinic (Hill District), Melting Pot Ministries (South Hills), Wesley Spectrum Services (Wilkinsburg). Twelve clinicians participated in three sets of workshops as well as consultation calls every other week.

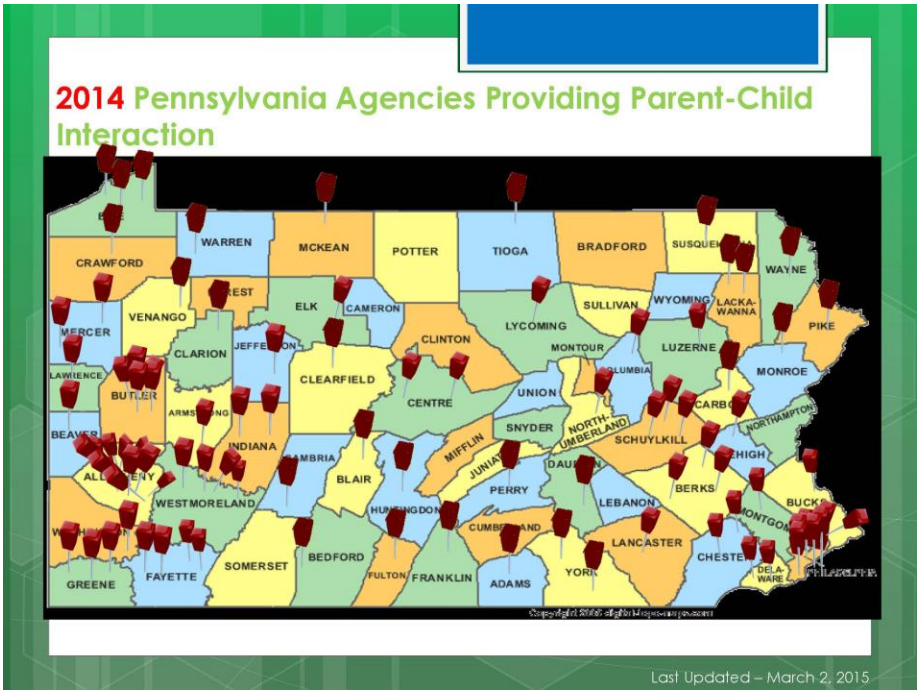
Also in 2011, the children's workgroup and early childhood mental health subcommittee of the Behavioral Health Alliance of Rural Pennsylvania (BHARP) collaborated with Community Care Behavioral Health (CCBH) and the Office of Mental Health and Substance Abuse Services (OMHSAS) to use reinvestment funds to provide training in PCIT. A Request for Qualifications (RFQ) was released by Community Care Behavioral Health at the end of July 2011. Following an applicants' conference, 13 providers submitted proposals for the five slots to be awarded the three-phase training in PCIT. The selection committee included an MH/MR Administrator, a CASSP Coordinator, a family and child advocate, a parent who has been through the PCIT process, a Service Coordinator for Early Intervention, a Children and Youth Director, a Community Care BHRS Care Manager, and a representative from the BHARP/BHAU. The following providers were chosen: Beacon Light Behavioral Health, Clearfield-Jefferson Community Mental Health Center, Emery Behavioral Health, Friendship House, and Individual

and Family CHOICES. A sixth provider, CMSU, also received the training due to their early prioritization of PCIT in the reinvestment planning process. Each provider received up to $2000 for equipment costs and up to $4000 for any required renovations. The reinvestment funds also included the training itself, lodging, and meals. Although some providers completed the training, others had more difficulty because of various factors, including staff turnover.

The Early Childhood Mental Health Committee submitted a budget to the board for a second round of PCIT training in early 2013, but funds were not available at that time.

In 2012, the University of Pittsburgh received a five-year grant from the National Institute of Mental Health which is building on already-existing efforts to implement PCIT statewide. The grant's purpose is to evaluate the effectiveness of three training models (Learning Collaborative (LC), Train-the-Trainer (TTT), and Web-Supported Self-Study (SS)) in the implementation of a well-established EBT in real-world, community settings. To accomplish this goal, the project is guided by three specific aims: 1) to build knowledge about training outcomes, 2) to build knowledge about implementation outcomes, and 3) to understand the impact of training clinicians using LC, TTT, and SS models on key client outcomes. Seventy-two licensed outpatient mental health providers across Pennsylvania are participating in four waves of training over two years. Each of these providers will be randomized to one of the three training conditions: 1) Learning Collaborative (LC), 2) Train-the-Trainer (TTT), or 3) Web-Supported Self-Study (SS). Every county in the state will have the opportunity for clinicians to be trained in PCIT at no cost while contributing to the research to learn about the effectiveness of various training approaches and outcomes for families.

Counties were encouraged to become part of the NIMH grant. Community Care continued to work with several providers who were not eligible for the NIMH grant. See the map below for where PCIT is currently being provided (updated March 2, 2015).



Also in 2012, a PA PCIT Implementation Statewide Steering Committee was formed to help guide the implementation of PCIT so that it is sustainable over time, and to inform the NIMH grant research design, including such questions as what measures will be collected, how and when they will be reported and to whom, and how to proceed with important study activities. The committee includes representatives from several stakeholder groups such as state policy makers, payers, consumers, service providers and academics from diverse but complementary areas (e.g., public health, social work, psychiatry). Meetings are held regularly at a central location.

Other Statewide PCIT Initiatives

Also in 2012 Pennsylvania received Title IV-E Waiver (commonly known as the Child Welfare Demonstration Project) approval for six counties through the Administration on Children, Youth and Families (ACYF) of the U.S. Department of Health and Human Services. These waivers have allowed states to test innovative practices in child welfare. Pennsylvania's Child Welfare Demonstration Project uses evidence-based programs to achieve several outcomes including increased parenting skills, decreased placement disruptions due to child and youth behaviors, and improved child and youth functioning at home, school and in the community. PCIT is one of the evidence-based programs that is currently being evaluated as an approach to support parental resilience, knowledge of parenting and child development, and the social and emotional competence of children in the six counties. All counties are actively engaged in implementation efforts at all levels. Presently PCIT is being implemented or is in the early stages of implementation for Allegheny (west), Crawford (northwest), Dauphin (central),Lackawanna (northeast), Philadelphia (east) and Venango (northwest) counties.

Western PA – Allegheny County: One feature of the Child Demonstration Project in Allegheny County is the Family Support Centers (FSC), which are community-based and participant governed service entities that promote the stability and healthy growth of families by providing supports around child development, parenting and goal planning. Because FFC's are stable and nurturing places that are typically located in underserved communities, Allegheny County believes that they are a natural fit PCIT. The Heinz Endowments awarded the Department of Human Services a grant to build five PCIT playrooms in Family Support Centers. Providers with Outpatient Licenses who are already providing PCIT were contracted through a Request for Interest (RFI) process to operate the PCIT playrooms in one of more FSC.

Northwest PA – Crawford and Venango Counties: Venango County, in the first cohort for the Child Demonstration Project, continues to identify providers for PCIT implementation. Crawford County is in the planning stages for implementing PCIT and recently began planning with the Child Demonstration Project in 2015

Central PA– Dauphin County: Dauphin County is in the early stages of PCIT implementation and has six clinicians who are PCIT trained and seeing families. Appropriate children and families in Dauphin County have had access to PCIT. The three providers all had their facilities remodeled to make the space "PCIT ready." The county PCIT implementation team worked to make certain that potential referral sources have been educated regarding what PCIT is, who is eligible and appropriate and how to make referrals. Two of the three providers have started to receive PCIT referrals from a variety of sources.

Northeast PA – Lackawanna County: Three providers are committed to offering PCIT and are also in the implementation stage with referrals. The Office of Youth and Family Services (OYFS) is presently tracking PCIT referrals. They have had discussions with staff from private PCIT providers, county behavioral health department and local managed care organization and its board.

Eastern PA - Philadelphia County: Philadelphia County currently has 13 behavioral health providers that offer PCIT in an outpatient setting. Each of these PCIT programs is open to all children in the Philadelphia area referred to those providers. Additional efforts have been put in place in Philadelphia to increase access to PCIT for children served by the child welfare system who are appropriate for such referrals. Of the 13 behavioral health providers in Philadelphia, three of them are also Community Umbrella Agencies (CUAs). CUAs are child welfare agencies that are responsible for the provision of direct case management services to families involved with the child welfare system. These CUAs have been set up in strategic geographic regions within Philadelphia to assure that services and resources are more accessible to children and families, within their own communities and neighborhoods. CUAs are designed to develop connections to formal and informal neighborhood networks that can strengthen and stabilize families and will be responsible for recruitment and retention of foster and adoptive parents in the neighborhoods where children live. In addition to three of the CUAs offering PCIT directly to families they serve in a child welfare capacity, all of the CUAs are working closely with the thirteen behavioral health providers, as well as Philadelphia's Department of Behavioral Health. These relationships have been established as a measure to increase access to PCIT, as well as other evidence based treatments within the demonstration project and beyond. Efforts within these partnerships have included increasing knowledge of the PCIT intervention for caseworkers and other staff who make referrals, creation of streamlined referral procedures, and provision of PCIT at locations convenient to the family, including within the CUAs.

Overall Progress from 2009 to 2014

Over the last five years substantial progress has been made in implementing PCIT across Pennsylvania. Currently, 238 Pennsylvania clinicians from 100 organizations and 60 counties have completed or are in the process of completing training in PCIT. Hundreds of families have received PCIT services and thousands of sessions have been completed. The PCIT Across PA Study delivered four waves of training in 36 counties involving 111 clinicians. In response to the growing number of clinicians, a statewide referral list of trained clinicians in each county by agency was developed.

The PCIT Across PA Study Team coordinated ongoing needs of clinicians in the state such as 1) organizing responses to training requests for clinicians who have not yet received but are interested in PCIT training; 2) supporting clinicians who have completed training; 3) receiving requests for agencies and clinicians offering PCIT in various counties; 4) participating in community meetings, training, or grant reviews when requested; and 5) communicating with other initiatives and organizations that involve PCIT and EBTs.

Since its inception, the PA PCIT Implementation Statewide Steering Committee has guided the implementation of PCIT toward sustainability, its major focus. The committee has met six times with consistently high attendance. Efforts of this group have contributed to successful progression of the NIMH initiative, as well as involvement with other statewide Initiatives that involve PCIT. The Steering Committee charged the Study Team with conducting interviews with 12 states that have implemented

PCIT on a large scale. The interviews centered on conceptualizing characteristics impacting sustainability and identifying obstacles and strategies used to increase sustainability. The Study Team compiled and presented initial results in order to begin incorporating committee feedback into a plan for a PCIT infrastructure based on interview outcomes and responses from committee membership.

Looking forward, there is excitement and thoughtfulness about how to coordinate tasks that move the state closer to being able to sustain PCIT for the long term and how PCIT will fit into the broader scope of Pennsylvania's infrastructure and future plans for the health and well-being of young children.

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