PARENT CHILD INTERACTION THERAPY

Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment developed by Sheila Eyberg, PhD for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT. Parents are taught and practice communication skills and behavior management with their children in a playroom while coached by therapists. The activities and coaching by a therapist enhance the relationship between parent and child and help parents implement non-coercive discipline strategies.

PCIT is a model used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the "Outpatient Therapy by Licensed Practitioners" section of this manual.

Evaluation of the Evidence Base for the EBP Model

Evaluation of the evidence-base for the PCIT model has been conducted by national registries.

Blueprints Programs lists PCIT as a Certified Promising Program:
http://www.blueprintsprograms.com/programs

PCIT has received a CEBC Scientific Rating of 1-Well Supported by Research Evidence by the California Evidence Based Clearinghouse:
http://www.cebc4cw.org/program/parent-child-interaction-therapy/

The model and research evidence for PCIT are also described in a fact sheet from The National Child Traumatic Stress Network (NCTSN):
https://www.nctsn.org/sites/default/files/interventions/pcit_fact_sheet.pdf

Target Population Characteristics

PCIT serves children ages 2-7 years old (can be up to 9 based on clinical judgement) with:

1. Disruptive behavior problems;
2. Attention-Deficit/Hyperactivity Disorder (ADHD);
3. Selective mutism; or
4. Anxiety.

PCIT may not be clinically appropriate for individuals with significant social reciprocity deficits.

PCIT effectively serves children whose parents:

1. Have limited experience with children;
2. Have limited support;
3. Feel overwhelmed by their child's behavior;
4. Feel angry at their child;
5. Have a child with an opposing temperament from their own; or
6. Feel their child is out of control.

Philosophy and Treatment Approach

PCIT is based on many of the same theoretical underpinnings as other parent training models. However, the treatment format differs from many other behavior parent training programs that take more of a didactic approach to working with families. Specifically, parents are initially taught relationship enhancement or discipline skills that they will practice in session and at home with their child.

In subsequent sessions, most of the session time is spent coaching caregivers in the application of specific therapy skills. Therapists typically coach from an observation room with a one-way mirror into the playroom, using a "bug-in-the-ear" system for communicating to the parents as they play with their child.

More recent advances in technology have allowed for coaching via video feed from another room which has reduced the need for adjoining clinical spaces. Concluding each session, the therapist and caregiver together decide which skills to focus on most during daily 5-minute home practice sessions the following week.

Goals

1. Improve parent/caregiver-child relationships;
2. Improve children's cooperation;
3. Increase children's abilities to manage frustration and anger;

4. Increase children's appropriate social skills;

5. Improve children's attention skills;

6. Build children's self-esteem;

7. Increase parenting skills; and

8. Decrease caregiver's stress.

Specific Design of the Service

PCIT can be provided in a clinic or home-based setting, and is typically provided in weekly therapy sessions. A typical course of treatment may average 15-20 sessions. However, traditional PCIT differs from other parent training treatment strategies in that treatment is not session-limited. Specifically, families graduate from treatment when parents demonstrate mastery of skills and rate their child's behaviors as being within normal limits. The model duration depends on clinical outcome.

Specifically, the first portion ("child directed interaction" is completed when a parent meets specific criteria defined as "mastery" of the skills of child directed intervention. The therapist first teaches the parent the Child Directed Interaction (CDI) skills in a didactic, parent-only session. Then in subsequent sessions, the therapist coaches the parent (through a "bug-in-the-ear" system") in the parents' use of those CDI skills during play with their child. CDI skills include the "PRIDE" skills: Praise, Reflect, Imitate, Describe, and Enjoy.

The second portion ("parent directed interaction") similarly depends on parental successful achievement of specific mastery criteria. The therapist first teaches the parent the Parent Directed Interaction (PDI) skills in a didactic, parent-only session. Then in subsequent sessions, the therapist coaches the parent (through a "bug-in-the-ear" system") in the parents' use of those PDI skills during play with their child. PDI skills include effective commands, and compliance strategies, including predictable and consistent consequences such as time out and removal of privileges.

Cultural Considerations

As summarized in the Blueprints Programs Fact Sheet on PCIT, diverse samples have been included in evaluation studies, including heavy concentrations of both White and African

American children and families. One study included Puerto Rican families. Cross-national generality has been demonstrated in a Chinese sample.

According to a review by The National Child Traumatic Stress Network (NCTSN), the PCIT model is broadly tailored and thought to apply across diverse groups. Researchers have also described specific adaptations of PCIT with Mexican American families, and with Native American families. PCIT does not pathologize normal cultural variations or impose a single standard of parenting and child behavior on clients. Cultural variations in tolerance for "disruptive" behavior in children are addressed in Dr. Eyberg's teaching by asking parents during live coaching if a particular child behavior is something they want to see reduced through strategic ignoring.

Additional culture-specific information on PCIT can be found in a NCTSN fact sheet at: https://www.nctsn.org/sites/default/files/interventions/pcit_culture_specific_fact_sheet.pdf

Provider Qualifications and Responsibilities

EBP Model Requirements

The provider must be credentialed by PCIT International and have an active PCIT certification. PCIT certification must be renewed every two years through PCIT International. The recertification requires the therapist to have obtained at least 3 hours of PCIT Continuing Education credit the last 2 years through educational activities sponsored by the PCIT International Task Force on Continuing Education.

Providers must submit verification of active PCIT certification to each MCO with whom it contracts to demonstrate eligibility for PCIT therapist status. Verification must be maintained in the therapist's personnel folder.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of this manual.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:
    a. 6A Psychologist – Clinical;
    b. 6B Psychologist – Counseling;

c. 6C Psychologist – School;

d. 6D Psychologist – Developmental;

e. 6E Psychologist - Non-declared;

f. 6F Psychologist – Other; and

g. 6G Psychologist – Medical.

2. PT 73 Social Worker (Licensed/Clinical) PS 73 Social Worker;

3. PT AK Licensed Professional Counselor (LPC)) PS 8E LPC;

4. PT AH Licensed Marriage & Family Therapists (LMFT) PS 8E;

5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;

6. PT 19 Doctor of Osteopathic Medicine PS:

   a. 26 Psychiatry;

   b. 27 Psychiatry; Neurology; and

   c. 2W Addiction Specialist.

7. PT 20 Psychiatrist PS:

   a. 26 Psychiatry; and

   b. 2W Addiction Specialist.

8. PT 78 Advanced Practice Registered Nurse PS 26;

9. PT 93 Clinical Nurse Specialist PS 26; and

10. PT 94 Physician Assistant PS 26.

Training

Basic Training. To apply for status as a Certified PCIT Therapist, an applicant must demonstrate appropriate Basic Training, as evidenced by the following:

1. 40-hours of face-to-face training with a PCIT Level II or Master Trainer that includes an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol. The 40 hours of training may be conducted via didactic training, a mentorship model, or any combination of the two. PCIT training is ideally offered over a period of time rather than limited to one time point, for example CDI training at one time, followed by PDI training at a later date;

2. 10 hours of online training from a program endorsed by PCIT International and 30 hours of face-to-face contact with a PCIT Level II or Master Trainer. Online training must be supplemented with skills review from a PCIT Trainer. Therefore, the 30 hours of face-to-face training may be conducted in didactic training, a mentorship model, or any combination of the two. This training will include an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol; or

3. 40 hours of PCIT training with a PCIT International Level 1 Trainer using a combination of didactic training and live co-therapy and supervision. Training from a PCIT Level 1 Trainer must include a minimum of 20 hours of co-therapy and/or live case supervision and continue until the trainee meets CDI and PDI coaching competencies. Video review or phone consultation cannot be used in lieu of the co-therapy or live-supervision requirements. This training will include an overview of the theoretical foundations of PCIT, DPICS coding practice, case observations, and coaching with families, with a focus on mastery of CDI and PDI skills, and a review of the 2011 PCIT Protocol.

Prior to PCIT certification, therapist trainees must complete two (2) cases under supervision with real time or video review of skills.

Quality Assurance

Outcomes

The treatment model depends on measurement of the Eyberg Child Behavior Inventory (ECBI) regularly throughout the treatment (minimally baseline, every 3-4 sessions, and at completion) as well as coding parent skills using the Dyadic Parent Child Interaction Coding System (DPICS) at each visit. The ECBI has established levels of symptoms under which the likelihood of relapse is diminished. DPICS skills are tracked and guide treatment.

Model-Specific Documentation Requirements

All PCIT sessions should be conducted with fidelity according to the appropriate session outline found in the PCIT International protocol (see PCIT Integrity Checklists at the end of each session outline). Sessions should be guided by real-time data, including a weekly ECBI, reported homework completion, and skills coding. Progress should be shared with the family at the conclusion of each session, as well as documented in their chart, using an ECBI (Eyberg Child Behavior Inventory), and a Skills Summary Sheet.

Both the ECBI and Skills Summary Sheet should be updated weekly, and both kept in the client's chart.

Fidelity

In order to reach the standard to be a Certified PCIT Therapist (as per PCIT International) the therapist must serve as a therapist for a minimum of two PCIT cases to graduation criteria as defined by the 2011 PCIT Protocol. Until the two PCIT cases meet graduation criteria, the applicant must remain in contact via real-time consultation (e.g., telephone conference or live, online, or telehealth observation) or video review with feedback with a certified PCIT Trainer at least twice a month. The PCIT protocol (which the therapist receives consultation on throughout the course of the case) includes therapist completion of a fidelity checklist at each session, and review of fidelity during supervision.

Fidelity is then directly assessed via the following requirement: Applicants must have their treatment sessions observed by a certified PCIT Trainer. Observations may be conducted in real time (e.g., live or online/telehealth) or through video recording.

PCIT therapist certification requirements can be found here:

http://www.pcit.org/uploads/6/3/6/1/63612365/therapist_training_guidelines_revised_1.25.18_final.pdf

PCIT does not require post-certification fidelity monitoring. PCIT does require re-certification every two (2) years, with evidence of PCIT Continuing Education hours.

Limitations/Exclusions

PCIT, as a service offered under Outpatient Therapy by Licensed Practitioners, has an initial authorization level of benefit, and services which exceed the limitation of the initial authorization may require approval for re-authorization prior to service delivery.

As per the PCIT model, families graduate from treatment when parents demonstrate mastery of skills and rate their child's behaviors as being within normal limits. PCIT sessions continue through completion of the "child directed interaction" component, and the "parent directed interaction" component, both of which are completed when a parent meets specific criteria defined as "mastery" of the skills. While a typical course of treatment averages 15-20 sessions, PCIT is not session-limited but instead the model duration depends on clinical outcome. Therefore, effective treatment duration may exceed the initial authorization level of benefit; in that case re-authorization should be requested indicating that the specialty model PCIT is being utilized and services appropriately may exceed the initial authorization and should be authorized for continuing services to complete the medically necessary treatment episode and provide evidence-based care to the youth and family.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. PCIT is a face-to-face intervention with the individual and caregiver present; however, the child receiving treatment does not need to be present for all contacts. If the child is not present, the appropriate procedure code must be billed, e.g. 90846 - Family Psychotherapy without Patient Present;

2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable;

   NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and

may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Therapists bill standard CPT individual and family therapy codes for sessions providing PCIT. The EB tracking code "EB03" should be indicated on claims to note that the therapy session utilized PCIT as an evidence-based model of therapeutic intervention; and

4. To use the PCIT EB tracking code of "EB03" on claims, the therapist must first provide documentation of their active certification from PCIT International to the MCO(s) the provider is contracted with, as part of the therapist's credentialing.