

inSocialWork Episode 289 – PC-Care: In-Home PCIT Intervention for Children: Lindsay Armendariz, M.S. & Brandi Hawk, PhD

[00:00:08] Welcome to inSocialWork. The podcast series of the University of Buffalo School of Social Work at www.inSocialWork.org. We're glad you could join us today. The purpose of inSocialWork is to engage practitioners and researchers in lifelong learning and promote research to practice and practice to research. We educate. We connect. We care. We're inSocialWork.

[00:00:36] From the University at Buffalo School of Social Work, I'm Peter Sobota and welcome to inSocialWork. Wishing peace and strength to all of our listeners in the New Year. Today will be talking with colleagues Lindsay Armendariz and Brandi Hawk about their work developing parent child care or PC care and in-home intervention for children, parents and foster parents in the foster care system. Lindsay Armendariz is the PCIT and PC care training coordinator as the Child and Adolescent Abuse Resource Evaluation Diagnostic and Treatment Center, or CARE at the Pediatric Department of the UC Davis Children's Hospital and co-developer of Parent Child Care. Brandi Hawk is a psychologist at the Care Center at UC Davis Children's Hospital, where she is a clinical manager and along with Lindsay, developed parent child care. Join us as Annette Semanchin Jones, associate professor at the UB School of Social Work, speaks with Brandi and Lindsay about how they assess the climate of the foster care system in Sacramento County, California, conducted research and responded with a new adapted intervention they call parent child care. Our interview was recorded in January of 2020.

[00:01:56] Hello, my name's Annette Semanchin Jones and I'm very excited to be talking with two colleagues today, Brandi Hawk and Lindsay Armendariz. Thanks so much for being here. I'm very excited to have this conversation with you. I thought first that maybe you could start by telling us a little bit about the child welfare climate in your area.

[00:02:15] I'd be happy to tell you that story because it really was the start of PC care and our decisions to come up with a new program that could be helpful for kids and families involved in the child welfare system. So in 2014, children in Sacramento County were entering the foster care system at a higher rate than they were statewide throughout California. So they were entering foster care at a rate of six point seven babies and toddlers, one to two year olds, and five point seven three to five year old young children per 1000 children. Whereas in California, on the whole, they entered at a rate of four point eight for the babies and toddlers, three point eight per 1000 children for the young children, those quite significant that we were seeing such a higher rate in Sacramento County in particular. And not only that, the entry rate was high and the placement stability was low. Unfortunately, now we know from the literature that placement, stability and consistency in a young child's life is an essential part of young children's mental health. And unfortunately, we were finding that 2014 to 2015, young children in Sacramento County, aged one to five years, were changing placement more frequently than the state. On the whole, we found that in California approximately forty six point seven percent. So almost 50 percent of children aged one to five years that entered the foster care system within a six month span were still in that same placement at the end of three months. No change in the placement changes. However, in Sacramento County, we were seeing only about 35 percent of kids in that age range. Still in the first placement at the end of three months, almost 40 percent had been in two placements within a three month period and twenty percent had been in three. Six percent had been in four or more placements. So lots of instability for these young one to five year olds. So this was sort of setting us up to

see goals and where the county was going to go in years to come. So in 2016, we got the continuity of care reform, which was passed in California, and this reform increased the emphasis on maintaining stable placements for kids in foster care. So not only there had previously been an emphasis on speedy reunification, kids going back to their biological homes as quickly as possible and safely. But now this reform was also going to put an emphasis on the ability and it charged counties with developing new policies and programs to support that placement stability. So this is around the time, actually, a little bit before that, we were taking a look at this climate and thinking maybe we can come up with one of those programs.

[00:04:57] Excellent. So could you tell me a little bit about how you develop that in your ongoing research around the dyadic? Interventions with foster children?

[00:05:08] Yeah, absolutely, so knowing sort of the climate of the child welfare system in our county, we knew that kids in foster care was really a population that we wanted to target. That was a population that we wanted to be able to serve better. And they were underserved at the time. And we knew from hundreds of studies on dyadic parent child interventions that those types of interventions were really successful in decreasing behavior problems, even trauma symptoms in young children with their biological parents. So we decided to take a look at foster children who were going through this type of intervention. Specifically, we looked at kids that were participating in PCIT or parent child interaction therapy. We ended up looking at 36 children referred to PCIT here at our clinic, which is both a mental health clinic and a research facility at the UC Davis Care Center. These kids came in to city first with their foster mothers. Those were all women caregivers and then with their biological caregivers, 35 of whom were mothers. One was a father. And we got some really interesting results. Just taking a look at kind of stability and outcomes for those young children. We found that the more a foster caregiver was participating, the more sessions and more kind of mastery of these PCIT skills and behavior management skills that they were learning actually led to better outcomes for that child and their biological caregiver once they participated in treatment. And that looked like potentially improved child behaviors. It looked like more sensitivity coming from the biological parent towards the child based on Biringen's emotional availability scales. And it also predicted actually a higher rate of reunification of that child with their biological parent. So we're seeing better outcomes for these kids after participating in a dyadic intervention with both their foster caregiver and biological caregiver. And this was sort of helping to dispel a myth that enhancing a relationship between a young child and a foster caregiver could be harmful to reunification or potentially the relationship quality with their biological parent.

[00:07:27] Yeah, absolutely. Is there anything else from the larger research on obesity that really led you to develop kind of in modify the interventions that you have done?

[00:07:38] Yeah, that's a great question. So one of the things that we knew about PKP and other dyadic interventions is that unfortunately, they have a really low retention rate, really high attrition rate. That's about 50 percent attrition of kids coming into PCIT program and then dropping out of treatment before completing, which is unfortunate because we do know that the longer that family participates in the program, much, much better outcomes they're likely to have. So the other thing that we knew is that PCIT is a very long program and we knew that kids in the child welfare system, they're moving placements so quickly. If we were going to get in and help them, we needed to do it quickly and succinctly. So maybe a briefer program that hopefully would have a higher retention rate. That was the goal.

[00:08:27] Great. Which I think leads us to my next question, which is really hoping that you could tell us a little bit about some of your current work and your current projects.

[00:08:36] Absolutely. We have currently a grant funded through SAMHSA to provide care services to all newly placed children aged one to five years old in new foster homes in Sacramento County. So part of this program is to provide a trauma screener to all of these children and then to offer PC care as a preventive intervention for these children and their foster caregivers for just the seven weeks of the treatment. So we offer services to children regardless of current behaviors or concerns. They don't need to have a mental health diagnosis. And our goal is to reduce children's trauma related symptoms and improve their adjustment to their new foster placement to enhance foster placement stability. And to do that, we've had to work very closely with CPS to develop a referral system. And so CPS has been wonderful working with us. They've assigned us a project, leads on how we communicate with regularly. They also created a system for referring all newly placed children that are aged one to five over to our services. They also work with us to talk to the frontline social workers, public health nurses and social workers, supervisors so that everyone is on board and excited about the idea of providing care to these foster placements. On our side. We are screening all of these children. We provide care and then we continue to make onward referrals. Mental health, if those are necessary, we give CPS, social workers information about the child's participation and progress in care, and we work with CPS on their system improvement plan committees to identify how P.C. care can even better work within the system and be sustainable for improving this placement stability. So, like I said, our services are for children aged one to five years, and it's for children who have entered a new foster placement within the previous 90 days. And this can be any type of foster placement can be county foster homes or foster family agency homes or with kinship caregivers. And so what we do once we receive that referral is we talk to the caregivers. We do a trauma screener to see how the child is doing if the caregiver is noticing any difficulties that the child is having. And then we offer this preventive service. The service consists of seven weeks of one hour long sessions with the caregiver and the child. Together, there's one assessment session and then there are six treatment sessions. The most important parts of care are that we have the parent and the child together at all times. So we are working with the foster caregiver to help them better understand their foster child. And we're working with the foster child to help them see their foster caregiver as safe and as reliable and as someone that they can go to. And we do this through live in the moment, coaching of parenting skills and self-regulation skills. We ask the caregivers and children to spend five minutes every day playing with each other. It's probably the best homework that I've ever given someone is just to play with their child. And then we ask them to just try new things and see how the child responds to it. We don't require them to reach a certain level of mastery or demonstrate that they're perfect at any particular skill. But we want to make sure that we are identifying what sort of parenting the child responds best to that will support the child to adjust the best into their new home. So we are working with one to five year olds on this project. But take care more broadly is appropriate for children one to 10 years old, and it can be used, as we do for this project, as a preventive intervention. We also use it in our outpatient clinic as a treatment intervention, either stand alone or in addition to other individual therapy treatments.

[00:12:33] That's great.

[00:12:33] I really appreciate to how this work is really being done in the home and with the Diatta relationship really working with both the children and the caregivers, who provides the services for this project? Who does the coaching and in-home work?

[00:12:48] That's one of the beautiful things about PC care, is that its training is not limited to license eligible mental health providers. So really, lots of people that are working with parents and children who may not be therapists can provide this service. And Dr. Hawk actually ran the numbers on our project. So far, we've got 18 providers on this project, four of whom are licensed mental health clinicians. Eight are unlicensed mental health therapists, and six of them are non licensable workers and the child serving workforce. That was something that we thought would be really important for a new program just to sort of broaden the range of people that can provide it across the country.

[00:13:29] Yeah, that's great. It seems like that would really make it more accessible to more communities. So that's really excellent.

[00:13:34] Can one of you tell us a little bit more about what you're finding to be the impact on families served? What are the outcomes so far in your research yet?

[00:13:43] So so far we have had four hundred and thirty three children referred to PC Care. We are looking at an age range of one to five and as you would expect, our average age is three. We have about 54 percent of the children are male. Forty six percent female. And that's pretty standard for the makeup of the children that are in CPS at that age. What we are finding is that our resource parents are reporting behavioral concerns for about 56 percent of these children. And I just want to put that within the context of the general population, where approximately 15 to 20 percent of children would be identified as having clinically significant behavioral problems versus this 56 percent that we're seeing with our foster children aged one to five. And these children all have various trauma histories, at minimum being separated from their biological parents. We see about 45 percent of our children have experienced neglect, 17 percent have witnessed domestic violence, and about eight percent have experienced physical abuse. We are seeing that about 69 percent of our foster parents agree to services. So this is a voluntary service. They are not mandated to do it. And because it is voluntary and because many of the children don't have difficult behaviors, we weren't. Sure, how many parents would want to participate? And so it's really nice to see that 69 percent of parents do want to participate. And then when we look at that by those who report behavior concerns, it's approximately 90 percent of caregivers who report behavior concerns that agree to participate in services, and about 45 percent of caregivers that report no behavioral concerns that agree to participate. So we are seeing that this is something that parents want when they're having difficulties, but something that can be acceptable even when they're not. They see the value in it, even if the child's not having difficulties in terms of retention rates. Lindsey pointed out that one of the difficulties with dyadic interventions is that retention rates tend to be high at about 50 percent. And what we're seeing is that our retention rate is about 83 percent for parents and children completing p.c care when we exclude children who didn't finish because they were reunified or had a placement change. So overall, 73 percent of our children complete treatment, but 40 percent of those who don't complete it's because they were reunified with their biological parents or were moved to another home. So when we don't include them, our retention rate is 83 percent, which is pretty amazing.

[00:16:22] Yeah, absolutely. That's great.

[00:16:23] Thank you. We are also seeing really wonderful outcomes for our children. So we measure outcomes in a number of different ways. One way is with a brief nine item measure of child behavior that we give the parents every single week. And we see on that measure a linear decrease in child behavior problems from the first session to the final

session. And this is highly significant. Our eight square measures are about point four five, which is pretty high. And it's very exciting to see parents consistently saying that every single week their children are more respectful, kinder, calmer, better able to focus and are complying more frequently. We also look at caregiver skills and how well they use the positive parenting skills that we're teaching. So we want parents to be able to communicate in a way that is safe and helpful and the best for the child. And we see that these resource caregivers are doing a great job of improving their use of these positive parenting skills from pretreatment to post treatment. And then what's really amazing is that we're seeing reductions in children's trauma scores from pre to post treatment. So we assess the number of trauma symptoms that these children have when we first see them. And then again on the last day that we see them. And we're seeing significant decreases in the number of trauma symptoms that caregivers are reporting that they see for the children. The other thing that we look at is children's resilience and protective factors, because we don't only want to reduce behavior problems and trauma, we also want to see these children thrive and be on a positive developmental trajectory. And so when we look at protective factors for children, we're seeing significant increases in children's initiative to meet their own needs and ability to go out and find the things that they need. And we're also seeing significant improvements in children's self-regulation abilities, abilities to modulate their emotions and remain calm when stressed or frustrated. We also see slight improvements in caregivers reported attachment relationships with the children. I say slight because this measure parents tend to report that their relationships are already good at the beginning of treatment. So we see improvements, but they're not as significant as are other measures where the parents are noting that initiative is an area of concern for children, where they're having difficulty with self-regulation at the beginning of treatment, and then they're no longer having those concerns at the end. And then the last piece that we wanted to look at is placement stability, because that's one of the primary reasons that we started this program, was to improve children's placement stability. And so when we look at children who completed PC care and we wait a month and then check in a month later, eighty five percent of the children that completed treatment are still in the same placement. One month later, about 12 percent of the children are reunified, which is a positive placement change because they're back home with their biological parents and only two percent have been changed placements to a new non relative foster placement. And that is in comparison to only 49 percent of the children who end treatment early or don't complete treatment. 49 percent of those children are still in the same placement and nine percent are in a second new placement one month after they have their final treatment session. So. Forty nine percent are in the same placement. And then there's another 17 percent that have moved but are still in that second placement one month later, but nine percent of these children have moved again from the second placement. So we are seeing that participation in park care is related to children staying in the same home longer and having fewer placement disruptions.

[00:20:26] That's really terrific.

[00:20:27] Again, I really appreciate the trajectory of this project, starting with how you really describe the climate and using the data within your community and county, really seeing a need and seeing how this program is really meeting and addressing that need. So that's terrific. How do you see your project fitting into the future goals of child welfare in your county, in your local area?

[00:20:50] Well, I think you just said it and that it's really been such a lesson in collaboration with our child welfare system here in the county, really learning what the families need, what the kids need to be safe and well, and the needs of the county workers

as well. So with that continuity of care reform that we spoke about, this program does seem to be a new program that's able to be offered quickly as a support for foster families and kids in new placements. So that's meeting that goal. And CPS, our child welfare system, has a system improvement plan, and one of the five focus areas in that improvement plan is improving the placement stability at this point. They're actually using our outcomes, PC care as a measure for that placement stability and wanting to provide more training for county workers as well so we can get more people on the ground in the homes offering this service.

[00:21:44] That's great news. And I like you mentioned earlier in our conversation, I mean, there is so much research and literature to show the negative impacts of placement moves and placement instability, particularly for this population when we're talking about very young children.

[00:21:59] So I think it's exciting that your local jurisdictions are using your promising outcomes and really kind of shifting the system. Is there anything else that you would want to share about why either of you think this is important for social workers and other providers?

[00:22:14] Yeah. Brandi, did you want to start? Sure. We are really excited about how this program can fit into the child welfare system and how it can be used by social workers and in conjunction with what social workers are already doing. So we know that developing these mental health child welfare collaborations is key to a system change. And I think that social workers are really at this amazing crux of mental health and child welfare, where you have licensed clinical social workers who might be doing mental health work or non licensed social workers working in the child welfare system. And you can have people doing both. And I think that the training that social workers have really set them up to support and fight for the collaborations between mental health and child welfare and having research like we're seeing is good support for them to be able to go to their agencies and seek policy changes that are going to support these collaborations, as well as working to promote preventive interventions as a way to support children before difficulties arise. And I also just wanted to add, I think it's been really powerful to hear from the families that participate in this program.

[00:23:32] We have foster caregivers who are saying they've fostered children, raised children for 30 plus years and are learning something new about the effects of trauma and emotion, regulation and young children and hearing even from biological caregivers that are grateful for the changes that they see in their kids when they do come back home.

[00:23:52] That's really great. And I'm sure there's a big difference, too, between foster parents and what they might get in pre service training before they even have children placed with them versus this very hands on kind of interactive approach.

[00:24:06] So I can imagine that foster caregivers and biological parents would really react and respond favorably to this program. What would you say is next for PC care and for PC care research?

[00:24:17] That is a great question. We have a few other research programs that we're currently working on. One is looking at the difference in outcomes for PC Care versus PISIT parent child interaction therapy. And so we've looked at children who complete the full seven weeks of PC care, and we're comparing them to children who complete seven weeks of PSAT. And we're seeing that in that time frame, the children who complete PC

care are showing greater improvements than the children that have participated and picked up until that moment. And this is important because it is an amazing evidence based program for children with disruptive behaviors and it has a large amount of research. We love to see and think that it's amazing for children. But we also know about the difficulties with retention, and so the fact that we're able to see greater improvements for PC care in a shorter period of time is very promising for families that might have difficulty maintaining their participation in Park City until the end or for parents that maybe don't need a longer term treatment, but can use the skills that we're teaching in a short period of time to effect similar changes in their relationship with their child. We also have a randomized control trial of PC care at the moment within primary care settings. So we have children who are referred by their pediatricians, participate in PC care in their pediatrician's office to promote coordination of care within the primary care center. And we look at children who either receive services right away or are on a wait list. And at the moment, we're seeing nice improvements for children that are in PC care that are greater than changes mean for families that are on the wait list. And so we're building up our evidence base to be able to promote PC care as an evidence based treatment.

[00:26:11] Well, I really want to thank both of you again for your time today and sharing the research and really the exciting work that you're doing with PC care.

[00:26:19] I think this really does fill an important need in child welfare. So I'm just very excited for the work you're doing.

[00:26:26] You've been listening to Lindsay Armendariz and Brandi Hawk discuss parent child care on inSocialWork. I'm Peter Sobota. Be sure to join us next month for a new podcast. And until then, have fun.

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