Internet Based-PCIT (I-PCIT): Recommendations for Service Delivery

Prepared in Response to COVID-19

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Table of Contents

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Crowdsourcing Innovation Related to I-PCIT

PCIT305 could not have compiled this document without the collective input of our team and trainers around the country. What we have learned about I-PCIT is that lots of people have great ideas about services delivery. In addition, technology moves so quickly. Therefore, we view this guide as a dynamic document that should be updated periodically as we learn from others regarding their own innovative technique or tips for tech options and/or service delivery. Therefore, we invite the PCIT community to share their ideas with us, which will allow us to build out this resource over time. At a minimum, we will add acknowledgments to your contributions. If you contribute significantly, we will add you as an author to the document. Our goal is to continue to make this resource free so that our PCIT community is as equipped as possible to serve families in need.

If you have ideas and/or content that you would like to contribute, please email Abby Peskin, the lead author of this guide with your ideas. She can be emailed at: apooch@med.miami.edu

Disclaimers:

- These guidelines, recommendations, and considerations were developed in part based on University of Miami operating procedures, DePaul University operating procedures, and Florida statutes guiding practice during COVID-19. Some of the recommendations provided within this document may not be permissible within your institution, your practice jurisdiction, or your selected video conferencing software. Each agency reviewing these guidelines and recommendations for practice is responsible for ensuring that the practice recommendations conform with existing laws, statutes, and regulations.

- The University of Miami utilizes REDCap, an online HIPAA compliant database for collecting assessments and weekly homework. This guide references REDCap frequently. This software may not be available at your agency. Whenever collecting any type of data or communicating electronically with families, please make sure that you have appropriately consented families to such practices. Always make sure to discuss potential privacy limitations of your chosen communication method.

- These suggested guidelines for I-PCIT practice heavily reference Zoom as this is the selected platform that is used within a Business Associate's Agreement (BAA) at the University of Miami. Some of the video conferencing software recommendations may not apply to your selected platform (including whether you have a BAA in place).

Audience:

- **Certified PCIT Therapists and Trainers**
- **Therapists currently being trained and receiving consultation from a certified PCIT Trainer**
- **This document is not intended for mental health professionals who have not received training in PCIT**
- **This document is not intended for families**

Course Objectives:

1. **Understand the technological options and set-up required for both therapist and parent to increase chances of a successful Internet-Based PCIT session and consistent audio and visual connection with the patient.**
2. **Learn how to tailor in-person PCIT delivery to make it successful when delivered via telehealth.**
3. **Analyze how stressors and changes in family routine change the setting for PCIT, and understand how to respond to those difficulties in a way that allows the treatment to be completed as close to fidelity as possible while mitigating the family's stressors.**

Section 1: Before Delivering I-PCIT Services

Department of Health and Human Service Guidelines during the COVID-19 Nationwide Public Health Emergency

- To read the guidelines in full or examine related resources, go here.
- The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, to protect the privacy and security of protected health information, namely the HIPAA Privacy, Security and Breach Notification Rules (the HIPAA Rules).
- During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules under typical circumstances when there is no national emergency declaration.
- OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.
- Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.
- Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.
- Under this Notice, however, Facebook Live, YouTube Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in **the provision of telehealth** by covered health care providers.

Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products. The list below includes some vendors that report that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA BAA.

- Skype for Business / Microsoft Teams
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet
- Cisco Webex Meetings / Webex Teams
- Amazon Chime
- GoToMeeting
- Spruce Health Care Messenger

Give your families and yourself a bit of a break as you try out this new technology for delivering I-PCIT.

- For a lot of therapists and families, this technology is new.
- Therapists and families should allow for patience as each party gets acquainted with this new form of technology.
- Acknowledge that beyond learning this new technology, each party is likely experiencing many other stressors so it is important to note that flexibility while providing services is key.

Informed Consent Considerations

- If your agency budget allows, you should attempt to utilize video conferencing software that has security features that allow it to be HIPAA compliant if used appropriately and that allows for a Business Associate's Agreement (BAA) between your agency and the software company.
- In the event that a provider is using anything that is less than this standard, even with the flexibility provided from the Department of Health and Human Services during the COVID-19 emergency, the provider should explain the potential privacy risks related to these new forms of service delivery.
- The truth is, even with a BAA in place, software still has the potential to be breached or hacked by outside parties.
- If you plan on communicating with families using a new format (e.g., email, text messages, WhatsApp), consent the families to this process and establish what types of communications will be allowed through these specific formats (e.g., appointment scheduling/confirmation, video conference calendar invite, etc.).
- Based on your agency's selection of software and implementation procedures, you may need to get families to sign a new written informed consent that explains these changes before proceeding with services.

- In the event the development of an updated informed consent is not feasible, these changes should be verbally explained to the family. The family should have the opportunity to have any questions answered. Then families can provide verbal consent and the provider should document that verbal consent was obtained before proceeding with services.

The Process for Obtaining Clinical Informed Consent during COVID-19

These are some suggestions for agencies to consider. However, each agency needs to make sure that their process is consistent with program, agency, state, and national standards/guidelines.

If you do not have consent to email forms to the family you serve, contact the family in advance by phone to explain the informed consent for telehealth. Ask for permission to send this form to them via email and explain any potential privacy risks associated with emailing the form or link to consent in the format your agency chooses. Make sure to utilize email encryption offered by your agency, if available.

Temporary Software Delivery Formats for Informed Consent

· Online survey tool (e.g., Qualtrics, REDCap) that allows for participant signatures and hidden signature fields for providers to sign once returned.
· DocuSign software (available for purchase) that allows for participant signatures and clinician signatures while ensuring no other changes can be made to the form.
· Adobe Acrobat (available for purchase): Utilizing the Fill and Sign Process:

1. Open Consent form in Adobe Acrobat
2. Select *Fill and Sign* on the toolbar
3. Select *Request Signatures*
4. Add guardian email address
5. Select *Specify where to sign*
6. Scroll down and select the line next to Name for parent to print name, Caregiver/Guardian Signature for caregiver to provide signature, and Date field for caregiver to provide date.
7. Then click *send*. If the caregiver/guardian does not receive it, have them check spam/junk email.
8. Once the individual signs the document, a copy is automatically sent back to the sender's email. This worked with significant ease when testing it out on a phone. ***There is no need to go to an Adobe App.***

How to Obtain Informed Consent

1.) Email a link of the informed consent (that you created in Adobe Acrobat or an online survey tool) to the guardian prior to session (with a link to sign the electronic consent).

2.) **Option 1:** Start telehealth session with guardian. Clinician then shares their screen that displays the informed consent and reviews the consent with the guardian. Clinician reviews informed consent, answers any relevant questions, and seek verbal consent. Then have guardian complete and digitally sign informed consent form. No services are provided until clinician confirms receipt of guadrian's signed consent.

Option 2: Call guardian by phone and instruct them to open up the link to informed consent on their device. Review informed consent, answer any relevant questions, and seek and document verbal consent.

3.) Your clinical team will need a process (e.g., support staff or therapist confirms receipt) for determining whether clinical consent was obtained via an online survey. The Adobe Fill and Sign approach should provide you with an emailed copy of the signed consent once completed.

4.) Once confirmed, proceed with the telehealth session.

Before the first session, call to schedule and have a discussion about family's tech options:

- Specific to transition to I-PCIT during the COVID-19 pandemic, it may be clinically determined a transition session to assess family stressors and plan for general health and well-being is appropriate. Considerations for a transition session are discussed in this document
- Check to make sure the family has high-speed internet with home Wi-Fi (can check internet speed by going to www.speedtest.net when the device is connected to WiFi [not cell service]). Greater than 5-10 Mbps download speed is necessary for I-PCIT (however this may vary depending on videoconferencing software). Family internet plan should allow for download of large amounts of data.
    - Low Income Internet Option: If families are not able to do internet-based telehealth because of lack of internet at home, Comcast has expanded its Internet Essentials program, which offers free internet services for eligible families for 60 days. Visit internetessentials.com to learn more.
    - Some families may also be able to use their video conferencing software on their phones with their data plans. Currently during the pandemic

several cellular providers are offering unlimited free data plans to address some of these needs.

- Check that the family has the basic necessary equipment, including:
    - A computer (with a webcam), tablet, or smartphone with your clinic's chosen video conferencing software app installed.
    - Bluetooth/wireless headphones (e.g., AirPods) to go with the device the family is using OR wired headphones, plugged in to either the device used for video, or a secondary device (e.g., a smartphone). *If the family has no access to headphones, then you may proceed to coach over the speaker. It will likely feel similar to in-room coaching.*
    - A tripod/other mounting device. If a clamp or tripod is not available, discuss with the family how the device might be propped up (e.g., between two books) so that the video shows as much of the play area as possible (e.g., tripod, clamp, selfie stick, bookcase).
- If necessary, explain that I-PCIT is effective and works well for PCIT's parent-coaching model and explain the purpose of this technology consult (e.g., test out videoconferencing software, going over a safety plan, etc.) is to make sure that services go smoothly.
    - Emphasize that one benefit of I-PCIT versus in person model is that coaching in the family's natural environment promotes generalization of skills from session to the family's daily life
- If a second caregiver is involved, explore whether the second caregiver could observe the coaching sessions using another device (e.g., smartphone). If so, your clinic's chosen videoconferencing software should be downloaded on that device as well. *If internet bandwidth is a concern, the second caregiver can join the meeting using the "join by phone" audio feature available for many videoconferencing applications (e.g., Zoom) and observe from afar. The second caregiver should remain muted to minimize audio feedback issues. In any event, you will want to test all devices the way a family will use them in a real session, and avoid assumptions of what will and will not work come "game time."*

Transitioning to Telehealth

Clinicians can provide the following iPCIT script for explaining technology and special time to child, especially those who have transitioned from in-clinic services

For families who switched from PCIT to iPCIT:

"You and your parent/s have been coming to our clinic to learn some new ways to get along better. In the clinic, your parent/s wore a little earpiece so that I could talk to them from the other room. Since we are meeting through the computer/phone/ipad now, I will need to talk to your parent/s through this earpiece/computer/phone/tablet. You may also be able to see me

sometimes on the computer/phone/tablet. Everything else will be the same, and you will still play with your parent/s while I sometimes say things to them through the earpiece/computer/phone/tablet. Do you have any questions?"

For families new to iPCIT:

"You and your parent/s are meeting with me through the computer/phone/iPad to learn some new ways to get along better. I'm going to talk to your parent/s through this earpiece/computer/phone/tablet so they can hear me. Sometimes I will tell them things to say while they play with you. Do you have any questions?"

Section 2: Setting up the Tech

Setting up the Tech: Prevention

- Prevention:
    - Make sure the parent has a phone with them for the session, and the phone is charged. The phone may serve as the primary device or the back-up device if their other mobile device fails during the session (e.g., if sound does not work in either direction, if the battery dies, etc.).
    - Have the family charge the videoconferencing device and bluetooth headset/AirPods before the session if using a bluetooth device.
    - If a family is using a mobile tablet or laptop for video and their phone for audio, make sure that both are charged and they have appropriate wired or bluetooth headphones.
    - Remind the caregiver that they need to make sure to possess and secure all the devices they need for session well before session starts (e.g., at least 1 hour before session starts). This will avoid a situation where caregivers have to take a device that a child is playing with (e.g., an iPad or tablet) away from the child to use during session. If caregivers wait too long to secure devices they need, taking them away from their children as session begins could cause significant tantrums and conflict and could cause the session to immediately get off track.
    - When creating the Video Conferencing appointment, select the following options (if using Zoom):
        - Under Video, select “On” for Host and Participants
        - Under Audio, select “Telephone and Computer Audio”
        - Click Advanced Options and select: “Enable join before host” and “Automatically record meeting” (if you received consent to record sessions for training or fidelity purposes)
            - Alternatively, therapists may elect to “Enable waiting room” to allow the family to logon prior to the therapist, but not be admitted to the session until the therapist is logged in and grants the family access to the session. Be sure to explain the nature of the “waiting room” to caregivers in advance to prevent hang ups.
        - For a broad list of meeting settings within **Zoom** to consider, see this resource. *This resource was developed for use at DePaul University and is not intended to serve as formal guidance for other agencies. Rather it is meant to serve as a potential template for settings to consider when establishing clinical service meetings within Zoom.*
    - Before signing in to the video conferencing session:
        - Open this family’s tracker for CDI/PDI skills and ECBI tracker
        - Open DPICS manual and PCIT Protocol to the page for that session

        - Open coding sheets
            - Can record coding on printed coding sheets.
            - Without access to a printer, some of our clinicians have also needed to be more flexible and use scrap pieces of paper.
            - Creating and using fillable PDFs or word documents as coding sheets is another option, as long as those digital copies are saved in a HIPAA compliant, secure location.
        - Open completed ECBI to see areas to target for labeled praise of positive opposites during coaching.
        - Open completed homework sheets to reference during check-in. If parent has not submitted homework sheets, open blank homework sheets
        - Open the family's telehealth safety plan so that you have phone numbers for parents and emergency contacts readily available.
        - Clear your desktop, and close any open documents and tabs on your internet browsers that contain confidential information about other patients or yourself.
        - Close email and any other applications that will make notification noises during session. Put your phone on vibrate or silent. Now that you will (likely) be working from home, think about how you can decrease the background noises in your home to keep the family focused on the play.
    - Clinicians should role-play how to help parents troubleshoot common tech issues before beginning I-PCIT sessions. This will enable clinicians to feel able to guide parents through troubleshooting a variety of issues while feeling calm and confident. The following list offers several helpful scenarios to role play that occur frequently during remote PCIT. Potential solutions for these concerns are addressed below in the section about dealing with tech issues.
        - Parent audio is not working once they connect to Zoom meeting
        - Clinician conducts a walking tour of the home
            - Clinician helps parent identify rooms with distractions
            - Clinician helps parent identify rooms with breakables
        - Setting up the camera angle based on the equipment that the family has
            - Practice scenario where there is mount for equipment
            - Practice scenario where there is no mount for equipment
            - Practice scenario where Bluetooth headset is not charged before session
        - Setting up and starting a co-therapy session
        - Setting up Time Stamps for DPICS for reliability checks. Make sure you have consent for recording.
        - How to handle two parent families via I-PCIT as it relates to coaching and observing the other parent practice
        - Scenarios where there is another child home and only one parent
        - Having a supervisor provide live remote video observation

        - Ensuring parent has correct amount of toys for Pre-Post DPICS and Coach sessions
        - Child keeps running off screen
        - Prepping the space for PDI
            - Time out chair
            - Time out space
            - Picking the best camera angle for PDI
        - When the child goes off camera during time out or time out room
        - Tech issues in the middle of coaching

Setting up the Session- Therapist:

- In some instances, you will be recording sessions if you received appropriate consent to do so. This should be for clinical training, supervision, or research purposes. Ideally, individuals should not be recording sessions unless they have a BAA in place for their video conferencing software company and their agency.
- In order to record a **Zoom** session on your local computer so that the main view is of the parent/child playing, once the host is in the zoom meeting, he/she should click “Gallery view” (located in the upper right hand corner of the screen) and it will display all participants in the meeting as a grid. Then hover over the view of the parent/child play space and in the upper right corner, select “pin video.” The recording will then have that view locked as the larger view displayed. Note: if there are two therapists in the meeting, the host of the meeting must be the one to make this change because the recording will be based on the host’s settings.
- Keep therapist audio and video on during check-in and check-out
- Turn off therapist video during coding and coaching so the child is not distracted. Before turning it off, let the parent know you will be turning it off, and why. Also let them know how to respond if the child asks why the video is off.
    - Can have parent say “CLINICIAN NAME’S video is off now so that you and I can pay attention to each other during our Special Time. Now it’s time for you and I to play together and have so much fun together!”
    - If child persists in asking questions in an attention-seeking manner, therapist can coach parent to ignore and describe their own play with the toys enthusiastically until the child rejoins play. Then the parent can provide labeled praise for the child joining them in play (e.g., “Great job coming to play with me”) and proceed in playing with child while practicing CDI skills.
- Therapist should mute microphone during coding

Setting up the Session - Family**:**

- Family must download Zoom or appropriate video conferencing app to all devices prior to session (it is free, and you do not need to create an account).

- Make sure all devices are fully charged before session.
- Similar to a typical PCIT session, you have a number of activities that you need to complete (e.g., check-in, homework review, coding, coaching, check-out). Because families may use video conferencing for social purposes, you may want to lay out the agenda for the session at the beginning to keep conversations focused.
- Instruct the family to click on the link within the email sent by therapist to join the Zoom session (or other teleconferencing software session if not using Zoom).
    - Make sure to have the family give Zoom permission to access the camera and microphone on the device. If families do not do this step, the therapist will not be able to hear them. If that happens, call the parent, have them go into the “System Preferences” or “Settings” on their device, open the Privacy setting, and have them toggle to give Zoom access to their microphone and camera.
- If a second caregiver is involved and will be observing, make sure the second caregiver also has the Zoom app downloaded on their phone and also has a headset/earphones available
    - During coaching with first caregiver, second caregiver will turn off video and audio while observing so child cannot see or hear them and be distracted.
- If using a Bluetooth/wireless headset, have family pair the headset with the device BEFORE joining the Zoom session
    - When joining meeting, select Bluetooth/wireless headset as audio preference
- To switch from device audio to Bluetooth/wireless audio, click the arrow next to the mute/microphone button, then select the Bluetooth/wireless headset under both microphone and speaker
- To switch from Bluetooth/wireless audio to device audio, just turn off the Bluetooth/wireless headset
- If using a separate device (e.g., phone) with a wired headset, instruct the family to join the zoom call by phone
    - Open the Zoom meeting invite in email, scroll down, and click “one tap mobile.” You do not need to enter a participant ID, just hit the # key when prompted

Dealing with Tech Issues:

- **If the parent does not sign into session on time**
    - Call the family 5 minutes after the session was supposed to begin.
    - After 15 minutes, send an email asking the parent if they need to reschedule, and sign out of the session.
- **If the parent turns off the camera accidentally (e.g., by pushing the power button on the bluetooth headset)**

    - Give the parent a minute to sign back in, but open their phone number on your phone
    - If they don't sign back in, call them on your phone to help them sign back in
- **If the child turns off the camera**
    - Minimize child's reach or access to equipment
    - Flip device to other camera so that the back of the phone/tablet is facing the child
    - Switch iPad or phone into guided access mode, which can prevent the child from exiting the session without the right passcode (https://support.apple.com/en-us/HT202612)
- **If the parent has difficulty following your directions for completing session, they can give you control of their Zoom** or you can request it following the Zoom instructions for remote control access: https://support.zoom.us/hc/en-us/articles/201362673-Request-or-Give-Remote-Control#heading=h.bdhzh38o7ljq
- **If someone can't hear!**
    - Have therapist wear headphones with microphone - this often makes it easier for the family to hear and helps with confidentiality within the therapist's environment
    - Family's audio input during the session can come through
        - Bluetooth headset/AirPods
            - **Pros:** best option because family can be far away from the iPad/computer and can still hear the therapist for the most part
            - **Cons:** Often hard to hear the child, sometimes hard for parents to hear clinician, parents have to remember to charge it
            - **If it is hard to hear the child when the parent is using AirPods:** One possible solution is to have the parent change the microphone that is picking up on their and their child's voices to the built-in mic on their device. To do this during a Zoom meeting, have the parent click on the arrow next to the mute button and under "select a microphone" click "built-in input (internal microphone)". This should allow the therapist to clearly hear the child and parent while using their AirPods.
        - Wired headset connected to video device
            - **Pros:** Does not need to be charged, usually fewer sound issues
            - **Cons:** The camera needs to be closer to the parent and child for the cord to reach the parent, so it is harder to see what is happening. More difficult for the parent to move around because they need to move the device with them.
        - Wired headset connected to phone, video through a separate device:
            - **Pros:** Parents can optimize the sound if they call into Zoom from one device. Sometimes also helps to improve the video quality because the devices are working together
            - **Cons:** Parent is still tethered to a cord, which makes it more obvious to the child that s/he is listening to something, and makes

it more likely to get caught on something. Harder to move around during PDI. If the clinician calls the parent through their phone number instead of the parent calling through Zoom, recording everyone becomes more complicated.

- Right through Zoom if the family does not have a headset (i.e., the child would be able to hear)
  - **Pros:** Family can still receive services despite lack of equipment. Therapist can more easily hear both parent and child. Parent can move away from the device because there is no cord connecting them.
  - **Cons:** Works best for young children because older children realize that the parent is being coached. Children are more aware of the device, and it becomes harder to keep them away from it.

- Please see this resource for a detailed guide for I-PCIT tech set-up in the event that you are utilizing Zoom for service delivery.
- See below for a chart of options about the possible combinations of video and audio input for parents to use for session from home:

Table 1: Possible Combinations of Video and Audio Input for Parents to Use for I-PCIT

Video	Audio	Earphones	Data Connection
Tablet/ Computer	Tablet/Computer (using videoconferencing app)	Bluetooth/wireless earphones (May also use Wired earphones, but limits mobility)	WiFi/Internet

Tablet/ Computer	Phone (when logged into Zoom via computer, change audio to phone and dial number; be sure to tell carer to enter Participant ID that pops up on their screen; this prevents dual audio login from phone and computer and that annoying never-ending screeching echo)	Wired	WiFi/Internet (Phone may be minutes/data)
Phone	Phone (using Zoom app or call the parent if volume is not working through Zoom)	Bluetooth/wireless earphones (May also use Wired earphones, but limits mobility)	WiFi/Internet (via app) or may use minutes/data
Tablet/ Computer	Phone (call the parent after coding, hold phone up to ear)	None (This should be a temporary solution, in the event that for *that session* the parent cannot locate their headphones)	WiFi/Internet (via app) or may use minutes/data
Tablet/Computer/or phone	Tablet/Computer/or phone (using Zoom app)	None (If parent does not have a headset and you feel comfortable with the child hearing your coaching, you can coach out loud)	WiFi/Internet (via app) or may use minutes/data

Section 3: Consent, Assessment, and Tech Considerations

Consent and Intake:

I-PCIT considerations

- If your consent is usually obtained in person, to learn how to obtain consent see the previous section on Informed Consent in Section 1 above. Technologies to use to obtain informed consent include:
    - Adobe fill and sign
    - DocuSign
    - RedCap
    - Qualtrics
    - Verbal Consent that the clinician documents/records
- Review PCIT consent via screen share
- Review PCIT telehealth consent (if you have a separate telehealth consent) via screen share
- Assess to make sure the parent understands both consents, and answer any questions related to consent
- Set expectations for who will be in the room at each session. Make a plan to have siblings occupied during sessions (e.g., using screen time, game, novel toys, another caregiver).
- Make sure space is set up for confidentiality and privacy (no other non-consented adults present – e.g., nanny, grandmother).

Unique Challenges Related to COVID-19

- There are several resources that can be incredibly helpful when communicating to families about COVID-19. With Dr. Robin Gurwitch's guidance, PCIT International has provided some helpful resources to the PCIT Community.
- In addition, it is recommended that Providers review resources related to Psychological First Aid. There are several free training resources and an App available.
    - **WHO- Briefing note on addressing mental health and psychosocial aspects of COVID-19 OutbreakVersion 1.0**
    - **Psychological First Aid Online Course**
        - **Note:** Be patient when clicking on this link. So many people are accessing this resource that it is taking longer for the page to load than normal. The link is not broken!
    - **Psychological First Aid App**

- Check in about new stressors early and often. Potential questions to ask are:
    - How are kids staying busy during the day/how are they accessing educational materials?
    - Did families receive resources through the school that are now difficult to access (e.g., meals)?
    - Basic life needs check-in.
- How to ensure that children are otherwise occupied while appropriately supervised during intake interview
    - Ideally watched out of earshot in another room by another caregiver or older sibling
    - If parents have a sliding glass door or large window they can also step behind/outside the door so that the child cannot hear them but they can continuously supervise the child.
    - Parent should be wearing headphones
    - If the child has headphones to watch movies (e.g., on a plane, in the car) they can wear those during session

Completing Assessments and Homework

- ECBI assessment options
    - Mail paper original copyrighted forms to families and have them fill them out, send in pictures to score
    - https://www.pariconnect.com/ Send ECBIs digitally (downside is that individual answers are not paired with the wording of the questions in the score report, so you need a paper ECBI to reference)

ECBI Item Responses

Item	Intensity response	Problem response	Item	Intensity response	Problem response
1	4	Yes	19	1	No
2	3	No	20	6	Yes
3	4	Yes	21	1	No
4	4	No	22	5	No
5	2	Yes	23	3	Yes
6	1	No	24	3	No
7	2	No	25	5	Yes
8	4	Yes	26	1	No
9	2	No	27	4	Yes
10	5	Yes	28	3	No
11	5	Yes	29	5	Yes
12	6	Yes	30	2	No
13	2	No	31	3	No
14	5	Yes	32	2	No
15	3	Yes	33	2	No
16	2	No	34	2	No
17	2	No	35	3	No
18	1	No	36	1	No

Note. Range is 1 (Never) to 7 (Always).
"—" indicates a missing response.

    - RedCap/Qualtrics - Administer ECBI and then attach/file paper measures later to account for copyrighted versions
    - Administer over the phone
- Discuss with parents when they will be most likely to complete assessments - usually the night before session or that morning. Schedule assessments to be sent then.
- If parents do not complete assessments before session, log in and help them access the assessment and recommend they complete them before the beginning session. While flexibility is needed during COVID-19, completion of the ECBI as regularly as possible helps guide treatment tailoring and allows more effective progress monitoring.
- Homework Sheet Completion Options (keep in mind what types of communications the parent consented to and the relative privacy limitations of each method listed below)
    - REDCap or Qualtrics - Homework can be sent connected to the ECBI so parents are expected to complete them at the same time
    - Fillable PDF that parents are expected to submit before session
    - Excel Sheet or secure Google Sheet that tracks homework week after week to be able to track trends in one place. Parents would email prior to each session.
    - Parents can print the homework sheet and send a picture to the clinician
    - Clinicians can send a reminder to complete homework when they send an email with the ECBI to be completed
    - If not completed before session, share screen with the family and complete the homework sheet with them as you would complete a paper version in the clinic

Tech Session

Ideally before a session when you will see the family with their child in tow, you want to schedule a “tech” session with the family. This is a 15-20 minute (or as long as it needs to be to get the tech right) videoconferencing session in which the clinician works with the family to make sure that:

- The family can access the link for session
- They understand how to access the assessments and homework
- Family and therapists can hear and see one another from the room where play will take place
    - If the video is choppy, have the family try different rooms. Sometimes the reception may be better in one room than another
    - Complete a video walk-through with the front-facing camera and identify potential hazards or distractions for sessions. Some objects may need to

be put away during session or temporarily stored during session if space allows.

- The family has a place to prop the video device that will allow for optimal viewing of the parent-child play
    - Get creative with how to prop up the video device
        - Stand a phone up between two books or other objects that are heavy enough
        - To get it to tip forward if placed on something high, may need to have the phone or tablet leaning forward onto something so that the camera faces downward into the play area
        - Some play areas may require the device to be placed on the ground so that the clinician can see, particularly if the parent needs to use wired headphones. If this is the case, make sure the parent sits in between the child and the device whenever possible.

Pretreatment/Intake DPICS

I-PCIT considerations

- Ensure that the family has the correct toys for DPICS - send the list from the CDI Teach ahead of time or this supplemental list provided by Steven Kurtz, and spend time at the end of the first intake session and beginning of DPICS session ensuring that the toys in the room are appropriate.
- Have the parent scan the room with the camera on the device so you as the clinician can make sure there are no DPICS-inappropriate toys in the room - remove if there are. Ask parent where other toys in the room are stored in case the child is likely to try to access other toys during the play.
- If the parent does not have appropriate DPICS toys, just document this deviation in your note and explain that it was due to COVID-19.
- Whereas families who come in person for DPICS have an understanding of the situation we are trying to create for I-PCIT sessions, families who only participate via telehealth do not. Providing a picture of the setup for an I-PCIT session/DPICS could be helpful so that the family understands why we are trying to have video and audio the way we explain and what floor play space we are trying to create. This picutre could be used as an example:

- Make sure the child will stay in the room - ideally choose a room that is closed-in rather than a room with an open plan.
- If the child is likely to try to leave the room, have the parent sit against the door during play (if your agency allows) or if child has no history of trauma
    - For young children, a door knob cover/child safety cover could be put on the door so that child is not able to flee the room

Unique challenges related to COVID-19

- Some families may have preferred coming to the clinic because they lack a variety of toys at home. Therefore conducting telehealth DPICS may require sending the family toys if that is in your clinic's budget, or improvising with other things around the house - empty bowls or containers, coloring with pencils and pens, etc.
- Families may be using a wide variety of combinations of devices for video/audio. Plan to spend extra time on a technology consult prior to the DPICS session to make sure the devices work together effectively. Having the child occupied in another room during this time can make this most efficient and avoids the problem of the child getting bored with the DPICS toys before the assessment has started.

Section 4: Child-Directed Interaction Considerations

CDI Teach

I-PCIT considerations

- **Before the session:**
  - Make sure parents (and therapist!) have toys available for role-play
  - Send parents handouts in case parents prefer to print them before session
  - Consider using “share screen” feature to display the handouts if that will help aid the presentation and discussion of the content.
  - Make sure children are otherwise occupied in an activity that will take the whole hour
- **To complete the role-play:**
  - If DPICS was recorded, show the child-led play video from DPICS to have the parent describe and praise what the child is doing
  - With a two-parent family, have the parents take turns role-playing as the child and the parent
  - Tip the camera so the parent can see your toys in your environment and play together to have the parent describe your play as you would in the clinic.

Unique Challenges Related to COVID-19

- If one caregiver needs to supervise other children during Teach session, you could record the session so that this caregiver can watch afterward. Alternately that parent could call in with a “phone audio only” option from a different device to at least listen during the session.
- If one caregiver needs to work during the day while the other is working from home, parents could either videoconference in from different locations or reschedule for a different session time when both could be home
- Discuss option of special time via Zoom/other video conference if a caregiver is quarantined (isolating from other family members) but healthy enough to practice PRIDE skills while their child is playing in another room.
- Children may have additional adults (aunts, grandparents, adult siblings) caring for them for longer periods of time due to school closures. Sharing PRIDE skills handout with these caregivers or considering inviting them to join a coaching session via Zoom is one option to promote use of skills across caregivers.

CDI Coaching

I-PCIT considerations

- **Structural:**
    - Make sure that toys in the room are appropriate for special time. Sometimes the parent will have taken out toys that are not appropriate despite all of your preparation. (e.g., swords for a sword fight, dodgeball, painting, bats (it is baseball season), board games, etc.)
        - Ideally we want parents to critically assess whether those toys are appropriate for special time by asking them pointed questions, including:
            - *Do you think you can avoid using questions and commands while playing _____?*
            - For rough play: *Do you feel like you can ignore if he gets rough with that toy? (e.g., Can you ignore if the ball hits the wall?)*
            - For a game: *Do you feel like you can ignore if s/he wants to play the game a different way? If she does not follow the rules can you ignore and continue the play?*
            - Ideally have the parent remove the toys that are not appropriate for special time from the room to decrease the need for directive statements or conflict during the session.
            - The parent can let the child know they can play with the other toys (i.e., games, active) **after** special time
            - I find that it helps to remind parents that we are trying to optimize the environment to be as easy as possible for learning the PRIDE skills and avoiding questions, commands and criticism.
        - Therapists have also found it successful to tell the child which toys we use during special time, giving the child examples and even explaining that there are some toys that make parents want to give them commands/tell them what to do, so we want to find toys that will help them (the child) be the leader
    - Minimize distractions
        - Play in a room away from other family members if at all possible. If not possible, make sure other family members are engaged in something that is not distracting to the child (e.g., sibling doing homework, another parent reading)
        - Remove pets from the room
        - Make sure that parents understand that special time means the child gets their full attention, so anything else that needs to be

done (e.g., folding laundry, cleaning, cooking) should wait until after session.
    - **Safety hazards need to be removed** (drinks, rolling chairs, outlets, hot water, fragile or breakable objects such as lamps, television sets, sharp corners of furniture should be covered, bookcases should be anchored to wall)
    - Secure the doors (this keeps the child safe by ensuring he/she cannot run out during session)
    - Consider physical placement of parent and child to optimize the space (have parent sit with back facing the door or other temptation such as a toy closet)- **if your agency allows this**
    - Try to have siblings occupied if possible doing something that will take most of the hour (e.g., playing a quiet game, doing homework, watching a movie, supervised by another caregiver, etc.)
    - Instruct family to have all equipment charged and all materials ready to go at least 1 hour before session and set up at least 15 minutes prior to start of session
    - Have the child use the bathroom before session
- Before coaching:
    - Make sure the parent **completes the ECBI**. Wait until they have completed it to complete check in or coaching. Though some flexibility in ECBI completion is warranted given the current COVID-19 situation, ECBIs should be completed as often as possible to track treatment progress. The therapist should explain that they need to see how the child's behavior differs from the week before, so they know what to focus on during session.
    - Make sure the parent **completes homework**. If the parent has not completed and submitted the homework, share your screen, open an electronic homework file (e.g., fillable PDF) and complete it with them.
    - Just like you would during the first CDI coach session, explain to the child the purpose of the parent wearing the headphones/earbuds so that the child understands the necessity of the parent keeping them on during play. This can be a very brief conversation and similar to in-person sessions, the child typically moves on as soon as the parent starts playing with them.
    - **Ensuring that the parent completes the ECBI and homework sheet before the session begins, shows parents that the sessions have a consistent structure. Modeling this consistency and structure helps parents to increase their own consistency and appropriate structure, both important goals in this treatment.**
- **During coaching:**
    - Give parent quick feedback about whether you need a different camera perspective/angle. Examples:

        - "The camera fell, so when you have a chance please turn it back to where it was."
        - "I don't know if you realized, but your video turned off. Can you still hear/see me?"
        - "[Child] moved to a different place in the room so I can't see him anymore."
        - Then always provide the parent with positive feedback about the new camera angle and thank them for adjusting. That positive feedback helps to take the frustration out of telehealth for the parent.
    - Children should not have access to the tablet/computer/phone
    - As a reminder, in 2 parent families the other parent could log into Zoom on another device and then mute the mic to observe. They can join the meeting using the phone only option to preserve wi-fi bandwidth
    - **Audio Problems:** For the audio connection with some families, there is about a quarter-second lag between you speaking and them hearing you. This makes it difficult to provide quick corrective feedback. If this persists, have the parent sign into the session with a phone as well, and switch to the phone audio. Below are some potential strategies to cope with this quarter-second lag problem if it emerges:
        - In these cases, provide corrective feedback to *groups* of DON'T skills instead of correcting each individual DON'T skill (e.g., "Remember when you say 'Look,' that is a command. You could ____ instead.")
        - Rely more on providing supportive/responsive feedback and ignoring inappropriate parent behavior during session.
        - Alternatively the therapist may occasionally need to be directive and give the parent a command or the therapist may need to anticipate something instead of coaching in the moment. For example, "When he comes to sit next to you, what praise could you give for that behavior?"
        - Provide major corrective feedback at the end of one session, and remind parents at the beginning of the next session about what was discussed.
        - If audio problems persist, conduct another tech set up session to troubleshoot as the therapist cannot provide the most effective treatment if they are constantly only able to provide partial coaching.
- **Coaching nuances:**
    - Reflections are sometimes more difficult for the therapist to hear and coach, as the child is often more difficult to hear than in the clinic

        - Solution: If the parent says something out of the blue after the child spoke, and it was spoken as a statement and not a question, coach it as a reflection
    - The parent has many more opportunities for real-life labeled praises of positive opposites in telehealth, so in telehealth introduce this concept much earlier than you would during in-clinic treatment. Example statements for parents to use:
        - "Great job coming back into the room." (after the child left for a moment, claiming he was going to get a snack)
        - "Thank you for sitting next to me" (after spinning around the room for 2 minutes)
        - "I love that you came back to play with me." (after the child looked at his fish tank for a few minutes, ignoring the parent playing)
        - "I love when you play calmly with the toys" (after the child has been climbing on furniture)
    - Behavior descriptions are sometimes harder for the therapist to coach because the therapist sometimes does not have a great view of the child's actions. It helps to instead use this to your advantage to get the parent to use more behavior descriptions. Example statements for therapists to use:
        - "I can't see him, what is he doing?"
        - "It looks like he's doing something with that box." (i.e., describe very vague and most parents will describe in more detail if they can see what the child is doing)
        - "I see he picked up a crayon, but I can't tell what he's doing with it."
    - For imitation/engagement, make sure ahead of time that there are enough of each toy so the parent and child can both play without the child feeling possessive of his/her toys
- Check-out:
    - Turn therapist camera view back on
    - It helps at this point to also give the child some positive feedback like you would when you went back into the room in the clinic
    - Then help the parent structure the environment so that when they speak with the therapist, the child is still engaged in an activity. The therapist should continue to coach the parent to utilize intermittent PRIDE skills to maintain the child's attention on the activity while the parent is talking to the therapist. For example, "Thank you for playing so nicely with Mr. Potato Head over there while I talk to [Therapist Name]."
    - Share screen with parent to show them their growth in CDI skills and change over time on the ECBI
    - Encourage the parent to continue to praise positive opposites by pointing out those you can observe from your limited view

Managing Dangerous and Destructive Behavior During CDI in I-PCIT

These suggestions are adapted from guidelines from Cheryl McNeil and Nancy Wallace for in-clinic strategies for these behaviors)

- **Important:** If you see behavior headed this way (e.g., child is escalating and becoming frustrated because the parent is early in CDI and perhaps being overly critical or issuing many commands) in coding during telehealth, it is often the better clinical strategy to sacrifice coding and help the parent navigate away from that behavior for that session. Future sessions will provide more opportunities for coding.
- If the child does something physically dangerous (e.g., climbing, running out of the room, self-injurious behavior)
    - Prevention is your best friend here. Remove anything from the room that will be a trigger for dangerous behavior like climbing. If needed take all chairs and low furniture out of the room.
    - Coach the parent to physically move the child if the behavior is dangerous.
        - Emphasize that the parent should provide no verbal attention (e.g., avoid saying “stop climbing on there! I’m going to get you down!”) while they are moving the child.
    - Ideally find a way to eliminate the danger (e.g., remove the chair from the room, close the door so the child cannot escape the room)
    - Then redirect the child by coaching the parent to block the dangerous behavior, play on their own enthusiastically until the child rejoins, and then look for praises that can be used when the child returns to play or at the very least returns to safe behavior
- If the child is destroying property (e.g., throwing a chair, breaking a toy, writing on the walls)
    - First, coach the parent to issue a warning statement - “If you write on the table again, the crayons will have to be put away.”
    - The next time the property is misused/broken, the toy is removed.
    - Then the parent should immediately redirect to a toy that is very different to the one that was prompting destructive behavior before
- If the child is aggressive toward the parent *or anyone else in the vicinity* (e.g., pet, sibling, other caregiver who wander in)
    - *In the clinic we use a swoop and go time out room. This strategy may be effective for some children. Particularly those who are aggressive toward their family members on a regular basis, where parents need a concrete strategy for managing this aggression. This procedure is described below.*

        - Have the parent say: “That hurt me. If you hurt me again, I will take the toys and wait outside the room.”
        - Right after you coach the parent to give this warning statement, begin to prepare them for what they will do if they are hit again
            - Does anything need to be removed from the room to make it safe?
            - Right after the next time the child hits, you want coach the parent to give the statement “You hurt me again so now I need to take the toys and wait outside the room.”
        - If you plan to use this strategy, it should ideally be planned ahead of time with the family, and you should explain the rationale to the family ahead of time. If you are unable to explain the timeout room strategy in advance, then you will want to explain this strategy to the parent as they are waiting outside the room for the child to calm down. Remember, families have not had the full time out room explanation yet (because they are in CDI), and you have not walked them through the timeout room procedure like we usually would in PDI. So, providing an explanation for what is happening is importnt.
        - Re-enter the room only after the child is quiet for 5 seconds (after 1 minute)
        - Child does not receive another warning that session for aggression. If s/he hits again, the parent leaves the room immediately.
    - For the majority of children in telehealth, the most feasible strategy for responding to aggression will be to end the play, which is what we coach parents to do when they practice special time at home on their own. If the aggression happens early within the session, then the therapist may want to re-introduce special time after the child calms down. The parent can still be coached to praise positive opposites (e.g., using gentle hands, keeping hands to self). Once play is ended due to aggression:
        - For the remainder of the session, coach the parent to ignore the ensuing tantrum, and praise any positive opposite behaviors that emerge as the child is calming down.
        - Coach the parent through consistency and standing firm, as this time after ending the play when the child is still upset will be most tempting for the parent to resume play with the child to alleviate the tantrum
        - Coach the parent to redirect their own attention to an activity they enjoy or needed to do (e.g., work if the parent is working from home you can have the doing their nails, reading a book, cooking)

Unique Challenges to CDI Coaching Related to COVID-19

- Additional siblings may now be in the home that were not there previously
    - While having multiple siblings in the home is not as controlled as a clinic setting, this gives therapists a really nice glimpse of what the family's typical life is like.
    - If multiple caregivers are available, have them take turns caring for the other children.
    - If only one parent is available, at a minimum attempt to help the parent to get the other children to engage in a separate activity at least during DPICS and CDI coding. This allows the therapist to at least assess progress on a weekly basis.
    - Consider scheduling sessions when the non-target sibling typically naps.
    - While it may not be possible to keep other siblings from joining the play for an entire coach session, structure the environment for success if the sibling needs to join the play.
        - Have the parent sit in between siblings. This allows for the parent to more easily mediate any conflict that may arise between siblings. This also makes it easier for the parent to provide visual attention to both children, which may make it easier to distribute PRIDE skills to both children.
        - By sitting between children, parents have more opportunities to praise sharing and taking turns as the children may be more willing to share with their parent than their sibling during these interactions.
        - Focus CDI coaching on behaviors that you would want to see happen more frequently between siblings (even if the child's behavior is directed at the parent). For example, consider coaching on some of the behaviors below:
            - Speaking nicely
            - Keeping hands to self
            - Taking turns
            - Working together on an activity
            - Waiting your turn
            - Sharing toys
            - Offering to help
- Homework with parents who are quarantined or parents who are isolating because they are healthcare workers or frontline responders:
    - Zoom/videoconference with child from a different room/location like parent would do during vacation apart from child
    - Keep toys in the location with the parent until they come out of quarantine, and disinfect thoroughly before bringing them home.

Clinical Decision Making Related to Starting PDI

Consider some of the following factors when deciding whether to transition to PDI in the I-PCIT delivery context:

- PCIT International has provided some helpful resources to the PCIT Community that may guide decision making related to starting PDI.
- Possible clinical considerations for PDI Transition in addition to CDI Mastery to weigh when doing I-PCIT (or even regular PCIT for that matter):
    - How is the family's attendance rate?
    - How is CDI homework completion?
    - Does caregiver effectively use strategic attention?
    - Are PRIDE skills generalizing throughout the day?
    - Does the interaction seem warm and genuine?
    - Does the child enjoy Special Time?
    - Is caregiver responsive to coaching?
- Will therapist and family be flexible to move down on the PDI Staircase if PDI not going as expected?
- Consider certain factors especially likely to be made worse by the COVID-19 crisis:
    - Parent life stress
    - Employment, housing, and food insecurities
    - Can others within the household handle screaming and yelling if conducting their own work (e.g., schoolwork, work video conference meetings)

Section 5: Parent-Directed Interaction Considerations

PDI Teach

I-PCIT considerations

- Before session: Send parents PDF handouts for session so they can print them out if they want
- Plan with parents which chair they will use and which room they will use.
    - Have them *show you* the chair.
        - Make sure the chair is heavy enough. *We once had a parent insist on using a camping chair despite being warned of the dangers of using a light chair. The child subsequently put a hole through a wall with that same chair. Pick wisely.*
        - Not a swivel chair or chair on wheels.
        - An adult-sized chair (not a child-sized chair).
        - Preferably a chair without arms (as children may got caught underneath chair arms if they perform chair gymnastics)
        - Typically a kitchen chair will suffice.
        - If there is no appropriate chair available, as a last resort parents could use as towel, blanket, or tape to mark of a “timeout square” that they could use for a timeout procedure. A chair is highly preferred though.
    - Have them *show you* where they plan to place the chair. It needs to be placed:
        - Away from breakable objects
        - Away from glass doors
        - Not facing the television or other media device that is entertaining
        - Away from siblings or caregivers who may be home
        - In a place free from distractions
        - Out of reach of toys the child might like.
- Have parents show you the proposed time out room and brainstorm how to make the room safe and boring for the child
    - Turn dresser around so drawers are not accessible
    - Remove toys
    - Lock cabinets
    - Turn off water in sink at source (if sink is in the timeout room)
    - Remove toilet paper from a bathroom if used as time out room space
- May need to consider changing the play room to make it closer to the room to be used as a time out room.

- Consider the swoop and go option because it is a less complicated option for conducting PDI
- Discuss where other caregivers, siblings, and pets will be during PDI practice
- Prioritize the camera view that is most important:
    - When parents have multiple devices available and appropriate bandwidth, they could join with both devices which would allow for playroom view and time out room view. While not necessary, this can be a unique help.
    - Make sure that the device has an appropriate protective case on it and is up and away from the child if possible.
    - Switch iPad or phone into guided access mode, which can prevent the child from exiting the session without the right passcode (https://support.apple.com/en-us/HT202612)
- **PDI Teach Role play:** have a chair you can use for time out in the family's identified therapeutic area, and have toys available to practice with the parent.

PDI Coach 1

I-PCIT considerations

- Explaining PDI to the Child
    - Speak to the child directly through the iPad before the parent turns on Bluetooth, or through the headset, using the script in the PCIT Protocol (usually for children ages 4-7 - this is preferable)
    - Coach the parent to explain PDI to the child using the script in the PCIT Protocol (usually for children ages 4-7, and with parents who are able to explain the protocol without changing the explanation you are telling them over the earpiece)
    - Coach the parent through the Mr. Bear (or Mr. "whatever the animal type" is available) procedure using a stuffed animal they have at home (usually for children 2-3 or children who are more developmentally delayed)
- Time out chair is in place before session
    - Sturdy, adult-sized chair
    - Ask: What would happen if the child tried to throw the chair, or tip it?
    - If no chair is available, parents can use a mat or rug so that it is a defined space.
- Time Out Back-up room (check this again on the day of the session. Things that may have looked fine the week before or during a consult session may have been moved or changed since that time).
    - Safety hazards removed (open windows, outlets, rolling chairs, beverages, hot water, fragile or breakable objects such as lamps, television sets; bookcases should be removed unless anchored to wall)
    - What types of breakables/valuables are in the room? Do they need to be removed?

    - Which way does the door swing? Can the parent place his/her foot in the door safely? It is ideal if there is a way to view/monitor the child while in the back-up room without potential for the child to escape.
- **Equipment**
    - Does Bluetooth work if caregiver walks out of the main room used for session and down the hall towards the timeout room?
    - Can a second device be set up in the back-up/timeout room (e.g., iPad high up on a shelf)?
    - Make sure devices are charged and that charger cables are readily available in the event of a long time out.
    - With two caregivers, is there an additional device that the caregiver who is not being coached can use to observe in a room away from the time out chair and room?

Unique challenges related to COVID-19

- Having a plan for occupying other siblings for longer than usual given the possibility of a long first time-out.
- If that is not available, develop a plan for praising siblings for staying away from the child in timeout and/or ignoring the child in time out.
- Assess parents' ability to commit to a longer session for a first time-out given that they may be working from home or have others in the house who are working from home. Discussing this possibility ahead of time and changing the time of session as needed to accommodate their schedule may be necessary
- Making the decision to assign homework in a time of crisis and high stress is difficult:
    - Assess whether parents are ready to handle the stress of PDI homework. If they are, consider having the PDI consult after the first PDI practice to check in and assess whether continued PDI practice is appropriate. If not, recommend that they only practice PDI during session until the child's time out behavior has de-escalated somewhat
    - Consider PDI role play practices that the parent can complete with a second parent or another adult so that they can work on memorizing the sequence based on the child's responses.

PDI Coaching

I-PCIT considerations

- Ensure parents already have everything set up at beginning of session, and if they do not, then take the time to have them set up timeout chair and room up

before the session begins. Even if this means only one parent practicing commands during the first session, that is fine.

- If using another device for the session, have parent keep their phone in a pocket in case the call drops during the time out process or they walk out of bluetooth range and cannot hear your coaching.
- **Transition statements are critical:**
    - Make sure parents introduce PDI practice and consequences of practice just like you would have them when they are practicing PDI in the clinic.
    - At end of session, the therapist can issue an additional "We are done playing today, but I loved how well you learned to listen" statement.
- Typically, parents issue/repeat several ineffective commands at a time, or issue multiple effective commands without correct follow-through. **FOCUS YOUR COMMENTS AND CORRECTIONS ON JUST THAT FIRST COMMAND THAT NEEDS CORRECTION.**
    - For example, remind the parent of the first command, and then have them assess if the child complied. *If the child complied, coach the parent to provide labeled praise for listening.*
    - If the child did not comply and the parent has since issued too many extra statements for a warning to make sense, *first* review the sequence with the parent. For example, “Remember after we give that direct command *Give me the block,* we want to wait those five seconds quietly until he does the command, and then give the warning if he doesn’t before giving a new command.” *Then* coach the parent to give the command again, and then *right* after they’ve given the command, praise them for waiting quietly as well. It should look like this:
        - Parent: “[Child name], give me that block.”
        - Clinician: “Perfect direct command, great waiting, 2, 3, keep waiting, 4, 5, now give the warning statement. If you…”
        - Parent: “If you don’t give me the block you will have to sit on the time out chair.”
        - Clinician: “Great job with that warning, nice staying quiet while you’re waiting, 3, 4, 5…”
- Some children are more reluctant to demonstrate noncompliance to play commands during I-PCIT than in the clinic
    - We rely more on what the parent is telling us during I-PCIT, but for compliance it is important to see what the child is doing, because some parents tend to give children the benefit of the doubt (i.e., that they are moving toward compliance). This is why patterns of noncompliance exist in the first place, so you want to be able to see if the child is listening to coach the parent to give the warning statement and the time out statement. Don’t be afraid to “overrule” the parent and say something like “It does not look like he is listening. Go ahead and issue the warning statement.”

    - Some parents will be reluctant to put their children in time out. Be directive about telling them to give the time out warning, and if they don't issue it before the child complies, then allow them to move back into CDI. If they start giving the time out statement (e.g., "You didn't do as …" and the child complies) then be directive with the parent about still putting the child into time out.
        - After the sequence is completed (either the child is through the time out, or the child has complied), then you can provide more detail (but still not too much) about the rationale for why you coached specific things, particularly if you needed to be very directive (e.g., "Remember you need to avoid saying anything between the command and the warning because it distracts him from the command.").
    - You can move to real life commands more quickly and more realistically during I-PCIT, because there are so many real-life home situations you can observe and coach. These include:
        - Brushing teeth
        - Getting ready for bed
        - Homework
        - Transitioning to bed (e.g., turning off technology, putting it away)
        - Cleaning room
- Checking in with parents during time out and time out room is vitally important.
    - A major challenge here is that you cannot always see the parent to know how they are responding to child behavior.
    - Whenever the child does something disruptive on the chair
        - If the parent says something, remind them to stay silent and then remind them why with whichever explanation resonates most with the parent:
            - If the parent is annoyed by the behavior, explain that ignoring will decrease the behavior, pointing out how the child does the behavior more when the parent talks about it.
            - If the parent is worried about the child's emotional state, explain that if they provide attention when the child is on the chair, it makes it confusing for the child. The child then thinks that sometimes they will get attention for talking, and it will take longer for them to get quiet and be able to leave the chair. In other words, the parent is setting the child up for success by staying quiet and looking away because they are communicating clearly that quiet is how the child gets what they want.
            - If the parent wants to explain excessively to the child, explain that when the child is distressed, they cannot

"hear" the parent's explanation for behavioral expectations. Have the parent reflect about how they communicated the expectations for listening effectively (i.e., the time out procedure) as well, but the child did not listen because verbal instructions are not as effective at managing behavior as consistent behavioral consequences

- If the parent stays quiet, immediately praise them for ignoring and for staying strong, validating that time out is not an easy process, but reiterating all of the amazingly valuable lessons they are teaching their child by staying strong and silent in that moment. Provide frequent labeled praises for:
  - Staying quiet
  - Looking away (if you can see this)
  - Ignoring (as long as the parent is not making noise)
  - Staying out of arms' reach of the time out chair

- When the child is in the time out room, check in with the parent. Ask how they are doing with the process. Ideally ask if you can speak to them so you can see them, but this may not be possible due to the parents' need to guard the door - s/he may not be able to get the video device as well.

Unique challenges related to COVID-19

- Additional caregivers working from home - may need to change time of session or have conversation with both caregivers to optimize the time of coaching
  - Parents may need to only practice on the weekends or at specific times of day when other caregivers are not working and will not be disturbed.

Public Behavior

I-PCIT Considerations

- Coach parent through public behavior session virtually using parent's smart phone
- Or meet the parent in public somewhere (not possible during COVID-19 pandemic but otherwise feasible)
- Or have the parent come to the clinic for this session (not possible during COVID-19 pandemic but otherwise feasible)
- Or role play through a public scenario if coaching in public is not feasible.

Unique challenges related to COVID-19

- Families cannot go to most public places, with the exception of going for walks outdoors.
- Option 1: Practice public behavior during a walk around the neighborhood/block (if allowable) respecting the local rules about masks and distance.

- Option 2: Brainstorm with parents about the particular strategies they would use (e.g., labeled praises, behavioral expectations, specific direct commands, ways to keep kids occupied) in a variety of settings after being allowed out of social isolation. Have parents record these plans to use in the future.

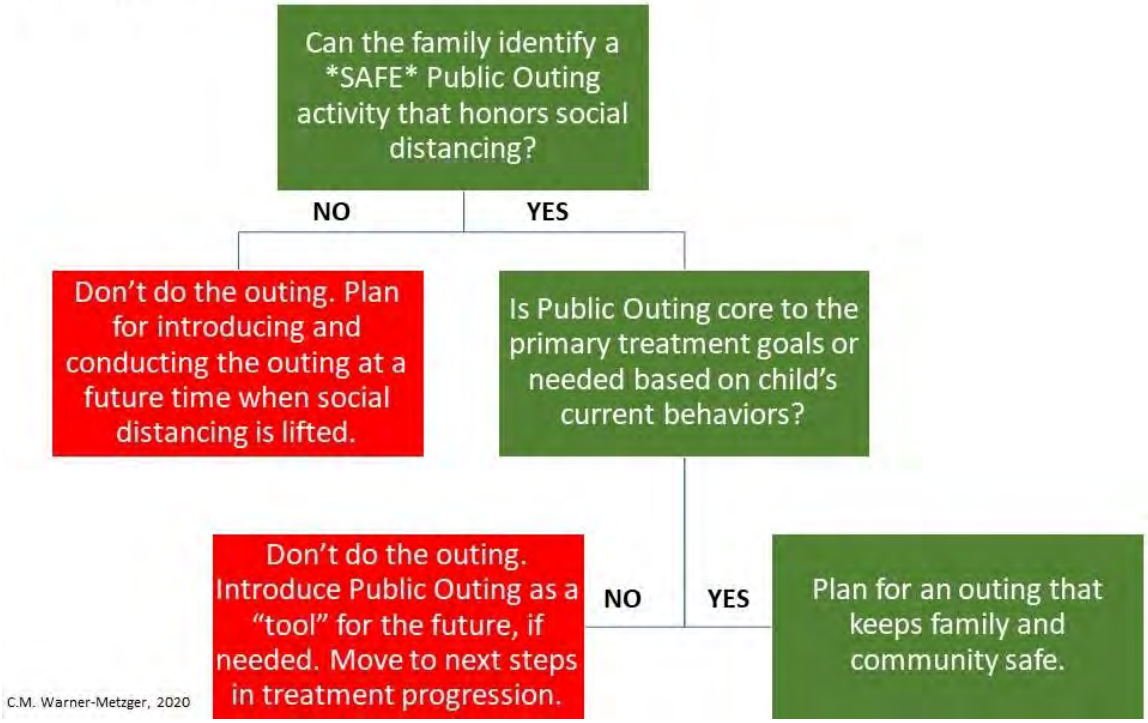
The following is Public behavior advice directly from PCIT International Global Trainer, Christy Warner-Metzger.

- The overarching goal of the Public Outing is to **apply PDI skills in an environment that is less structured than the household**, therefore allowing further generalization of skills. It is an opportunity for the parent to communicate clearly to the child that PCIT goes where you go, regardless of venue or occasion. While Public Outing often includes a social component (e.g., going to the grocery store or the park), an important delineation is that "public" in this sense *does not necessarily mean* "social." It's possible to walk around the block, and not interact with anyone else. Particularly in these times of social health concerns restricting social contact, in order for parents to conduct a Public Outing presently, they need to remove the "social" aspect of that outing. In other words, strategies taught in the Public Outing session are skills that will be helpful in managing behavior outside of the home, and in the future perhaps in social outings.
    - With the overarching goal of Public Outing being generalization of skills outside the home, a trip outside the door is practice. Some of the examples below are places to start where families can begin to generalize skills but avoid social contact with others.
        - Practice commands outside in the yard/patio/enclosed private outdoor area
        - If the client lives in an apartment building, take a trip downstairs and upstairs, either via the stairs or the elevator
        - Walk to pick up the mail (or get it from the apartment mail room)
        - Help take out the trash
        - Practice complying with commands during a brief car ride (may need to start just in the driveway, practicing getting into the car and sitting with seat belt on)
        - Walk around the block while following social distancing recommendations
    - In a rural area and limited in options for public outings? Some might consider a country walk, but before doing so, ascertain:
        - Is this a gravel road (where traffic tends to go much slower) or a paved country highway (which translates often to a race track)?
        - Are there safe outlets off the road (can I easily walk into the field next to the road, or will I have to jump a hazardous ravine)?
        - Is this an activity that the family typically does and/or are comfortable doing safely?
        - Would a walk through a field or into the forest better accomplish an outing safely?

- Another overarching goal for Public Outing is **understanding rules for safety**. This applies doubly in our current state of public health during the COVID-19 crisis, as we not only have the broad safety expectations during typical times of 1) follow the caregiver's established physical boundaries/limits, 2) keep your hands to yourself, and 3) do as the caregiver says, but also these expectations are *even more important* in times of social distancing.
    - The questions to ask your families for determining if now is a reasonable time for them to conduct a *safe* Public Outing might be:
        - What activities do you feel safe and comfortable doing outside of the house at the current time (and that are within your local, state, and federal guidance for social distancing)?
        - Is Public Outing one of the areas that the caregivers identified as one of their primary treatment goals for PCIT (i.e., from intake, they said that getting their child to listen in public was a primary treatment goal)?
            - If not, and if the child's behavior has been well-managed in public recently, then a review of the Public Outing procedure may be adequate and presented as something to keep in the toolbox.
            - If Public Outing is a primary treatment goal and there is a safe mechanism for the outing, then you can proceed to plan the Public Outing. Good news is telehealth makes it easy to join the family on their outing!
            - An alternate option may be to teach parents about the strategy for the Public Outing now before the stay at home orders are lifted, and offer the option of a planned booster session to address Public Outings more thoroughly once parents can again engage in social activities that may be more difficult for the child.
        - Can they practice safe hygiene before, during, and immediately after the outing?

- In the end, the resounding take-home should be: **public health is more important than a Public Outing right now.** So if there is not a safe and reasonable mechanism for conducting an outing, then it should not be done.
- And I know we sometimes end a Public Outing (or Adventure, as we call them in our clinic) with a social reward, so here's a good one to use (thank you for the share, Robin Gurwitch): Wash Your Hands

Socially Responsible
Public Outings
during Times of Social Distancing



Section 6: Graduation Considerations and Summary

Making decisions about graduation during a pandemic

- Family stressors are constantly in flux during this pandemic.
- Many caregivers are losing their jobs, certain caregivers have become more unavailable because of increased social isolation/distancing, and some caregivers will suddenly be present in the home but unavailable to the child because they are quarantined to prevent the spread of the coronavirus.
- Parents are working right now to manage their own worries about the unknowns in the current situation, as well as helping their children maintain a routine and somehow also complete all of their online learning despite huge changes in software and accessibility.
- We have no clear guidelines for how long families will need to be living in this state of stress and uncertainty.
- However, as practitioners we also know that continuing therapy indefinitely does not bode well for long-term independence using the skills learned in treatment. **So how do we balance the concern for the client's ability to manage their child's behavior among shifting stressors, and our need to help them to graduate from PCIT so we can serve more families?**
- There are no perfect answers here. Instead, we offer the following list of things to consider as you decide whether to graduate families during this time.

  Things to consider:
  - Is the family connected with any other services? Are other vital services available for the family at this time?
  - Will the family be able to maintain their progress given the stressors they are experiencing due to social isolation?
  - Is this family likely to experience new stressors that will impact the family dynamic or greatly increase family stressors (e.g., loss of job may lead to eviction, family conflict may lead to physical conflict, etc.).
  - Can you offer an in-person booster session for when social distancing is lifted?
  - If social distancing stays in effect for a longer period of time, can you offer a booster session via I-PCIT?

Section 7: I-PCIT Training and Co-Therapy/Supervision Options:

Training Considerations:

- Please see the resources that PCIT International has provided for getting started with I-PCIT. This link provides additional telehealth training guides, equipment set-up guidelines, YouTube training, downloadable resources related to the PCIT International protocol and COVID-19. Specifically, see the **I-PCIT and Training** section in this document as a theoretical framework for conducting mentorship or live supervision consistent with PCIT International practices during these times of COVID-19 response.
- In particular, it is highly advised that supervisors and trainers spend time simulating common problems that can occur during I-PCIT. Simulation of these activities before service delivery can make real I-PCIT sessions run much smoother because therapists are more ready to respond **when** these issues arise.
- Example simulation Activities are below:

Simulation
Parent cannot connect to Zoom meeting
Parent audio is not working once the connect to Zoom meeting
The walking tour of the home
Rooms with distractions
Rooms with breakables
Setting up the camera angle based on the equipment that the family has (Mount for equipment; No mount for equipment)
Bluetooth headset is not charged before session
Setting up and starting a co-therapy session
How to handle two parent families via I-PCIT as it relates to coaching and observing the other parent practice
There is another child home and only one parent

Having a supervisor provide live remote video observation
Ensuring parent has correct amount of toys for Pre-Post DPICS and Coach sessions
Child keeps running off screen
Prepping the space for PDI (Time out chair/space; best angle for PDI)
When the child goes off camera during time out or time out room
Tech issues in the middle of coaching
Children with ASD and related disabilities -transitioning to a new set-up

Co-Therapy/Live Remote Supervision Options:

- *Each agency needs to review the types of consents that parents sign and the level of electronic communication that can occur. Text messaging and/or electronic chats are less secure and the parent should be made aware of any potential privacy limitations if these communication methods are going to be utilized.*
- Determine ahead of session who will be the lead therapist for:
    - Check in/check out
    - Coaching both parents
- Discuss with co-therapist how they would prefer you to contribute to coaching support. Depending on independence level of co-therapist, ask if they would like you to contribute spontaneously, or warn them ahead of time when you will coach directly.
- The pacing of your feedback as a supervisor during session should not be so overwhelming that it negatively impacts the flow of coaching because the therapist is too distracted by your feedback statements.
- Therapists who are less experienced may need more frequent feedback/coaching.
- Provide overarching feedback when parents are switching places and there is a minute or two of down time.

Option 1: Phone Coaching Support

- The supervisor/coach/co-therapist mutes their audio and keeps their video off during coaching within the video conference.
- Outside of the video conference session, the co-therapist/supervisor calls the therapist. The therapist would wear a single bluetooth or headphone so that they can receive live coaching feedback from the supervisor. Benefits of this include the clinician receiving more live feedback, which enables them to more quickly change their coaching of the parent. Unfortunately live coaching can also be overwhelming for some clinicians, and including another method of technology increases the likelihood of technological glitches interfering with the session. This option is also often unavailable if the clinician needs to call the parent during the session.
- As a worst-case scenario, the therapist and/or supervisor can let the family know during the session that they are going to pause coaching to have a brief discussion and then the therapist mutes their audio for the video conference call. Make sure that this does not compromise coaching/support of the family. Coaching should always take precedence over trainee coaching, and your trainee can always receive feedback after the session during supervision and video review.

Option 2: Private Chat Coaching Support within Video Conference or Encrypted Text Messaging System (e.g., WhatsApp)

- Utilize **Private** chat on Zoom (i.e., **only** shared with the other therapist) to provide feedback and statements to coach them.
- Alternatively, the therapist “hosting” the Zoom conference can set the chat settings to “Host Only” or “No One.”
    - The “Host Only” setting allows chats only from participants (i.e., supervisor and family) to the hosting therapist, although caregivers should be advised not to use the chat function.
    - The “No One” setting disables chat from participants to the hosting therapist.
- If possible, turn off the chat for families so that they cannot access it.
- Ensure you are not typing anything you would not be comfortable with the parent seeing.
- Make comments vague and coaching related.
- Please note that Zoom chats are not HIPAA compliant with appropriate encryption, so consultant/supervisor chat to the therapist should avoid using Protected Health Information (PHI).

- Depending on your video conferencing software, some chats are available for everyone to see or can include private chats. There are potential risks in the treatment process related to the use of the chat beyond privacy. These include:
    - The therapist types something inappropriate in the chat.
    - The parent prefers one therapist over the other so only sends chat messages to the preferred therapist.
- Alternatively, a chat system *outside* the video conferencing system may be used. Again, avoiding PHI is highly recommended combined with vague or coaching-related comments if this chat option is selected.

An Example of a Zoom (or Instant Message) Private Chat between Supervisor and Therapist:

Scenario: This was a Zoom Chat at the end of CDI coding. The cat had gotten into the room and the child picked it up despite the parent's protests.

Therapist: What do you want to do about the cat?

Therapist: Ignore?

Supervisor: I would ignore for now

Therapist: I'm ignoring the question tip up

Supervisor: you can do some child observations, that might help too. "He's building a tower."

Supervisor: He's putting the blue pieces together

Supervisor: good ignoring

Supervisor: if he leaves [the cat] on the floor, praise leaving her there

Supervisor: how can she get his attention without saying look

Supervisor: and he said he was going to build one too! (this was observed as the therapist did not hear it)

Supervisor: great child observations

Supervisor: instead of telling him what to do, notice what's happening - that helped her redirect

Section 8: Take Home Points and Summary

- Given the time of high parental and child stress, services like PCIT can make a huge impact on our communities, even decreasing child risk of abuse.
- As PCIT Therapists you are providing an invaluable resource to families. You are helping families establish consistent responding, routines, and positive parent-child interactions during a time where many other routines and activities are either completely on hold or are inconsistent at best.
- With COVID-19, many people feel a complete lack of control. PCIT can provide parents with the opportunity to feel like they have the ability to have more control in one aspect of their lives.
- All parents will have different levels of willingness/ability to engage in telehealth. Parents who are better at using technology are usually more willing to engage in treatment online, but that doesn't mean that parents with no ability cannot engage. They just may need more flexibility and support until they feel comfortable.
- Most therapists are new to this. Parents are new to this. Learn together and express calm when working with them to complete the session. You don't have to be confident at first, but if you keep calm, you and the family will get through PCIT services together.
- When something goes wrong technologically, move on quickly. The problem will not go away on its own and the family will likely be looking to you for a solution, so try multiple solutions until the view of the family and the sound is good enough to complete a session. It doesn't have to be perfect. *You always want to optimize coaching time over everything. If you can hear, and the parent can hear well enough to coach, start coding and coaching.*
- As you learn new and effective strategies for delivering I-PCIT services, be willing to share those tips with the broader PCIT community. Most of the guidelines in this document were developed through a collective effort of PCIT clinicians and trainers sharing their wisdom with one another. We view this guide as a starting point. As technology advances and more and more clinicians gain experience with I-PCIT, we expect that this guide can become even more robust.