Discussion

Translating evidence-based treatments into child welfare services through community-university partnerships: A case example of parent-child interaction therapy

Joshua P. Mersky⁎, James Topitzes, & Katelyn Blair

Helen Bader School of Social Welfare, University of Wisconsin-Milwaukee, United States
Institute for Child and Family Well-being, United States

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ABSTRACT

Children served by the child welfare system count among society's most vulnerable members given their history of abuse, neglect, and other potentially traumatic experiences. Once they enter the system, however, these children seldom receive empirically validated interventions to mitigate the effects of trauma. This article highlights the promise of parent-child interaction therapy (PCIT), an evidence-based treatment (EBT) for trauma-exposed children in the child welfare system. Barriers to implementing PCIT and other EBTs in child welfare are discussed along with ways that community-university partnerships can help to navigate these barriers. Preliminary supporting evidence from a community-university partnership in Wisconsin is presented, followed by a set of recommendations for future work aimed at translating science into practice.

1. Evidence-based treatments for trauma-exposed children

Compared to their peers in the general population, children and youth in the child welfare system are at risk for many maladaptive outcomes. For instance, up to 80% of children placed in foster care present with mental health disturbances (Keil & Price, 2006). However, well-validated treatments for these symptoms are often unavailable or inaccessible, especially for families with young children (Burns et al., 2004; Kerns et al., 2014).

There is no shortage of EBTs that are known to significantly enhance

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the well-being of children. **Trauma-focused cognitive behavioral therapy** (TF-CBT), for example, is an evidence-based treatment that has been validated with children from ages 3 to 18. Several trials with diverse populations have shown that TF-CBT can ameliorate various child symptom profiles, including anxiety and PTSD, cognitive and affective dysregulation, and behavioral and interpersonal problems (see Cohen, Mannarino, & Deblinger, 2012). Two treatments that have been linked to improved outcomes for infants and toddlers are **child-parent psychotherapy** (CPP) and **attachment and biobehavioral catch-up** (ABC). Both CPP and ABC have been shown in studies with high-risk families to successfully address attachment and regulatory problems (Cicchetti, Rogosch, & Toth, 2006; Dozier et al., 2009). Further information about these treatments can be obtained through the National Registry of Evidence-Based Programs and Practices, the California Evidence-Based Clearinghouse for Child Welfare, and the National Child Traumatic Stress Network.

Parent management training (PMT) models represent another class of interventions that have been successful in treating emotional and behavioral disturbances in young children with trauma histories. PMT interventions differ somewhat in scope, intensity, and duration, but they share a focus on alleviating child externalizing problems such as aggression and defiance by helping caregivers learn behavior management and positive parenting skills. Multiple PMT models have been shown to be efficacious with children and families in the child welfare system, including the Multidimensional Treatment Foster Care for Preschoolers (MTFC-P) program (Fisher, Kim, & Pears, 2009) and the Incredible Years® (Webster-Stratton & Reid, 2010). Below we describe a third PMT intervention, Parent-Child Interaction Therapy (PCIT), an EBT that has been validated with both biological and foster families in the child welfare system (Mersky et al., 2016; Chaffin et al., 2004; Timmer et al., 2006).

### 1.1. Parent-child interaction therapy

Developed by Dr. Sheila Eyberg in the 1970s, PCIT is an evidence-based treatment for children ages 2–7 with externalizing problems. Like other PMT models, PCIT targets young children because they are sensitive to corrective experience and their behaviors are significantly influenced by caregivers during this period (Topitzes, Mersky, & McNeil, 2015). PCIT is usually provided over an average of 12–14 weekly sessions by a therapist who helps caregivers develop specific parenting skills through psychodidactic, coaching, modeling, and role-play.

PCIT is a two-stage treatment model. During the first stage, child-directed interaction (CDI), a clinician coaches a caregiver during structured interactions with a child to foster authoritative parenting and parent-child bonding. More specifically, caregivers learn to give children labeled praises, reflect their speech, imitate their behavior, describe their behavior, and enjoy playing with their children—collectively known as PRIDE skills. Grounded in play therapy techniques and social learning principles, PCIT aims to help caregivers implement PRIDE skills while following the child's lead in play and offering consistent reinforcement through attention, affection, and guidance (Topitzes et al., 2015). PCIT clinicians promote CDI skill-building through direct instruction, demonstration, simulation, and live coaching (McNeil & Hembroff-Kigin, 2010).

Once parents have mastered CDI skills, a second phase of treatment ensues: parent-directed interaction (PDI). During PDI, caregivers learn specific disciplinary practices and behavior management skills that help to promote children's emotional and behavioral regulation. PDI aims to extinguish negative parent-child interactions by helping parents implement verbal and non-verbal behaviors that gradually modify and reinforce children's behavior patterns (McNeil & Hembroff-Kigin, 2010). Like CDI, PDI is mastery-based, requiring caregivers to effectively enact learned parenting skills and children to demonstrate compliance and sub-clinical behaviors.

Many studies have shown that PCIT is efficacious. A meta-analysis by Thomas and Zimmer-Gembeck (2007) reported that, compared to waitlist controls, PCIT is associated with medium-to-large effects on child behavior according to parent report (d = 0.61–1.45) and teacher report (d = 1.21–1.57). An updated meta-analysis by Thomas, Abell, Webb, Avdagic, and Zimmer-Gembeck (2017) also confirmed that PCIT effects did not vary by the number of completed sessions or whether services were delivered in an academic or community setting. While its original intent was to address externalizing symptoms, growing evidence suggests that PCIT is also a promising treatment for internalizing symptoms such as depression and anxiety (Mersky et al., 2016; Brendel & Maynard, 2014). Maintenance of effects has been found to last up to six years post-intervention (Hood & Eyberg, 2003). In addition, PCIT has been linked to sizeable effects on parenting behavior per parent self-report (d = 0.76–5.67) and observational data (d = −1.03). PCIT also has been shown to enhance parent-child interactions and to reduce caregiver stress and child abuse potential (Batzer, Berg, Godinet, & Stotzer, 2015; Cooley, Veldorale-Griffin, Petren, & Mullis, 2014; Thomas et al., 2017).

PCIT was first tested in the child welfare system by Chaffin et al. (2004) with a sample of 110 physically abused children and their biological parents. Results revealed that PCIT was more effective at reducing maltreatment recurrence than standard parenting interventions, and that reductions in negative parent-child interactions helped to explain this effect. Reinforcing these findings, a randomized trial conducted by Thomas and Zimmer-Gembeck (2012) with 150 biological mothers indicated that, compared to mothers who terminated services prematurely, those who completed PCIT were less likely to be referred to child welfare services.

PCIT also has been shown to enhance the caregiving of foster parents and the mental health of their foster children. Foster parents often report high levels of caregiving burden and parenting stress (Murray, Tarren-Sweeney, & France, 2011), and a sizeable minority struggle to provide adequate caregiving (Barth et al., 2008). One study by Timmer et al. (2006) showed that conventional PCIT services were associated with significant improvements in the caregiving behaviors of foster parents. Another randomized field trial was recently completed that introduced foster children and their foster parents to PCIT using a group-based training approach (Mersky, Topitzes, Janczewski, & McNeil, 2015). Because foster parents typically receive training in a group setting, PCIT was adapted to fit within this context to promote its sustainability as routine care. Results showed that, compared to usual services, receiving group-based PCIT supplemented with phone consultation was associated with significant improvements in the caregiving behaviors of foster parents.

In summation, research conducted over a 35-year span has demonstrated that PCIT is an efficacious clinical treatment for child emotional and behavioral dysregulation. Applied researchers have replicated these findings with children served by the child welfare system, a population that is at high risk of emotional and behavioral disorders. Owing to its robust effect sizes and relatively modest cost per client, scholars have also demonstrated that PCIT yields a positive economic return on investment (Goldfine, Wagner, Branstetter, & McNeil, 2008).

### 1.2. Barriers to treatment

Despite its apparent effectiveness and cost-effectiveness, PCIT has been slow to gain a foothold in child welfare. From its inception, the child welfare system was not designed to provide or secure access to intensive therapeutic services (Pecora, Whittaker, Maluccio, & Barth, 2009). Rather, the system emerged as a means of last resort to ensure that endangered children are safe, first and foremost, and that they reside in stable, permanent homes. With the passage of the Adoption and Safe Families Act (ASFA) in 1997, child welfare policy began to regard child well-being as a third goal that should stand alongside the two traditional pillars of safety and permanency. Despite this welcome
philosophical and policy shift, child welfare agencies continue to face residual barriers that hinder the uptake of EBTs. To begin, a small proportion of federal child welfare funding goes toward child abuse prevention and intervention. In 2015, for example, only about 8% ($664 million) of nearly $8 billion in federal child welfare allocations originated from Title IV-B of the Social Security Act, which states may use to fund services and supports for children and families (Stoltzfus, 2014). Most of the remaining federal funds derive from Title IV-E, which largely goes toward foster care subsidies, adoption assistance, child welfare training, and independent living programs. Some states have addressed the lack of funding for prevention and intervention by launching child welfare waiver demonstration projects that permit Title IV-E funds to be reallocated toward services that are supported by Title IV-B so long as the project is cost neutral. Nevertheless, most states struggle to support and sustain therapeutic services for children and families in the child welfare system (Government Accountability Office, 2013).

Operating within this federal policy context, child welfare agencies face challenges to procuring high-quality mental health services for the large number of children that enter the system with qualifying emotional and behavioral problems. Funding constraints are compounded by a lack of mental health professionals outside the child welfare system to whom agencies might refer their clients for services. As evidence to this effect, Burns et al. (2004) found that roughly half of children who were the subject of a maltreatment investigation had a clinically significantly emotional or behavioral problem, but only 1 out every 4 of these children received mental health care in the previous year. The shortage of mental health clinicians is felt nationwide, and it is particularly acute in our home state of Wisconsin. Archival data from the Health Resources and Services Administration indicate that, as of this writing, only 23.4% of Wisconsin’s mental health needs were met across its 130 mental health care HPSAs (Health Professional Shortage Areas), ranking it 47th out of 50 U.S. states (U.S. DHHS, 2016).

Given the limited supply of service providers to whom agencies may refer, the notion of integrating EBTs into routine child welfare practice holds some appeal. Yet, minus other federal, state, and municipal investments, agencies may be reluctant to implement PCIT and other EBTs due to their initial and ongoing costs. For instance, PCIT practitioners are required to complete an extensive process of training and supervised implementation to become certified. Staffing interventions like PCIT with appropriate service providers can be difficult because most child welfare workers do not hold clinical licenses (Clark, Smith, & Uota, 2013). Training and supervising clinicians and other agency staff may be cost-prohibitive, particularly considering the high rates of staff turnover that often plague child welfare agencies (Mor Barak, Nissly, & Levin, 2001; Shim, 2010). Efforts to promote staff retention are not only fiscally prudent, but they also may enhance efforts to implement and sustain EBTs with fidelity, which should lead to more effective service delivery and better outcomes (Williams, Glisson, Hemmelgarn, & Green, 2017).

Along with the challenge of training and retaining mental health professionals, child welfare agencies may need to reconfigure their operations to ensure that children are assessed and referred to services in a consistent and timely manner. Despite the preponderance of children in the system who might benefit from mental health services, child welfare agencies have reported difficulties with sustaining a steady supply of referrals to PCIT (Timmer et al., 2016). Once families are referred, agencies also will need to identify ways to minimize client attrition. As is the case with many forms of family therapy, PCIT dropout rates are often high (Fernandez & Eyberg, 2009), and retaining child welfare clients may be particularly challenging. Foster parents, for example, frequently care for multiple children with complex needs. Because they often report high levels of caregiving burden along with their own employment demands, they may be unable to engage in a lengthy course of weekly treatment sessions (Mersky et al., 2016). Agencies are likely to encounter barriers to engaging biological parents as well, including a lack of transportation as well as perceived stigma related to the involvement in the child welfare system (Kemp, Marcenko, Hoagwood, & Vesneski, 2009).

### 1.3. Bridging gaps through translational research and community-university partnerships

There is growing awareness of nationwide gaps in EBTs for children and families in the child welfare system (Osofsky & Lieberman, 2011). Calls for action to increase access to therapeutic child welfare services recently culminated in the 2016 Family First Prevention Services Act (H.R. 5456), which aimed to direct a greater percentage of Title IV-E funds toward, among other services, mental health and substance abuse prevention and treatment and in-home parent training programs. Although this major federal legislation was not enacted, many statewide initiatives have led to wider implementation and dissemination of EBTs, including PCIT (Beveridge, et al., 2015; Herschell et al., 2015; Timmer et al., 2016). For example, since 2012, the Wisconsin Trauma Project has trained hundreds of TF-CBT providers across 43 counties and three tribal areas. With funding from the Substance Abuse and Mental Health Services Administration through the National Child Traumatic Stress Initiative, this program was recently expanded to include training for PCIT and CPP as well.

Although large-scale policy and system changes are needed to diminish the mental health service gaps in child welfare, there are ways to use existing resources and partnerships to increase access to EBTs at a local level (Littell & Shlonsky, 2010). Scholars from social work and allied fields are increasingly partnering with community-based agencies to conduct translational research that implements and evaluates treatment protocols under generalizable conditions. There are many translational approaches, but the most basic two-stage model differentiates T1 science, which refers to basic or experimental research that has implications for usual care, from T2 science, which tests T1 innovations under real-world conditions (Spath et al., 2013; Woolf, 2008). Once efficacy is established through T2 research, further studies can test the effectiveness of clinical applications through delivery, dissemination, and diffusion research—sometimes referred to as T3 research (Khoury et al., 2007).

Translational research of this kind flourishes within the context of community-university partnerships, but there are many challenges to forging such partnerships in the child welfare arena. For instance, it is not uncommon for multiple nonprofit agencies in large metropolitan areas to receive public child welfare dollars to deliver contracted services (Unruh & Hodgkin, 2004). Working with one agency may limit the validity of research in various ways (e.g., restricted sampling frame; reduced generalizability), while working with multiple and sometimes competing agencies can undermine collaboration and compromise model fidelity. In addition, motivating administrators and direct line workers to endorse new policies or evidence-based practices can be a formidable task given the bureaucratic nature of the child welfare system (Aarons & Palinkas, 2007). Once agency partnerships are established and service providers are identified, researchers and service agencies still must agree on program and evaluation implementation protocols, which may require resolving logistical and ethical concerns.

The National Implementation Research Network (NIRN) has outlined effective strategies for navigating barriers to implementation research within the context of university–community partnerships (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). It is important, for one, to consider how research and evaluation contributes to the agency’s mission. In addition, implementation protocols and adaptations should be developed collaboratively and roles and responsibilities should be elucidated. Researchers often must relinquish full control of project procedures, accommodate agency protocols, and help fulfill agency missions and budgetary needs to secure buy-in from administrators and staff. Meanwhile, to support project aims, agency personnel may be asked to implement rigorous design and measurement
protocols. These processes generally take sacrifice, compromise, and time (Topitzes et al., 2015).

Despite the challenges, examples of effective community-university partnerships in child welfare are beginning to take root (DePanfiliis, 2015). Guiding frameworks are also being developed to articulate how such partnerships are sustained by adhering to common principles such as trust, shared commitment, and equal distribution of power (Hogan, Tynan, Covill, Kilmer, & Cook, 2017). If successful, community-university partnerships can confer multiple benefits. They may facilitate the transition from scientific discovery to implementation, a translational process that is often protracted and poorly understood (Morris, Wooding, & Grant, 2011). They also can accelerate the implementation and dissemination of evidence-based practices (Testa, DePanfiliis, Huebner, & Dionne, 2014). In turn, these partnerships may help to move the needle on critical outcomes such as child maltreatment and interpersonal violence (Finkelhor, Turner, Ormrod, & Hamby, 2010). They may also produce knowledge about what services are effective, for whom, for what outcomes, and under what conditions. The next section illustrates how one community-university partnership in Wisconsin is working to fulfill these objectives.

1.4. Illustrating the promise of community-university partnership

The Institute for Child and Family Well-being (ICFW) is a community-university partnership between Children’s Hospital of Wisconsin and the Helen Bader School of Social Welfare at the University of Wisconsin-Milwaukee. The partnership is dedicated to improving the lives of children and families by translating evidence into generalizable practices and policies through three interrelated processes. First, it serves as an incubator for prevention and intervention solutions that can be implemented in diverse health and human service settings. Second, both novel and usual care conditions are subjected to rigorous evaluation, yielding local practice and policy implications along with evidence for the field at large. Third, the ICFW analyzes how policies shape and inform practice, advocates for use of evidence to inform policy, and works to change policy by fostering collective action among stakeholders and partner agencies.

One of the top priorities of the ICFW is to increase the availability and accessibility of evidence-based services in the child welfare system. Doing so requires identifying models that are not only effective but that also fit with child welfare timelines. The fact that PCIT can be completed within a brief period counts among the reasons why it was selected by the community services agency as a preferred treatment model. PCIT also was selected because it is a two-generation approach that been implemented effectively with families in child welfare using conventional and innovative modalities. For example, the community services agency has worked with its university partners to implement a novel PCIT model that replaces its usual delivery with an approach that combines group-based training and telephone consultation. Foster parent-child dyads attend two full-day group PCIT trainings with six to eight families, thereby introducing opportunities for live coaching, skill development, and parent-child interaction within the context of foster parent training. Below we summarize the model (for additional information, please see Mersky et al., 2015; Topitzes et al., 2015).

Training day 1 begins with didactic instruction in CDI. Afterward, each parent-child dyad is directed on a rotating basis to a clinical room to practice CDI per conventional PCIT standards. Meanwhile, another parent who is scheduled next for CDI coaching is asked to watch the previous session. The observing parent then transitions to the clinical training room with her foster child while the outgoing parent transitions to the observation room. While the private coaching sessions occur, the remaining parent-child dyads practice CDI at work stations in a group setting with a PCIT clinician until it is their turn to receive individualized treatment. This process continues until all dyads complete at least two coaching sessions. The training day ends with a group discussion aimed at consolidating learning and planning for homework activities.

The second training day focuses on PDL. Following the same schedule and format as the first training, didactic and experiential activities are scheduled throughout the day to help foster parents learn behavior management and positive discipline skills. During the closing group discussion, parents are prepared for the next phase of the intervention, which entails routine homework exercises and up to six telephone consults over a period of eight weeks. The 15-minute phone calls are designed to refresh parents’ knowledge of PCIT principles, review progress, and prepare for PCIT homework activities. Following standard PCIT procedures, parents are also asked to devote 5 min daily to practicing PCIT skills.

Along with the group-based model, the community service agency provides conventional, dyadic PCIT services. The paper’s second author, who is a Level 1 PCIT trainer and clinical director of the ICFW, works with agency administrators and supervisors to ensure that each PCIT model is implemented with fidelity by well-trained practitioners. Regularly scheduled supervision sessions are held, during which cases are presented, practitioner skills are reviewed, and clinical challenges are discussed. In addition, PCIT coaching skills are reviewed in person or from videotaped sessions to ensure that the practitioners meet PCIT International fidelity standards. The agency also promotes model fidelity by integrating measures such as the Eyberg Child-Behavior Inventory and Child-Behavior Checklist into its assessment protocols.

Given the considerable resources that must be devoted to training and supervising clinical staff, the ICFW developed three retention incentives to minimize staff attrition and thereby promote service continuity, quality, and sustainability. First, during the PCIT training period, clinicians carry smaller caseloads to promote skill acquisition, treatment fidelity, and job satisfaction. Second, all PCIT practitioners can attain PCIT therapist certification and state clinical licensure if they fulfill workload and competency requirements. Finally, once they earn state licensure, clinicians receive a salary increase.

The ICFW has applied several fiscal strategies to promote model sustainability in the short term. Whereas initial efforts to adapt, implement, and test PCIT were supported with funding from the National Institutes of Health (R15HD067829), PCIT providers now bill health insurance, primarily Medicaid, for their clinical services. If delivered by pre-licensed practitioners, such services are reimbursable if the clinical supervisor has at least five years of licensed clinical experience. In addition, the community agency offers PCIT services to clients of other local service organizations, for which the agency receives compensation. The agency also delivers group-based PCIT service in partnership with community foster parent training partners, generating modest revenue in the process. In the long term, the ICFW is also working with state-level policymakers to identify creative financing solutions that have been applied successfully in other states to support the uptake of EBTs in the child welfare system (see Pires et al., 2013).

Another way that the ICFW has promoted the uptake and sustainability of EBTs is by creating a specialized internship program for students in the partner university’s master of social work (MSW) program. Many of the students selected for these placements also complete a trauma-informed certificate program, which prepares MSW students for careers in trauma-informed and trauma-focused practice settings. The internships reinforce the MSW curriculum by providing an opportunity for students to develop specialized skills in direct practice, program administration, and evaluation. Interns with a focus on direct practice gain exposure to evidence-based models of assessment and intervention, including EBTs such as PCIT and TF-CBT. Interns with an interest in administration can work with agency directors and team leaders to design and develop new programming, manage projects, and develop grant proposals. Interns that express an interest in evaluation assist with data systems management along with program evaluation and research.

The internship program illustrates how community-university collaboration can be mutually beneficial. Student interns are introduced to state-of-the-art, evidence-based macro and micro practices that reflect...
the emerging trend in child welfare of incorporating strengths assessment and well-being promotion alongside risk assessment and mitigation. Plus, within the community services division of Children’s Hospital, the ICFW is developing staffing and organizational structures that provide career advancement opportunities for MSW graduates. Students may, therefore, earn special consideration for post-graduate job placement. The direct benefits to the community services program are also significant. Along with the immediate returns that well-trained students offer by providing high-quality service free of charge, the internship program supplies a pipeline of talented professionals that are needed to sustain specialized treatments such as PCIT in the child welfare system. In the next section, we present evidence indicating that it is feasible for a child welfare agency to implement PCIT and, in so doing, enhance the well-being of trauma-exposed children.

2. Proof of concept

Data for this study were drawn from clinical assessments that were completed with biological or substitute caregivers of children placed in out-of-home care. In total, the sample includes 87 caregiver-child dyads that completed PCIT. Children ranged in age from 2–7 years of age and the majority were male (56%) and African American (54%). Agency records revealed that 96% of children had a substantiated report for some form of child neglect and that 38% had a substantiated report for physical abuse. Over half (54%) of the participating caregivers were biological parents, and the remaining caregivers (46%) were licensed foster parents. All primary caregivers were female. Each caregiver-child dyad in the sample received PCIT from the community services division of Children’s Hospital between 2014 and 2017.

Services were delivered by seven MSW graduates and several MSW interns from the Helen Bader School of Social Welfare who completed training from a PCIT Master Trainer and received supervision from a Level 1 PCIT trainer. PCIT was delivered as individualized treatment to 69 parent-child dyads (79%) in clinic or at home, while 18 dyads (21%) received PCIT as a two-day group training approach, described above. The median number of individualized PCIT sessions per dyad was 13.0 (SD = 8.2). Implementing multiple modalities of treatment enables the agency and its clinicians to tailor services to the needs of children in diverse caregiving arrangements. Across treatment modalities, fidelity to PCIT was maintained by implementing the same model applications: CDI and PDI.

The Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) was used to measure caregiver ratings of child behavior problems at two time points—a pre-treatment assessment of baseline functioning and a post-treatment assessment of functioning after the last PCIT session. The ECBI contains 36 items and produces two subscales. The Intensity subscale assesses the frequency of challenging child behaviors; scores of 131 or above are clinically significant. The Problem subscale measures caregiver tolerance and distress associated with the child’s behaviors; scores of 15 or above are clinically significant. Table 1 presents descriptive statistics for the sample, including the means and standard deviations for the Intensity and Problem subscales at pre-treatment and post-treatment. A paired-samples t-test was used to determine whether pre-treatment scores differed significantly from post-treatment scores for the full sample. Statistically significant change at the individual level was tested using the reliable change index (RCI; Jacobson & Truax, 1991). The RCI is a standardized score that indicates whether the observed change in a client is greater than expected by random chance (i.e., whether observed differences represent true improvement in functioning or measurement error). The RCI is derived by dividing the difference between pre- and post-baseline scores by the standard error of the difference between the scores.

Results demonstrated that the mean ECBI Intensity score at baseline was 128.8 (SD = 38.9), slightly below the cutoff for clinical significance. Of the 87 sample children, 42 were subclinical on the Intensity scale and 41 were subclinical on the Problem scale (see Fig. 1). The findings are consistent with the agency’s protocol to provide therapeutic services to children with identified needs, even in the absence of clinically significant externalizing symptoms. Table 1 shows that the mean Intensity score dropped to 103.1 (SD = 36.6) at the post-baseline assessment, representing a statistically significant change. Similarly, the mean ECBI Problem score decreased significantly from pre-treatment (μ = 15.4; SD = 8.0) to post-treatment (μ = 8.70; SD = 8.4).

As shown in Fig. 1, out of the 38 children who had clinical ECBI Intensity scores pre-treatment, 23 had non-clinically significant scores at post-treatment. Among these 23 cases, 65% exhibited reliable change from clinically significant to non-clinically significant Intensity scores. Two-thirds (28) of the 42 children with clinical scores on the ECBI Problem scale at pre-treatment exhibited subclinical scores post-treatment. Of the 28 cases that transitioned from clinically significant to non-clinically significant behavior problems, 86% exhibited reliable change.

Because PCIT was delivered to multiple client groups (biological and foster parents) using multiple modalities (group-based and individualized services), we ran a 3 × 2 MANCOVA to assess whether intervention effects varied by client group and service modality. That is, we analyzed the effects of three conditions (biological parents who received individualized services; foster parents who received individualized services, foster parents who received group-based services) on post-baseline ECBI Intensity and Problem scores while controlling for baseline ECBI Intensity and Problem scores. The results showed that controlling for baseline ECBI scores, post-baseline ECBI scores did not vary significantly across the three conditions (F(4, 156) = 2.158, p = 0.08, partial η² = 0.052).

The preceding results should be interpreted with caution given the limitations of this study, including its single-system design and modest sample size. As a result, the observed pre-post treatment changes are more safely interpreted as correlational than casual. In addition, the 87 dyads that completed treatment represent less than half (48%) of all clients that were referred for PCIT and completed an intake assessment. Thus, the results may not generalize to clients who do not complete the expected course of treatment. Further research based on an

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<td>8.70 (4.84)</td>
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Table 1: Pre-test and post-test ECBI intensity scores and significance tests.

Note: RCI = reliable change index. * p < 0.05.
experimental design and intention-to-treat protocol is needed to generate more robust estimates. Moreover, it is important to acknowledge that some parent-child dyads did not respond to PCIT as expected. In fact, a small number of children in the sample moved from subclinical scores at baseline to the clinical scores post-baseline on the Intensity scale (n = 7) and the Problem scale (n = 4). This is likely because the clinicians at the community services agency do not use parent report of child symptomatology as a criterion upon which they assess readiness to complete treatment. Instead, graduation status is conferred once parents demonstrate mastery of PCIT skills. This approach differs from conventional PCIT, where clinicians do not typically discharge clients until a child’s symptoms are subclinical per parent self-report.

Analyses that aim to uncover the predictors of treatment non-response among foster parent-child dyads are currently under way. Although our provisional analyses indicate that it is possible to implement PCIT successfully under everyday child welfare conditions, further research on a broader set of program effects is warranted. To that end, analyses are also planned that will examine the effects of PCIT on parenting practices and satisfaction levels as well as an array of child safety, permanency, and well-being outcomes. We are also conducting qualitative research that examines barriers to treatment faced by caregivers of children in foster care along with potential adaptations that may help to circumvent these barriers.

3. Future directions

The Institute for Child and Family Well-being (ICFW) is in the early stages of developing other approaches through which PCIT and other EBTs can be integrated into its service menu. For example, building on evidence that significant PCIT effects emerge within the first few sessions (Hakman, Chaffin, Funderburk, & Silovsky, 2009), a brief PCIT model has been introduced that combines clinic-based services with ongoing intensive in-home services for biological families whose children are at risk of being placed in out-of-home care. Like group-based training for foster parents, the abbreviated treatment approach adapts PCIT so that it can be implemented via existing service mechanisms instead of adapting the system to fit the model.

Successful adaptation hinges on close attention and fidelity to the active ingredients of the intervention. In the case of PCIT that means (a) treating children and parents jointly, (b) using psychoeducation, live parent coaching, modeling, and role play, and (c) assessing progress consistently so that treatment continues to match the child’s development and parent’s emergent skills (McNeil & Hembree-Kigin, 2010). If it proves to be effective, taking the model to scale could help to distribute scarce child welfare resources to many more children with qualifying mental health problems. Furthermore, tailoring PCIT and other EBTs to match existing agency service structures and protocols may be a wise cost containment strategy that helps to promote the longevity of the intervention (Mersky et al., 2015).

The field of social work is well positioned to lead the charge of bringing clinically validated EBTs to community markets. Social work practitioners routinely serve trauma-exposed clients in an array of community-based human service settings. By the same token, social work scholars often conduct applied research in concert with direct service providers. In addition, social work practitioners and scholars are trained to foster interdisciplinary collaboration to address complex problems (Brekke, 2012). By forming strong community-university partnerships, social work professionals can help to break down disciplinary silos as well as the organizational and financial barriers that hinder the process of moving from clinical efficacy to real-world effectiveness. These partnerships have the potential to maximize scarce resources by translating EBTs into routine child welfare services for the benefit of children and families who need them most.

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References


