

**Initial Training Course in**

**Parent Child Interaction Therapy (PCIT)**

Interactive online course

sponsored by the

University of Florida Department of Psychiatry

**Application Form**

**Contact Information**

Agency Name/Address:

Clinician Info:

|  |
| --- |
| Name:  |
| Title: |
| Telephone Number: |
| Degree/Certifications: |
| Email Address: |
| Fax Number: |
| Mailing Address: |
| Primary Role: (Select one[[1]](#footnote-1).) [ ]  *Clinician* [ ]  *Supervisor*  [ ]  *Program/Clinical Director*  [ ]  *Other, specify role*:  |

Names of Other Clinicians applying from your agency and their roles:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Description of Agency, Team, Implementation Plans, and Experience**

1. Overall, what types of populations are served at your agency (e.g., age ranges, diagnostic populations, racial/ethnic populations, SES, etc.)
2. In the past 6 months, about how many children between the ages of 2-6 years have been referred to you for treatment?
3. In the past 6 months, when treating a client between the ages of 2‐6 years, about what percentage of your caseload was spent providing:
	1. Individual Child Therapy: \_\_\_%
	2. Family Therapy with the child present: \_\_\_%
	3. Family Therapy without the child present: \_\_\_%
4. In the past 6 months, how many clients/patients between the ages of 2‐6 years have been referred to you for treatment of child disruptive behavior specifically? \_\_\_\_
5. In the past 6 months, what has been the length of an average course of treatment for a child in your practice, assuming successful treatment completion?

[ ]  1-5 sessions

[ ]  6-10 sessions

[ ]  11-15 sessions

[ ]  16-20 sessions

[ ]  21-30 sessions

[ ]  31-50 sessions

[ ]  More than 50 sessions

1. In the past 6 months, what has been the rate of clients failing to successfully complete treatment (e.g., the drop‐out rate)for your caseload or agency as a whole?

[ ]  Less than or equal to 25%

[ ]  Between 26 and 50%

[ ]  Between 51 and 75%

[ ]  Between 76 and 100%

1. What do you consider to be the most common reasons clients/patients drop out of treatment prior to completion?
2. Please rate your comfort level in adhering to a manualized, evidenced‐based practice:

[ ]  Very Uncomfortable

[ ]  Somewhat Comfortable

[ ]  Unsure

[ ]  Somewhat Comfortable

[ ]  Very Comfortable

1. Please list any evidence‐based practices you currently use in your clinical practice, regardless of whether they are child/family focused.
2. Please describe your personal experience with PCIT or other parent training programs including trainer, location, training date, and duration.
3. Please list any other clinical training programs in which you are currently enrolled or that you will be involved in during the timeframe of this PCIT training curriculum (January 2019-April 2020).
4. What do you hope to achieve by participating in this training?

**PCIT is a fast‐paced model requiring the therapist to respond to parent and child behaviors in the moment. Review the following two video segments:**

[**Link to Video 1**](https://youtu.be/jwaDyIIGYbU) **|** [**Link to Video 2**](https://youtu.be/2yxnzPv6h-Q)

**After viewing the video segments, please answer the following questions:**

1. Based on your review of the video clip what are the components that you find most interesting?
2. Based on your review of the video clip what are the components that you find most concerning?
3. Based on your review of the video clip, please indicate your overall comfort level in learning to deliver this model:

[ ]  Very Uncomfortable

[ ]  Somewhat Comfortable

[ ]  Unsure

[ ]  Somewhat Comfortable

[ ]  Very Comfortable

1. Does your agency have in place appropriate space and equipment for providing PCIT?

A childproofed therapy room and separate observation room with either a two‐way mirror or video monitoring. [ ]  Yes [ ]  No

A communication system (e.g., speaker system, in‐room phone, baby monitor, bug‐in‐the‐ ear) that allows the therapist (in a separate room) to speak in real‐time to the parent during parent‐child interaction **and** hear the parent‐child interaction. [ ]  Yes [ ]  No

Capacity to record sessions (and other materials) for review by trainers? [ ]  Yes [ ]  No

Policy for sharing clinical information (e.g., session videos) with trainers? [ ]  Yes [ ]  No

Capacity to participate in online teleconferences via website or mobile app (i.e., computers with webcam and microphones, tablets, etc.)? [ ]  Yes [ ]  No

If these resources are not in place, please describe your agency’s plan to obtain this space and equipment prior to the beginning of the Initial Training Course.

1. Clinicians participating in the training are expected to ***begin providing PCIT approximately 3 months into the Initial Training period.*** Who will identify and screen clients to ensure that they are appropriate for PCIT treatment? When will the process of identifying and screening begin?

**Expectations (Please initial each item to signify understanding and agreement.)**

***All Clinicians will:***

* Participate in completion of PCIT assessment activities including completion of clinical assessments/measures as introduced through the training for children receiving PCIT throughout treatment.
* Attend all training teleconferences and complete any assignments to prepare for training calls.
* Submit necessary videos for skills reviews including role plays and session videos.
* Participate in the training evaluation including completing questionnaires (e.g., to provide feedback about the training experience) if requested.
* Provide PCIT to a minimum of two clients during the consultation call period, with both cases begun within the first six months of training onset and two cases completed before the conclusion of consult calls.

Please elaborate on any challenges in agreeing to the conditions above and proposed solutions:

**Agency Directors or Management will (Please initial each item to signify understanding and agreement.):**

* Hold team members accountable for training participation and implementation of the model, including initiating cases and participating on scheduled calls and administration and submission of data for each PCIT client seen.
* Ensure that all team members have the necessary support to participate in the training, including time to attend all training meetings; regular access to and use of email and the Internet; video recording equipment and capability; and time, materials, and support from agency leadership necessary to implement the PCIT model and attend scheduled calls. This includes sending videorecordings of PCIT sessions with clients to trainers at the University of Florida for training purposes.

***Note:* This training will help participants prepare for**

**eligibility for national certification in PCIT. All decisions regarding certification are made by PCIT International, Inc.**

Date application reviewed and approved by Authorized Agency Director: \_\_\_\_\_\_\_\_\_\_\_\_

Signature, Printed Name, and Title of Authorized Agency Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Submit this application along with your CV to Ms. Monica Brook:*** ***monicaross@ufl.edu***

*Confirmation of receipt of this application form will be sent to your contact person within two business days. If you do not receive this confirmation, please email or call Monica at monicaross@ufl.edu or 352-265-8853. Once initial review of applications is completed, selected participants will be scheduled for a follow up online interview in order to determine appropriate fit for training, discuss potential barriers, and finalize participant group.*

 *Thank you for your interest in our PCIT Training Program!*

1. To check a box, double click on the box and select *Checked* under *Default value*. [↑](#footnote-ref-1)