

Integrating and Sustaining Evidence-Based Mental Health Services in Child Welfare

Joshua P. Mersky, Ph.D.
Professor & Co-Director

Chien-Ti Plummer Lee, Ph.D.
Associate Scientist

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

Background

- Children in the child welfare system seldom receive mental health care that is consistent with best practices
 - Many are not provided MH treatment in any form, and most do not receive EBTs

- Lack of access is not due to a lack of EBTs
 - **82** MH treatments are rated by the California Evidence-Based Clearinghouse for Child Welfare as supported/well supported

Background

- Parent management training interventions are highly effective
 - Enhance parenting attitudes and practices
 - Reduce externalizing symptoms (e.g., aggression; hyperactivity)

- **Parent-child interaction therapy (PCIT)** is backed by 40 years of research, including 17 separate RCTs
 - Evidence suggests PCIT also mitigates internalizing symptoms, and it has been validated with abused & neglected children

Barriers to Care in Child Welfare

- ❑ Limited community-based MH service providers—especially that accept public insurance
- ❑ Within the child welfare system:
 - Leaky MH service pipeline
 - Limited funding for preventive services
 - Poor fit between EBTs and CW services & timelines

Project Connect

- Novel PCIT intervention for foster parent-child dyads
- Full-day trainings with up to 8 dyads
 - Individualized PCIT with lead clinician **plus** opportunities for observational learning
 - Group-based PCIT activities with MSW student trainees
 - High-quality child care
 - Phone consultation & homework

Study Design

- Randomization (N = 128)
 1. Waitlist control group received services as usual
 2. Brief PCIT (Two-day workshop + 8 weeks of homework)
 3. Extended PCIT (Three-day workshop + 14 weeks of homework)

- Assessments at baseline, 8 weeks & 14 weeks post-baseline

Sample Description

Characteristic	Waitlist Control	Brief PCIT	Extended PCIT	Sig.
Child age (range 2.5-7)	4.6	4.7	4.4	.72
Child sex (% female)	63%	55%	46%	.30
Child race (% black)	63%	59%	60%	.92
Foster parent age (range 23-69)	45	44	45	.87
Foster parent race (% black)	52%	43%	40%	.50
Foster parent educ. (range 1-5)	3.4	3.4	3.2	.57
Foster parent married (%)	52%	51%	51%	.99
N. of children (range 1-7)	3.1	2.8	3.0	.55

Research Questions

1. Compared to waitlist controls, do children who received group PCIT show greater improvements in emotion regulation (ER)?
2. Based on foster parent ratings of child externalizing, internalizing, and ER symptoms, how many latent mental health classes best fit the data?
3. Are there significant differences in latent class group membership between the treatment & control groups?

Outcome Measures

- ❑ ***Child Behavior Checklist*** (Achenbach & Rescorla, 2001)
 - Standardized measure that produces broadband **externalizing** and **internalizing** problem scales

- ❑ ***Emotion Regulation Checklist*** (Shields & Cicchetti, 1997)
 - 15-item subscale of **lability** and **negativity** (e.g., arousal, reactivity)

Data Analysis Plan

1. Multivariate regression to test effects of PCIT on lability/negativity
2. Means comparisons to confirm externalizing/internalizing scores were associated with lability/negativity scores
3. Latent profile analysis of aggregate symptoms over time
 - Class enumeration based on low Bayesian information criterion (BIC), high entropy, and bootstrapped likelihood ratio tests
4. Resulting latent classes regressed on treatment condition using multinomial logistic regression

Results

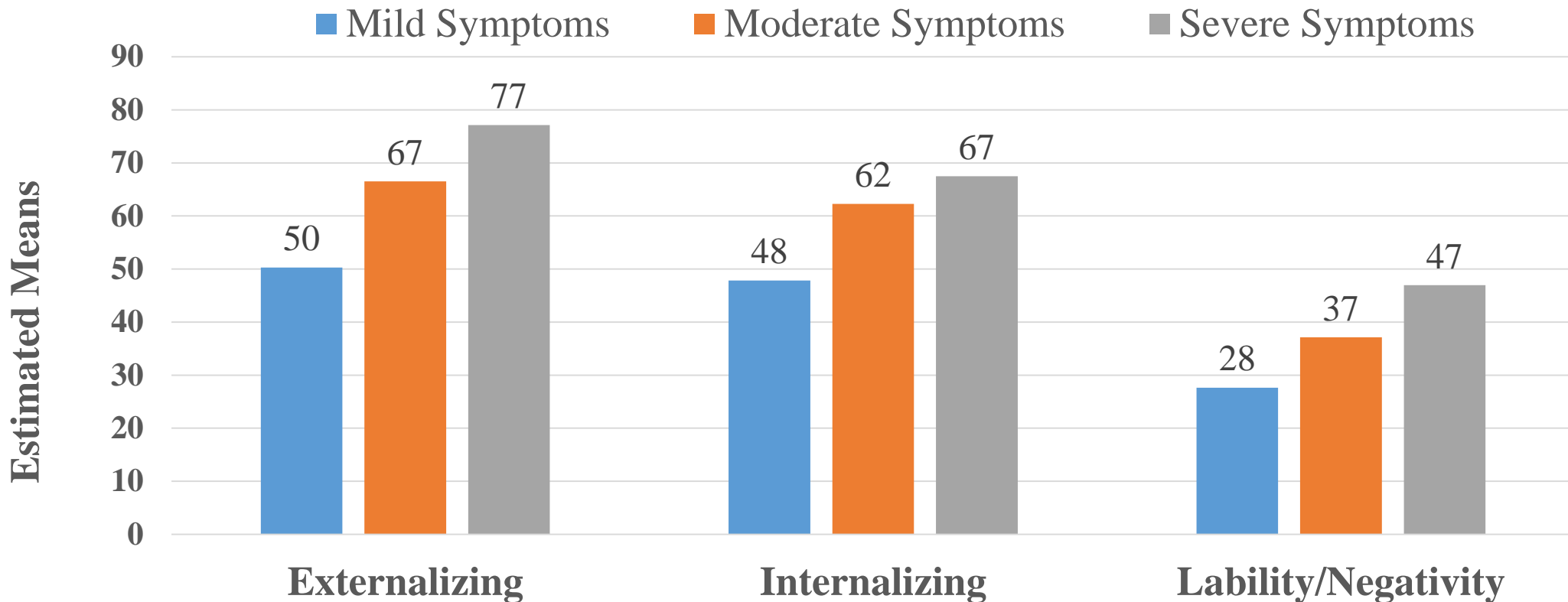
Step 1. Compared to controls, children who received PCIT had lower post-baseline lability/negativity mean scores (38.7 vs. 34.5, $p = .003$)

Step 2. Lability/negativity scores at baseline were higher among children with externalizing scores in the clinical range than non-clinical range (42.9 vs. 32.2, $p < .001$)

➤ Lability/negativity scores were also higher among children with internalizing scores in the clinical range than non-clinical range (42.6 vs. 35.4, $p < .001$)

Results

Step 3. A three-class solution fit the data well



Latent Profile Analysis: Model Fit

- (1) Mild symptoms = 31.3% of the sample; (2) Moderate = 51.5% of the sample; (3) Severe = 17.2% of the sample
- The 3-class solution fit the data better than the 2-class solution:
 - Lower BIC values (2802.1 vs. 2797.3)
 - Higher entropy values (.817 vs. .831)
 - Significant bootstrapped likelihood ratio test ($-2LL = 43.6, p < .001$)
- Average probabilities for most likely class membership were .944, .915, and .923, indicating good prediction of class membership

Results

Step 4.

- ❑ Children who received PCIT were more likely to have mild problems than severe problems (OR = 4.14, 95% CI = 1.31-13.10)
- ❑ Children who received PCIT were more likely to have moderate problems than severe problems (OR = 5.86, 95% CI = 1.59-21.59)
- ❑ PCIT and control groups did not differ in odds of presenting with mild and moderate symptoms (OR = 1.42, 95% CI = 0.43-4.63)

Study Limitations

- Brief period of observation
- Measurement of emotion regulation
- Attrition ~ 25%
- Generalizability

Implications

- ❑ PCIT is an effective treatment for diverse MH challenges
 - Can maximize limited resources
- ❑ Transdiagnostic treatment approaches (e.g., MATCH-ADTC) are ascendant
 - Common factors such as ER deficits underlie many MH problems
 - Similar approaches are needed for young children

Implications

- ❑ Growing interest in translational research that tests clinically validated interventions in real-world settings
 - We need solutions that are generalizable, sustainable and scalable
- ❑ ***Reverse engineering*** may help to increase the likelihood that EBTs are integrated into services as usual

Implications

- ❑ New resources available through the 2018 Family First Prevention Services Act (P.L. 115-123)
- ❑ FFPSA empowers states to use Title IV-E financing to pay for services that stabilize families and reduce out-of-home placements
- ❑ A Prevention Services Clearinghouse has been established to regulate which interventions are approved for reimbursement
 - PCIT is one of six well-supported interventions currently listed by the Clearinghouse

Acknowledgments

- ❑ Funding Source: National Institutes of Health, National Institute of Child Health and Human Development Award Number 1R15HD067829-01A1
- ❑ Mersky, J. P., Topitzes, J., Janczewski, C. E., Plummer Lee, C., McGaughey, G., & McNeil, C. (2020). Translating and implementing evidence-based mental health services in child welfare. *Administration and Policy in Mental Health and Mental Health Services*.



Institute for Child & Family Well-Being:
[@icfwmilwaukee](https://www.facebook.com/icfwmilwaukee)

ICFW Website:
<http://uwm.edu/icfw/>