Parent-Child Interaction Therapy (PCIT)

Key Continuous Quality Improvement (CQI) Considerations

CQI BRIEF FOR CALIFORNIA COUNTIES AND EBP PROVIDERS

INTRODUCTION

As California continues to strive for excellence in child welfare, the implementation of evidence-based programs (EBPs) is a fundamental component of the Family First Prevention Services (FFPS) prevention plan. **This policy brief is designed to provide counties and providers with a comprehensive framework for implementing Parent-Child Interaction Therapy (PCIT)**, a well-supported evidence-based program approved by the Family First Prevention Services Clearinghouse to meet the diverse needs of at-risk youth and their families.

As you review this information, consider how you will measure the success of PCIT within your county and how you can develop or refine your implementation to ensure eligibility for IV-E reimbursement, as well as improved outcomes for children and families.

Counties and providers can utilize this Brief to facilitate discussions at the county, agency, and community levels, aimed at identifying best practices for tracking and sharing data. These discussions should also focus on reviewing the CQI prompts to assess program delivery and implementation, making necessary adjustments as needed. Additionally, counties and providers should use these Briefs to establish feedback loops for sharing qualitative data on family-specific needs, ensuring that future efforts to serve and support families are informed and responsive.

The information presented in this resource, including service descriptions, target populations, program or service delivery, and implementation details, is informed by several key sources. These include meetings with California's Family First Prevention Services CQI Subcommittee, Family First Prevention Services Advisory Committee, Community Pathway Subcommittee, IV-E Subcommittee, and PCIT International.

Key Terms

Developer/Purveyor: The entity responsible for creating and supporting the implementation of the EBP. They provide training, resources, and guidance to ensure fidelity and effective implementation.

Provider: The individual or organization delivering the EBP services directly to children and families.

PARENT-CHILD INTERACTION THERAPY PROGRAM OVERVIEW

Parent-Child Interaction Therapy (PCIT) is an intensive, evidence-based treatment for children aged 2 to 7 and their parents or caregivers. PCIT aims to reduce externalizing behavior problems in children, enhance positive parenting practices, and strengthen the parent-child relationship. Through weekly sessions, therapists coach caregivers in skills such as child-centered play, effective communication, increasing child compliance, and problem-solving. Using "bug-in-the-ear" technology from behind a one-way mirror—or in some adaptations, in-room live coaching—therapists provide real-time guidance. Parents or caregivers progress as they master specific skills, with most families completing the program within 12 to 20 one-hour sessions.

Who is Eligible?

Families with children who are between two and seven years old and experience emotional and behavioral problems. PCIT is not recommended for children outside the 2–7 age range, those with severe developmental disabilities, parents with severe untreated mental health issues, or families experiencing ongoing domestic violence.

Program Goals

Build close relationships between parents and their children using positive attention strategies

Help children feel safe and calm by fostering warmth and security between parents and their children

Increase children's organizational and play skills

Educate parent about ways to teach child without frustration for parent and child

Enhance children's self-esteem

Improve children's social skills such as sharing and cooperation

Families Need to Know

PCIT is typically delivered over 12–20 weekly hour-long sessions, but the exact treatment length varies based on the needs of the child and family

Treatment is considered complete when a positive parent-child relationship is established, the parent can effectively manage the child's behavior, and the child's behavior is within normal limits on a behavior rating scale

PCIT is usually delivered in playroom settings where therapists can observe behaviors through a one-way mirror

Cultural Relevance

PCIT has been shown to have positive outcomes for Asian and Black children and families

PCIT has materials available in English and Spanish

MEASURING PROGRAM SUCCESS

Measuring the capacity, reach, fidelity, and outcome data outlined below can greatly enhance the implementation and effectiveness of PCIT. Regular quality assurance monitoring ensures this adherence.

Data Collection for Federal IV-E Reimbursement

Under the Family First Prevention Services Act (FFPSA), federal IV-E reimbursement for evidence-based programs (EBPs) is contingent upon several requirements described on pages 27, 39, and 52 of the federally approved California Prevention Plan. To meet these requirements and ensure accurate cost tracking:

- **The PCIT developer/purveyor currently does not provide reports on capacity, reach, outcomes, or fidelity measures.** Therefore, providers must establish and maintain internal systems to monitor key metrics, including service capacity, reach, fidelity, and outcomes.
- **PCIT providers will enter reach and capacity data into the CARES provider portal on a monthly basis.**
- Tracking both outcome and fidelity data is required for IV-E reimbursement.
- **Outcome and fidelity data will be reported by the PCIT providers and submitted to CARES using the designed provider template provided in Appendix A.**

The **CDSS FFPS Program** will:

- **Upload outcome and fidelity data** into the backend of CARES.
- **Translate the reach, capacity, outcome and fidelity data into Tableau reports for use in state- and county-level FFPS CQI processes.**

Key Metrics for Continuous Quality Improvement (CQI)

To measure the success of PCIT, it's important to regularly review data in four key areas:

1. ***Capacity –*** *staff requirements*
2. ***Reach –*** *the extent to which children and families are being served*
3. ***Fidelity –*** *adherence to model implementation requirements*
4. ***Outcomes –*** *impact of services on children and families*

These metrics provide a comprehensive view of program effectiveness. More information on this framework can be found here: Measurement Framework for Implementing and Evaluation Preventive Services.

PCIT MEASUREMENT FRAMEWORK

The **PCIT Measurement Framework** provides standardized metrics for California counties and EBP providers to evaluate **capacity**, **reach**, **fidelity**, and **outcomes**, supporting continuous quality improvement (CQI) and compliance with the Family First Prevention Services Act (FFPSA) for federal IV-E reimbursement. The following data tables outline these measures and expectations for tracking critical program components. **It is recommended that all stakeholders review and familiarize themselves with this information to clearly understand the expectations for tracking and assessing critical components of program implementation.** CQI prompts are included to guide discussions, identify successes, address barriers, and support effective program implementation and oversight.

Capacity

Capacity refers to the resources dedicated by the agency or program to effectively deliver services to children and families, including staffing, infrastructure, and service availability. Adequate capacity is essential for successful implementation of PCIT and influences the program's ability to meet community needs.

Table 1 outlines key capacity measures required to monitor program implementation. **PCIT providers will submit capacity data for each provider site monthly through the CARES provider portal.** Counties should review capacity data and conduct CQI activities monthly.

Table 1. Description of PCIT Capacity Data Elements

Measure	Indicator
Staffing	Total # of provider agency sites
	Total # of full-time model-trained or certified practitioners
	Total # of supervisors
Supervisor / Practitioner Ratio	N/A
Full-time Caseload *(Part-time practitioners are not permitted)*	N/A
Service Duration	14 sessions

Capacity CQI Prompts:

- **Analyze Reach and Capacity Data: Combine reach data, capacity data, and waitlist information to assess if additional PCIT clinicians or service slots are needed in specific communities.**
- **Address Staffing and Caseload Standards: If Supervisor/Clinician ratios, caseloads, or adherence to session duration are not meeting standards, the CQI team should work with providers to identify challenges and develop solutions.**
- **Evaluate Infrastructure Adequacy: Regularly review the physical infrastructure, such as observation rooms with one-way mirrors and bug-in-ear technology, to ensure it supports high-quality PCIT delivery. Identify any limitations and consider adjustments to optimize facility use.**

Reach

Reach refers to the extent to which the program engages its target population by ensuring eligible children and families are identified, referred to, and actively enrolled in services. It measures how well PCIT is serving those it is intended to reach and whether the service is accessible to those in need.

Table 2 lists the reach data elements to be tracked for effective outreach and engagement. **PCIT providers will submit reach data monthly through the CARES provider portal.** Counties should review reach data and conduct CQI activities monthly.

Table 2. Description of Standardized Reach Data Elements

Measure	Indicator
Eligible Child Welfare & Probation Candidates *(This data will come from the Title IV-E agency)*	Total # of FM/VFM/602 youth who come to the attention of the agency*
	Total # identified as a Family First candidate • FM – Family Maintenance • VFM – Voluntary Family Maintenance • 602 WIC Petition**
	Total # identified as a Family First pregnant or parenting youth in care (PPY)
	Total # not identified as a candidate
Eligible Community Pathway Candidates *(This data will come from the Title IV-E agency)*	Total # of community pathway children granted IV-E agency candidacy approval

	Total # of community pathway children denied IV-E agency candidacy approval
	• Reason for denial
	  ○ MH, SA, or PS imminent risk/need not identified
	  ○ Child outside of age range of the recommended EBP

EBP Referrals to Providers	Total # candidates referred to an EBP provider
EBP Service Uptake	Total # candidates who started the EBP

	Total # candidates who did not start the EBP
	• Reason did not start the EBP
	  ○ No action taken; referral still in process
	  ○ Placed on waitlist; median days on waitlist
	  ○ Provider rejected referral
	  ○ Provider unable to contact or engage with the family
	  ○ Family did not consent, etc.
	  ○ Other

EBP Service Completion	Total # candidates who completed the full EBP

	Total # candidates who did not complete the full EBP
	• Reason did not complete the full EBP
	  ○ Provider unable to contact or engage with family
	  ○ Family withdrew
	  ○ Family no longer eligible
	  ○ Provider capacity issues
	  ○ Other

**Total number of referrals to Probation (inclusive of citations and arrests)*

***Youth referred to Probation by a Law Enforcement Agency for alleged involvement in delinquent behavior that could result in a WIC 602 petition*

Reach CQI Prompts:

Look at eligible child welfare and probation candidates and compare with the number referred to PCIT, started PCIT, and completed PCIT. Discuss strategies to address:

- **Service Flow: Compare eligible candidates to those referred, enrolled, and completed.**
- **Waitlists: Identify causes and reduce delays.**
- **Referral Rejections: Address common reasons for declined referrals.**
- **Family Contact: Improve provider outcome and engagement.**
- **Consent Issues: Increase family consent rates.**
- **Withdrawals: Identify strategies to reduce early terminations.**
- **Eligibility Changes: Minimize service disruptions.**
- **Provider Capacity: Align staffing and resources to demand.**

Outcomes

Outcomes refer to the measurable impacts of the program on children and families, demonstrating whether PCIT is achieving its intended goals. These metrics help assess program effectiveness and inform continuous quality improvement efforts.

Table 3 outlines the key outcome measures needed to monitor and evaluate program success. **PCIT providers will use a standardized template to submit outcome data to CDSS biannually. The CDSS FFPS team will upload provider outcome data into the CARES backend for county CQI activities.** Counties should review outcome data and conduct CQI activities quarterly.

Table 3. Description of PCIT Outcome Data Elements

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Increased Positive Parenting Practices	% of caregivers who demonstrate improvement on the PRIDE skills.	50%	Dyadic Parent-Child Interaction Coding (DPICS-IV) Coding Sheet	Therapist administers every session; may also be administered at completion.	None; provider-specific
	% of caregivers who demonstrate goal criteria in Phase 2, Parent-Directed Interaction (PDI). Note: "Goal criteria" means at least 75% of caregivers' commands meet criteria for being "effective".	75%	DPICS-IV Coding Sheet		
	% of caregivers who have a decrease in ECBI score at service completion/discharge.	75%	Eyberg Child Behavior Inventory (ECBI)		
Reduction in Negative Child Behaviors	% of children whose behavior is rated in the normal range (≤114) per the ECBI Intensity Scale.	75%	Eyberg Child Behavior Inventory (ECBI)		

Outcomes CQI Prompts:

- **Assess Population Impact: Combine outcome and reach data to identify which populations benefit most from PCIT.**
- **Evaluate Child Behavior Outcomes: Review child behavior improvement data, such as reductions in ECBI scores from intake. Ensure strategies are in place to support consistent score decreases.**
- **Monitor Parenting Goal Achievement: Assess family progress in achieving key parenting goals (e.g., Child-Directed Interaction and Parent-Directed Interaction criteria). If families are not consistently meeting these goals, explore additional supports or modifications in delivery.**

Fidelity

Fidelity refers to how closely the program follows the prescribed PCIT model to ensure services are delivered as intended. Maintaining high fidelity is crucial for achieving positive outcomes and ensuring program integrity.

Table 4 outlines the fidelity measures required to assess program adherence. **PCIT providers will use a standardized template to submit fidelity data to CDSS biannually. The CDSS FFPS team will upload provider outcome data into the CARES backend for county CQI activities.** Counties should review fidelity data and conduct CQI activities quarterly.

Table 4. Description of PCIT Fidelity Data Elements

Measure	Indicator	Target Level	Data Collection Instrument	Frequency	Standardized Reports
Provider Received & Maintained Required Training	% of therapists who complete basic and consultation training.	100%	N/A	Collected as training occurs.	None; provider-specific
	% of therapists who complete at least 3 hours of PCIT Continuing Education credit.	100%		Collected after therapist completes Continuing Education credit.	
Meets Staffing Qualification Requirements	% of therapists that have at least a master's degree and are licensed as mental health practitioners.	100%	N/A	Collected during hiring process.	
Use of Eyberg Child Behavior Inventory (ECBI) **or** Use of the Weekly Assessment of Child Behavior (WACB)	% of cases were ECBI was completed for every session. OR % of cases where the WACB was completed for every session.	90%	Eyberg Child Behavior Inventory (ECBI) Weekly Assessment of Child Behavior (WACB)	Completed by parents of children ages 2-16 years old at every session.	
Use of Dyadic Parent-Child Coding System (DPICS-IV)	% of cases were DPICS-IV was completed for every session, except session when the child is not present.	90%	Dyadic Parent-Child Coding System (DPIS-IV)	Completed by therapist to evaluate parent-child interactions during pre-, mid-, and post-treatment.	

Fidelity CQI Prompts:

- **Review Staffing and Training Compliance: Conduct biannual reviews of PCIT staffing data to ensure adherence to training requirements, staff qualifications, and continuing education standards.**
- **Evaluate Session Adherence: Assess provider adherence to the prescribed 12-20 PCIT sessions based on family needs. Monitor how frequently families complete treatment within this range and identify justifiable reasons for early or extended treatment durations.**
- **Address Identified Challenges: If data reveals challenges, contract holders should collaborate with providers and the model developer to discuss and implement improvement strategies.**

RESOURCES

To ensure the successful implementation of PCIT, it is crucial to establish a strong relationship between the PCIT provider, the PCIT developer/purveyor, and the county. Here are the steps to initiate this process:

Providers Contact PCIT: Reach out to PCIT International, the official developer/purveyor of Parent-Child Interaction Therapy. Contact information can be found on their website: https://www.pcit.org/. Initiate a conversation to discuss your interest in implementing PCIT and to seek guidance on the next steps.

Providers and County Leaders Contact Your Local CPP Lead: Providers or counties looking to implement PCIT for IV-E reimbursement should contact their local Comprehensive Prevention Planning Lead to ensure their implementation plans align with state and federal requirements, including IV-E reimbursement guidelines. Follow this link to determine your point of contact: https://cdss.ca.gov/Portals/9/CCR/FFPSA/ffps-title-iv-eagency-county-contact-list.pdf

You can also submit additional questions to the FFPS Inbox at FFPSAPreventionServices@dss.ca.gov

STAY TUNED!

In the coming months, the CQI Subcommittee and statewide advisory committees (see Page 1) will be drafting a comprehensive California Continuous Quality Improvement Plan. The content will include governance structure recommendations, CQI focused resources/policies, data analysis, and feedback loops. Stay tuned for these updates as we enhance our statewide CQI practices for Family First Prevention Services.

REFERENCES

Chapin Hall at the University of Chicago. (n.d.). Measurement framework. https://www.chapinhall.org/research/measurement-framework

Hyland, S. T., & O'Brien, J. (2023). Evidence-based programs desk guide 2023. Chapin Hall at the University of Chicago.

PCIT International. (n.d.). *Parent-Child Interaction Therapy (PCIT) International*. https://www.pcit.org/.

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (n.d.). Title IV-E prevention services clearinghouse. https://preventionservices.abtsites

APPENDIX A: PROVIDER OUTCOME & FIDELITY TEMPLATE

PCIT Outcome Measures

Parent-Child Interaction Therapy (PCIT)				
Provider sends the percentage for <u>each location</u> in a data file.				
Measure	**Reduction in negative child behaviors**	**Increased positive parenting practices**		
Indicator	*% of children whose behavior is rated in the normal range per the ECBI Intensity Scale.* *Target range is an ECBI raw score of ≤ 114.*	*% of caregivers who demonstrate improvement on the PRIDE skills.*	*% of caregivers who demonstrate goal criteria in phase 2, Parent-Directed Interaction (PDI).*	*% of caregivers who have a decrease in ECBI score at service complete/ discharge.*
Target Level	50%	75%	75%	75%
Site 1				
Site 2				
Site 3				

PCIT Fidelity Measures

Parent-Child Interaction Therapy (PCIT)						
Provider sends the percentage for <u>each location</u> in a data file.						
Measure	**Provider received and maintained required training**		**Meets supervision and consultation requirements**	**Use of the Eyberg Child Behavior Inventory (ECBI) or Use of the Weekly Assessment of Child Behavior (WACB)**		**Use of Dyadic Parent-Child Interaction Coding (DPICS-IV) Coding Sheet**
Indicator	*% of therapists who have completed basic and consultation training.*	*% of therapists who complete at least 3 hours of PCIT Continuing Education credit.*	*% of therapists that have at least a master's degree and are licensed as mental health practitioners.*	*% of cases where ECBI was completed for every session.*	*% of cases where the WACB was completed for every session.*	*% of cases where DPICS-IV was completed for every session (except sessions when child*
Target Level	100%	100%	100%	90%	90%	90%
Site 1						
Site 2						
Site 3						