Illinois Department of
DCFS
Children & Family Services

Illinois Family *First*
Prevention Services Act Manual

February 2024 (updated)

Section 1: Introduction

Overview

This manual provides an overview of the Family First Prevention Services programming in Illinois. The information provided here is designed to support staff in the implementation of the program and application of the information acquired in training in your work with families. This manual focuses on prevention programming including the use of Motivational Interviewing by staff.

Introduction

The federal Family First Prevention Services Act (PL 115-123; Family First) provides an unprecedented opportunity for jurisdictions to implement preventive services aimed at strengthening and supporting families and preventing removals to foster care. Illinois is leveraging the opportunity to mobilize and broaden the array of evidence-based parenting skills, substance use disorder prevention and treatment and mental health services; and strengthen and improve the ability to engage families as active partners in identifying and meeting their own needs.

By maximizing the use of existing evidence-based resources and building upon the system's capacity to engage families, the state will not only build a continuum of care that provides comprehensive and coordinated support to families to prevent them from entering the child welfare system, but also reinforce the family-centered, trauma-informed and strengths-based approach to engaging families that has been implemented over the last 10 years. In partnership with Child Welfare Contributing Agencies (CWCA), sister state agencies and local community networks, the Illinois Department of Children and Family Services (DCFS) is building cohesive community supports and resources to help each child realize their potential and safeguard vulnerable families.

Together, we aim to reduce the stigma of child welfare involvement through a personalized approach to partnering with families that emphasizes sustaining and preserving family connections. Preventing foster care placements requires that all staff authentically engage and build trust and motivation with families and provide access to the evidence-based treatment the children and families need.

What is my role as a caseworker when a youth or family member is involved in a Family First intervention?

As a caseworker, you are the first-line resource for:

- Questions about the intervention.
- Concerns.
- Issues and needs that become barriers to participation.
- Monitoring progress and application of new skills.
  - During visitation.
  - On monthly visits.

Your role is critical to the success of the intervention!

The information that has been provided here gives you talking points when you are meeting with the family. This is not only important for getting them across the street, but also essential for supporting their engagement and successful outcomes. Having a bit of background information is key to asking about progress. It also helps to invite these providers to child and family team meetings to share information about progress and status.

Overview of the major components of the Family First Act

The Family First Prevention Services Act (FFPSA -P.L. 115-123) provides an unprecedented opportunity for system transformation as we work toward a vision of an Illinois where children, youth and families thrive. Illinois will leverage the Family First Prevention Services Act (Family First) to mobilize and broaden the array of evidence-based interventions for parenting skills, substance use disorder prevention and treatment and mental health services and strengthen and improve the ability to engage families as active partners in identifying and meeting their own needs. New options are available for states and tribes to receive 50% federal

reimbursement for services to strengthen families and prevent unnecessary placement of children in foster care.

Prevention services

Prevention services are eligible for up to 12 months of federal reimbursement for:

- Substance abuse prevention services.
- Mental health services.
- In-home parenting skills.

Improved quality of foster care

For those children who cannot remain safely at home, there are new federal policies to:

- Encourage and support kinship care.
- Decrease the use of unnecessary congregate care.
- Improve the quality of care for children for whom congregate care is appropriate.

Through critical partnerships between the private and public sector, we will:

- Challenge old norms around child welfare.
- Focus not only on preventing child maltreatment, but also on strengthening families.
- Develop multi-system collaborations for the biggest impact.

Background and overview of jurisdictional considerations related to Family First

System transformation efforts toward increased prevention of child maltreatment and foster care reductions

In the late 1990s, Illinois accomplished historic reductions in the numbers of children removed to foster care using a suite of strategically calibrated policies, fiscal levers and practices. These innovations began with the subsidized guardianship waiver (see following page), the standardization of front-end safety assessment with the Child Endangerment Risk Assessment Protocol (CERAP) and the intensification of preventive services. Recognizing that the child welfare system must constantly evolve to meet the needs of the families it serves, the department has continued to leverage funding opportunities, research partnerships and deep collaborations across all three branches of government to examine and refine its approach to identifying and responding to child and family needs. On the heels of this success, in the mid-2000s the department embarked on a coordinated strategy to incorporate brain science and accumulated knowledge on the impact of trauma to inform the development of a family-centered, trauma-informed, strengths-based (FTS) practice model that would incorporate new knowledge within a coordinated strategy to serve families, promote permanency and prevent harm to children.

Beginning in 2014, some of these strategies were piloted and evaluated rigorously in the context of "immersion sites," or specific regions that would serve to test a set of strategies aimed at improving child and family outcomes. These strategies included enhanced child and family team meetings (CFTMs), the operationalization of the FTS practice model and the implementation of a new model of supervisory practice. Immersion sites have allowed the department to learn not only about the impact of these strategies, but also important lessons about the sequencing, phasing and layering of interventions for successful installation.

At the same time the department's preventive program, intact family services, continued to evolve through partnerships with private providers and the incorporation of strategies that had positive effects in waiver demonstrations. Lessons learned through subsidized guardianship were incorporated in the Extended Family Support Program, which supports families in which children are voluntarily placed with relatives. The success of Alcohol and Other Drugs of Abuse (AODA) waiver's recovery coaches was incorporated into Intact Family Recovery, a service offered to a geographic subset of cases incorporating evidence-based recovery coach strategies into family preservation. Other evidence-based approaches have been incorporated by subgroups of providers, such as solution-based casework for engaging families in service planning, retention and the achievement of family goals.

While the intact program serves families following a child abuse or neglect investigation, other preventive efforts work upstream to meet the needs of families in communities prior to any child welfare system involvement. One of these efforts, family advocacy centers (FACs), provide local hubs for the delivery of concrete supports, linkage to community services and opportunities for peer support among parents in the form of Parent Cafes[1].

In 2019, the newly elected governor took an interest in front-end and preventive child welfare practices, commissioning a report to examine the effectiveness of these practices for ensuring child safety and identifying opportunities for improvement in the Intact Family Services program. In response to the report's recommendations, the department has identified, and is

[1]Be Strong Families (2018). Parent Café Evaluation summary. Retrieved on 9/28/19 from *https://www.bestrongfamilies.org/parent-cafe-evaluation*

in the process of implementing, a set of innovations that will streamline processes, heighten responsiveness and coordination and enhance the effectiveness of preventive interventions.

Illinois is a model of a successfully "privatized" child welfare system; that is, private provider agencies, incentivized by performance-based contracting and rigorously monitored by the department, partner to manage 80% of foster care and the majority of preventive cases and provide an array of community-based services. This partnership continually presents opportunities to accelerate innovation and broaden the preventive service array. In the context of Family First, DCFS's partnership with private agencies offers opportunities to engage a broad group of stakeholders as well as to build upon the success of numerous implementations and evaluations of evidence-based approaches.

Shift from Title IV-E Waivers to Family First implementation

The proposed transformation under Family First will build upon the progress made through existing IV-E waivers; namely, Illinois Birth-to-3 (IB3) and Alcohol and Other Drug Abuse (AODA), which were merged into a single waiver that also included immersion sites. IB3 is particularly relevant, as it provides local evidence of the effectiveness of strategies that target the needs of young children and their parents. IB3 supported the adaptation of evidence-supported, trauma-informed parenting programs to the care and permanency planning for infants, toddlers and preschoolers who were taken into DCFS's legal custody. The selected interventions, Child-Parent Psychotherapy (CPP) and Nurturing Parenting Program (NPP), were adapted to fit the needs of child welfare-involved children and are intended to support parents and caregivers in creating supportive, developmentally appropriate parenting environments. The IB3 evaluation found that children receiving the intervention achieved a rate of reunification or legal guardianship with biological and fictive kin that was 23% higher than children assigned to services as usual. At the close of the observation period, there was an estimated 7.8 percentage point difference between the likelihood of family unification in the IB3 Services group compared to Services as Usual. As a result of these demonstrable improvements in family reunification and other positive outcomes, Illinois will be expanding implementation of the Nurturing Parenting Program through its Family First prevention plan.

Subsidized guardianship

Illinois began providing options to caregivers of youth in care for subsidized guardianship, beginning with a Title IV-E waiver approved in 1995 and initiated in May 1997. By July 2002, the subsidized guardianship demonstration enabled more than 7,300 children to achieve permanency through subsidized guardianship. Based upon a historical comparison group that did not have access to the subsidized guardianship program, this policy increased permanent placements for children in child welfare by 6.4 percentage points and increased permanency rates without adversely affecting safety and well-being of those children in subsidized guardianship care (Children and Family Research Center, 2004).[2] Illinois plans to build on this history of offering subsidized guardianship by expanding its Extended Family Support Program and by working to ensure that children in subsidized guardianships at risk of placement disruption receive evidence-based program support for permanent placement.

Alcohol and Other Drugs of Abuse (AODA) Program

The AODA waiver supported the implementation and effectiveness evaluation of the use of recovery coaches (substance use workers), in tandem with DCFS caseworkers. This waiver program began in 1999 with

[2]Children and Family Research Center (2014). Subsidized guardianship and permanence – Policy brief. Champaign, IL: Author. Retrieved from *https://cfrc.illinois.edu/pubs/bf_20040801_SubsidizedGuardianshipAndPermanence.pdf*

a pilot in Cook County with family members with substance-exposed infants (including fetal alcohol syndrome). The initial evaluation findings showed an increased likelihood for family reunification and shortened time to reunification for the program participants vs. comparison group. The initial evaluation demonstrated the need to tailor services to family members with co-occurring disorders (comorbid substance abuse with mental health, domestic violence or housing needs). As a result, in the second waiver extension period (2007), DCFS added special mental health recovery coaches to the recovery coach teams, augmented assessment with domestic violence screening tools and expanded linkages with the DCFS housing advocacy office. Due to the importance of the timing of assessment and referral to treatment, DCFS added a mobile assessment component to the Juvenile Court Assessment Program to allow parents to be assessed who could not attend the temporary custody hearing. In Cook County, the use of recovery coaches with these additional support services showed a positive impact on time to family reunification as well as likelihood of reunification compared to the comparison group.

Based on initial success of the AODA waiver, the use of recovery coaches and supportive services expanded from Cook to Madison and St. Clair counties during the waiver implementation period (through 9/30/19). Illinois has also begun testing the effectiveness of integrated child welfare and recovery coordinator services in six Illinois counties (Boone, Grundy, Kane, Kankakee, Winnebago and Will) with four agencies partnering with the DCFS Intact Division. Family members with substance use disorders eligible for Intact Family Recovery (IFR) Services are participating in a five-year randomized controlled trial on the effects of this intervention.

Training

Subsequent to a pilot period for training and curriculum development, DCFS implemented a Title IV-E Training Waiver in June 2003 that allowed Illinois to expand training services to private child welfare agency staff, in addition to DCFS agency staff. A total of 130 private agency workers participated in enhanced training services, while 148 private agency workers were in the wait-list control group for enhanced training services. The evaluation did not show intervention effects for recurrence of abuse or neglect reports, likelihood of restrictive placements, reunification and time to reunification or likelihood of adoption or guardianship. The only intervention effect between groups was shown in shorter time to adoption among children served by staff trained through Enhanced Training services.[3] Subsequent to this training waiver, Illinois has reorganized its training delivery and expanded training delivery to child welfare staff in private agencies. Illinois partnered with the University of Illinois Springfield and Southern Illinois University Carbondale to develop, implement and evaluate simulation-based trainings for child welfare workers.

Other initiatives

The Illinois department of Healthcare and Family Services (HFS) built a statewide network of care coordination through the HFS HealthChoice Illinois program. The HealthChoice Illinois program consists of three care coordination programs throughout the state. Those three programs are: HealthChoice Illinois (HCI), YouthCare, the Medicare Medicaid Alignment Initiative (MMAI) and Integrated Health Homes (IHHs). These programs together provide community-based support and services to Medicaid eligible youth. Of the three programs, YouthCare is the program that is directed toward youth in DCFS care.

[3] Children and Family Research Center (2014). Subsidized guardianship and permanence – Policy brief. Champaign, IL: Author. Retrieved from *https://cfrc.illinois.edu/pubs/bf_20040801_SubsidizedGuardianshipAndPermanence.pdf*

YouthCare

YouthCare Health Plan provides physical and behavioral health, dental and vision care directed at Medicaid eligible youth in care that are under the age of 21. For more information on YouthCare visit: *https://hfs.illinois.gov/medicalproviders/cc.html*

Pathways to Success

The Illinois Department of Healthcare and Family Services (HFS) implemented the Pathways to Success program for Medicaid-enrolled children under the age of 21 in Illinois. This program focused on providing support to individuals under the age of 21 with complex behavioral health needs, as identified on the Illinois Medicaid Comprehensive Assessment of Needs & Strengths (IM+CANS). In 2022, HFS began working closely with DCFS to implement The Pathways to Success program at DCFS. HFS and DCFS are collaboratively spearheading the effort to enroll qualified youth in the Pathways to Success program. For more information on Pathways to Success visit *https://hfs.illinois.gov/medicalproviders/behavioral/pathways.html*.

Infrastructure supporting the implementation and evaluation of evidence-based practices

In response to a 2003 review of Illinois DCFS documenting ACYF concerns about inadequate efforts to meet children's mental health needs, the director commissioned a number of strategies including a pilot study of three evidence-based practices within the system of care program (currently named the Intensive Placement Stabilization – IPS program)[4]. This pilot served not only to demonstrate evidence for the effectiveness of trauma-informed treatment, but also to familiarize the department with the implementation of evidence-based practice that included managing fidelity, data collection, group assignment, recruitment, retention and training. DCFS selected three developmentally appropriate evidence-based practices (EBPs) for implementation with three different age-based populations: Child Parent Psychotherapy (CPP) for young children (0-6 years old); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for school-aged children (6-12 years old); and Structured Psychotherapy for Adolescents Responding to Chronic Stress for adolescents (12-17 years old). While implementation challenges varied by model and location, these EBPs were found to be feasible and effective with foster care populations, and the models were adapted and sustained for Illinois implementation. Further, the Northwestern study noted that "culturally sensitive adaptations were made to treatment approaches to improve client retention and outcomes" and it found "no racial differences in retention in the program and no differences in outcomes between minority youth exposed to the intervention and other participants." (Weiner, Schneider & Lyons, 2009, p. 1199)[5].

As previously discussed, the IB3 waiver also supported implementation of two EBPs (Child-Parent Psychotherapy - CPP and Nurturing Parenting Program - NPP), which demonstrated positive impacts

[4] Illinois Department of Children of Children & Family Services (2004). State of Illinois Department of Children and Family Services – Child and Family Services Review Program Improvement Plan. Chicago.

[5] Weiner, D. A. Weiner, D. A., Schneider, A., & Lyons, J. S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth: Treatment retention and outcomes. Children and Youth Services Review, 31(11), 1199-1205. *http://dx.doi.org/10.1016/j.childyouth.2009.08.013*

on relevant child welfare outcomes for participating families. Lastly, from November 2016 to March 2019, 43 pregnant and parenting youth in care participated in Healthy Families Illinois (HFI) home visiting services.[6] Chapin Hall Center at the University of Chicago conducted an implementation evaluation of this pilot program using program data collected from home visitors and doulas; interviews with home visitors, doulas, supervisors and young parents; and analysis of child welfare administrative data. Illinois will continue to expand the utilization of Healthy Families through Family First.

DCFS' experience with implementing EBPs with child welfare involved children, youth and families provides a foundation of implementation experience for Title IV-E prevention planning and implementation with children, youth and families at imminent risk of coming into care. Illinois' approach to selecting evidence-based interventions for its Family First Prevention Plan is to build from existing state capacity with various EBPs, taking into consideration Title IV-E Clearinghouse ratings on those EBPs.

Cross-system infrastructure to support prevention services

Illinois' prevention services approach will rely heavily on inter-agency collaboration to enhance service provision. DCFS continues to participate in ongoing dialogues with its sister human service agencies to coordinate these efforts. Among several ongoing forums for these discussions is the Human Services Partnership Committee. This collaborative convenes leadership from state agencies under the Department of Human Services (DHS) umbrella, the Department on Aging and the Illinois State Board of Education. (ISBE). DHS agencies represented include: Division of Substance Use Prevention and Recovery (SUPR), Division of Developmental Disabilities, Division of Family and Community Services (DFCS), Division of Mental Health (DMH) and Division of Rehabilitative Services. Many recipients of DCFS programs such as Temporary Assistance to Needy Families (TANF); Women, Infants and Children (WIC); and Supplemental Nutrition Assistance Program (SNAP) are involved with child welfare services. DHS funds Healthy Families Illinois, which implements the Healthy Families program with new and expectant parents. For the purpose of Title IV-E prevention services planning, DCFS will continue to coordinate closely with the Early Learning Council, particularly as it relates to Healthy Families, to expand the delivery of home visiting services.

Another important cross-sector and public-private partnership involves the department's participation in the Early Learning Council (ELC) in serving the 0-5-year-old population. Among the many charges of the ELC is improving the quality of and access to evidence-based home visiting programs for families and increasing coordination between home visiting programs at the state and local levels. DCFS will continue to work with the ELC, particularly its Home Visiting Taskforce, to coordinate management, policy and practice needs for the Family First expansion of home visiting services to a larger segment of at-risk families and pregnant and parenting youth in care.

As described above, family advocacy centers (FACs) also offer an opportunity for prevention through service provision and linkage. Family Advocacy centers are community-based agencies located across the state of Illinois that partner with many other community and government agencies and have comprehensive networks with their own local areas. They work with families who are involved with the child welfare system and with families who have never been involved. In doing so, they extend the reach of intact prevention services by accepting referrals for aftercare when intact and Division of Child Protection (DCP) placement cases

[6] Dworsky, A., Gitlow, E. & Ethier, K. (2018). Evaluation of the Home Visiting Pilot for Pregnant and Parenting Youth in Care: FY 2018 Preliminary Report. Chicago: Chapin Hall at the University of Chicago.

close. They also accept caseworker referrals and referrals from investigations whether there was an indicated or unfounded finding. In FY22, FACs served over 8,501 families including 11,389 children. There are 16 FACs in Cook County, five in the Northern Region, eight in the Central Region and four in the Southern Region. A generalized expansion plan includes both new and current centers for a family advocacy center presence in 51 counties in Illinois. New in 2022 is the initiation of DCFS Alumni Drop-In Centers for former foster care youth up to age 30 and support for the Extended Family Support Program (aka kinship navigator program) providing support for family members who have taken on the role of caretakers for children to prevent their entry into the child welfare system.

FACs each develop their own network of local providers in their community; enhancements to the approach are planned to include a wide range of social services available through different entities including the state, county and municipal agencies. Mental health, medical care and education are other areas of consideration. Many agencies have community liaisons through which they enhance their networks. Specifically, FACs have already begun to work with the WIC local area offices to promote co-referrals between the two programs. At the end of this initial five-year plan, FACs have a goal to have liaisons in not only the local FAC areas but in an extended network that includes every local DCFS field office. Establishing and maintaining these local networks will be key to preventing involvement or re-involvement with the department. Please refer to Appendix C for the Proposed Five-Year Plan for Family Advocacy Centers.

Stakeholder consultation and coordination in the planning process

Since August 2018, more than 300 stakeholders have participated in Family First committees to learn about the implications of the legislation and contribute to the design of programming in Illinois. This list of participants includes community-based providers, DCFS leadership and staff, researchers and policy advocates. From August 2018 to March 2019, eight committees worked on planning and design for the implementation Family First provisions. These groups included: Prevention, Intact Family Services (IFS), Residential & Congregate Care, Licensing, Data & Performance, Financial & Federal Compliance, Legal & Policy and Technology. Illinois conducted an initial survey of providers in the fall of 2018 to gather baseline information about the provision of evidence-based practices (EBPs), implementation of child and family team meetings (CFTMs) and delivery of trauma-informed services. In a similar approach, participants conducted analyses of statewide provider capacity from data available in the Service Provider Identification & Exploration Resource (SPIDER) online database (please refer to Section 3 for more information). More recently, in the summer of 2019, DCFS solicited feedback from agency administrators delivering intact family services

(IFS) and supervisors of IFS caseworkers to gather in-depth understanding of service coverage and gaps in parenting education, substance abuse treatment, mental health treatment and domestic violence services to support planning and implementation of EBPs for this population. Lastly, DCFS has established a Family First communications liaison and has partnered with Casey Family Programs to engage birth and foster families, foster youth alumni and family members in learning about opportunities under Family First and participate in planning.

Target populations

1. Children being served by:
   - Intact Family Services.
   - Intact Family Recovery Services.
   - The Extended Family Support Program (EFSP).
2. Children in:
   - Recently reunified families (within the last 6 months).
   - Adoptive families.
   - Families who obtained subsidized guardianship or are relatives.
3. Pregnant and parenting youth in care and pregnant and parenting youth who recently aged out up to age 21.

Vision for transformation

The Illinois Department of Children and Family Services envisions a transformed child welfare system with a strategic framework that recognizes:

- Families are the drivers, identifying their own goals and the customized, evidence-based interventions and supports that will help them meet these goals.
- An understanding of the impact of past and present trauma, systems of oppression, racial inequities, environments and experiences informs all interactions with families.
- Cohesive communities have the resources and capacity to support families and take collective responsibility for doing so.
- Efficient technology and effective communication create streamlined and clear processes that minimize the barriers to families seeking and receiving help.
- Front-line staff are prepared with a broad array of tools, information and knowledge to consistently assist families in accomplishing their goals, navigate complex systems and minimize additional involvement at any stage of their child welfare system involvement so that we can:
  - Promote longstanding consistent connections among children and adults.
  - Reduce the stigma around needing help.
  - Enable seamless, prepared transitions between levels of care when needed.
  - Realize each child's fullest potential and safeguard vulnerable community members.

Alignment of the vision for transformation with the DCFS mission

This vision extends the department's work, already underway, to ensure safety, deliver permanency and promote well-being within its family-centered, trauma-informed and strengths-based model by enhancing the department's ability to:

- Protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them.
- Provide for the well-being of children in our care.
- Provide appropriate, permanent families as quickly as possible for those children who cannot safely return home, including supporting kinship caregivers and exploring guardianship and adoption.
- Support early intervention and child abuse prevention activities.
- Work in partnerships with communities to fulfill this mission.

Vision for congregate care transformation

The Family First Prevention Services Act focuses on child welfare system changes in prevention, as noted above, and system change related to congregate care. We aim to reshape the system culture to view congregate care as a time-limited, focused treatment intervention with a purpose and outcome to support youth pathways to permanency and youth living in family homes. We will do so by:

- Transforming the continuum of placement approaches as well as the practices of providers, caseworkers and caregivers to provide more effective interventions.
- Acknowledging the risk inherent in serving youth with high service needs in community settings and generating additional placement resources that provide intensive services in more family-like settings.
- Requiring and supporting congregate care treatment providers to plan for transitions and remain engaged in post-discharge linkage to community resources.
- Requiring and supporting caseworkers, foster parents and families to remain engaged with youth while they receive treatment interventions in congregate care settings.

We believe this will increase the effectiveness of congregate care interventions, shorten lengths of stay, promote successful transitions between settings and promote engagement and longstanding connections between children and helping adults.

For more information on Illinois child welfare congregate care practices and procedures visit *https://dcfs.illinois.gov/about-us/ffpsa.html*

Why assessment matters

In keeping with our commitment for individualized, holistic, culturally appropriate services, we must conduct thorough assessments in order to engage families, allow them to share their stories, communicate their needs and make appropriate plans to effectively meet identified needs. Assessment is a core practice of the DCFS Core Practice Model.

> *"We go out and listen to stories no one wants to endure. The fact that we listen to these stories, bear witness to them and acknowledge and validate the people telling them is a huge part of our job that has never been captured in our official job description. We listen to the stories no one else will hear. But the important thing is not that we listen but how we listen. We listen to validate their pain and simultaneously acknowledge their resilience - the "keep on keeping on" of everyday life. That resilience gets lost in the crap of daily problems and our job is to remember it, keep it alive and honor it." [p 11].*

Overview: Intact family services population

This section will focus on assessments, giving particular attention to the largest population served by Family First, intact family services.

The statewide population referred to intact family services:

- Is relatively diverse.
- Has many young children.
- Has had varying types of adverse traumatic experiences.

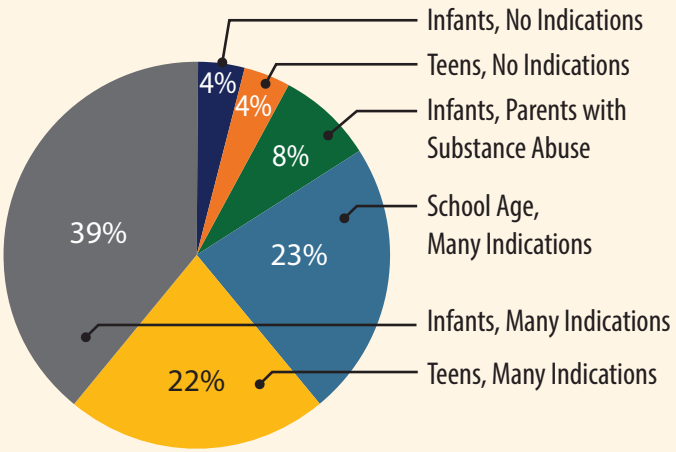
When we review the data on this population, the following is known:

- One fourth to one third of IFS children are in families with low social support.
- About one-third of IFS children are in families with environmental/financial barriers.
- Nearly half of IFS children are in families with deficiencies in parenting skills.
- Nearly half of IFS children are in families with substance misuse.
- Nearly half of IFS children are in families with mental health diagnoses.
- Nearly half of IFS children are in families experiencing domestic violence.
- More than one third of IFS children demonstrate a need for services themselves.

It is important that you look at this data with a keen eye. Even in high prevalence needs where nearly half of the population experiences a need, another half do not. It is the responsibility of our professional staff to make these determinations thoughtfully using information revealed during the assessment period. Our statewide data highlights the need for:

- Cultural proficiency.
- Early intervention.
- Developmentally appropriate care and services.
- Trauma-informed approaches.

6 Sub-Population Classes in Intact Family Services



The critical role of the CANS

The Child and Adolescent Needs and Strengths (CANS) tool is used for communication between parties in the case and to inform action and decision making for children and their families. All members of the child welfare system that are case-carrying should be trained in the valid use of the CANS.

Decision support: What model should I use?

What is a Decision Support Tool?

All the evidence-based interventions that are available can be hard to remember every time you open a new case. We have built behind-the-scenes support that is driven by your scoring of the CANS to help you match the child or family member with an evidence-based intervention that would best meet their needs. The Decision Support Tool will look at the scores you enter for each individual and give you recommendations of resources to discuss with the family and link them to providers. ***It's a tool that runs behind the scenes!***

Decision Support Tool = Recommendations

- For the Decision Support Tool to recommend services for a family, each individual member's relationship to the child needs to be identified correctly in the CANS.
- If a caregiver is assessed on a later date, the child(ren) must also be assessed for service recommendations at the time the caregiver is assessed in order for the caregiver to be eligible.

Because of the importance of the CANS to Family First Prevention Services, our IT team has built in some new tools in SACWIS to help everyone remember to complete the CANS by day 45.

- On Day 30 from case opening, if there is not an approved CANS in SACWIS, the caseworker will receive a reminder or tickler to complete the CANS.
- On day 45, if there is still a missing approved CANS, the caseworker and supervisor will receive alerts on their SACWIS desktop until the CANS is completed and approved.
- Remember, SACWIS only sees a CANS as completed once it has been approved by a supervisor, so allow enough time for you and your supervisor to review, approve and possibly edit the CANS prior to the 45-day deadline.

Making connections

Prevention services are most effective when children and families are identified and linked to holistic, appropriate services. This section will cover the process for getting families to needed interventions. There are many factors that the caseworker and their supervisor will take into account:

- Is the family motivated?
- Is the intervention really accessible to the family?
  - Consider distance & other transportation issues.
  - Health/mobility.
  - Community characteristics (safety, resources)
  - Are there costs involved (i.e. co-pays)?
- How does this intervention fit into the overall case plan?
  - Consider scheduling logistics.
  - Discuss work, childcare, school and other potential barriers.
  - Can all of these requirements be balanced in such a way that it is reasonable for the family to succeed?

Resolving the last issue (balancing the plan and the strategy to implement the plan) must be a collaboration with the family. We want to avoid service burden which occurs when all the time needs required for the family are not considered. If a family member succeeds in one step of the plan, their motivation is increased to persevere.

We describe this process as: ***Getting them across the street.*** This is a relationship-based partnership. The sheer number of needs can be overwhelming for the family and the professionals who serve them. Making lasting change requires focus and practice. This is why we create a team to support the family. Effective child and family team meetings are opportunities for planning and problem-solving that includes the natural support network. These important resources can assist with reminders, transportation and emotional support when needed.

What is trauma-informed practice?

For successful implementation of Family First, it's important to define trauma informed practice and evidence based interventions. Trauma-informed practice involves recognizing and responding to the impact of traumatic experiences on those who have contact with the child welfare system, including children, caregivers and service providers. Programs and agencies that work with individuals who have experienced traumatic situations must infuse and sustain trauma awareness, knowledge and skills into their organizational cultures, practices and policies to maximize physical and psychological safety, facilitate the recovery of child(ren) and families and support their ability to thrive.

For many of the youth that we serve, trauma can be poorly assessed and quickly ignored. The resulting behavioral concerns that are often linked to trauma can become the focus, leading to challenges for the child's healing and development. The interventions that have been adopted by DCFS for Family First can be effective in addressing a range of needs including trauma exposure.

For more information on trauma-informed care and trauma-informed child welfare systems: *https://www.childwelfare.gov/topics/responding/trauma/*

What are evidence-based interventions?

Understanding the impact of trauma and shifting our mindset to view families through a trauma-informed lens creates a more compassionate and effective approach while serving families using interventions that are known to be effective. Evidence-based interventions involve approaches to prevention and/or treatment that are validated by documented scientific evidence. This includes findings established through controlled clinical studies, but other methods of establishing evidence

are valid as well. Understanding the impact of trauma, along with providing the appropriate evidenced-based intervention to families, will lead to more positive and sustainable outcomes for children and their families.

Family First interventions

Illinois has selected the following evidence-based interventions (EBIs) for implementation in the first iteration of our Family First Prevention Plan. These interventions were selected due to a combination of their appropriateness for the populations served and the capacity of the state to implement these interventions efficiently and effectively using existing connections, contracts and resources. Below is a summary of each EBI.

Positive Parenting Program (Triple P)

Focus of intervention:

- The primary emphasis of Triple P is to teach parents how to enhance and build their relationships with their child while also addressing the child's emotional and behavioral challenges.
- Triple P is an educational intervention designed to support parents or caregivers of children from 6-12 years old. Triple P is an in-home approach which includes support in the office.
- Triple P is a skill-building approach that encourages the development of healthy problem-solving skills.
- Triple P guides families dealing with behavioral and emotional challenges such as: repeated difficulty following directions, aggression, "temper tantrums," difficulty maintaining emotional regulation and other behavioral concerns that cause disruption in the family system, school and community.
- Families learn how to monitor behavior and set specific, observable goals for change.
- Interventions are tailored to meet each individual family's needs, to support parental problem-solving and improvements in the child's behavior.

Benefits for families:

- Reduce behavioral, emotional and developmental challenges.
- Increase the family's capacity to develop positive coping strategies.
- Improve family relationships.

Duration of services:

- Illinois is implementing Level 4 Triple P, which supports families involved in the child welfare system.
- Typically requires 8-10 sessions over a span of 4-5 months.

What parents need to hear:

- Triple P is a parenting program that is designed to fit the needs of each individual family.
- Families are provided concrete interventions and guidance on how, when and where to use interventions. Triple P gives parents a roadmap to follow when faced with difficult behavioral and emotional challenges.
- The family is provided a "toolbox of ideas" and can choose the most effective tools for their family.
- Triple P builds parental confidence and enhances proactive interventions which prevent children's outbursts.

Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)

Focus of intervention:

- TF-CBT is a therapeutic intervention focused on helping children, adolescents and their parents or caregivers overcome the impact of traumatic events.
- This intervention involves supporting the child(ren), youth and family members to manage behavioral triggers while promoting a safe home environment.
- Caregivers are included in situations where they did not cause the trauma and when they are able to maintain child safety.

- Sessions engage child(ren), parents and/or caregivers together to treat the effects of trauma.
- In-home sessions cover a range of topics including education and parenting skills.
- Sessions may include joint time with the youth/ caregiver(s) and/or separate time with the youth, as well as separate time with the caregiver(s).
- Parents receive therapy to address their past trauma, triggers and stress reactions.

Benefits for families:

- Improve management of behavioral triggers.
- Increase parental understanding of trauma.
- Increase personal safety and encourage ongoing growth.
- Identify and resolve feelings of shame, distorted beliefs about self and other complications of trauma.
- Minimize harmful parenting practices.
- Support a safe home environment.

Duration of services:

- Services typically lasts 12 to 16 sessions; however, may be delivered in as few as eight sessions and as many as 25 sessions.
- Weekly sessions vary in length from 45 to 90 minutes.

What parents need to hear about TF-CBT:

- Parents often need to believe that young children will not remember trauma or that talking about it may make it worse. Typically, when problem behaviors arise, parents do not connect this to the trauma. Through TF-CBT parents will learn how to support their children to:
  - Understand the trauma was not their fault and they do not have to deal with the trauma on their own.
  - Identify and recognize their feelings.
  - Manage their emotions.
  - Tolerate reminders/triggers of the trauma through learning and using relaxation strategies.
- A goal of TF-CBT is to help identify negative and self-defeating beliefs to increase the understanding of how trauma has impacted the entire family.
- Parents can replace negative thoughts with positive affirmations and problem-solving skills to assist with creating a psychologically safe environment for the child.

Child Parent Psychotherapy (CPP)

Focus of intervention:

- CPP is a trauma-informed, relationship-based therapy focused on improving parent-child relationships and healing for children 0-5 years old who have experienced trauma.
- The child-caregiver relationship is central to support the child's recovery from early childhood trauma and for the child to restore healthy development.
- CPP is a play-based, attachment-focused intervention for both the parent and child that seeks to strengthen the parent-child relationship.
- CPP is designed for young children who are at high risk of developing emotional/ behavioral and attachment difficulties, as a result of early traumatic experience(s).
- CPP may occur in the family's home or therapist's office.

Benefits for families:

- Provides parents with developmental guidance.
- Provides concrete assistance with problems of daily living.
- Helps the caregiver provide both physical and emotional safety for the child.
- Helps caregiver interpret the child's feelings and actions and link past to present.
- Emphasizes that the past includes both risk and protective factors.
- Attends to family's cultural norms and values.

Duration of services:

- CPP recommends weekly sessions of 1 to 1.5-hours for 6 months to one year.

What parents need to hear about CPP:

- We know parents are the most important people in their children's lives.
- Emotional and behavioral problems in infancy and early childhood need to be addressed in the context of the child's primary attachment relationship(s).
- Despite the young age when trauma occurred, child development will be impacted by early childhood trauma.
- Child Parent Psychotherapy is an effective therapy to heal early childhood trauma exposure.
- Research has shown that early intervention and support for the parent-child relationship is an effective way to address and heal trauma for very young children.

Nurturing Parenting Program (NPP)

Focus of intervention:

- NPP is an intervention for parents that uses cognitive-behavioral groups and in-home parenting coaching and education.
- NPP supports families with children 0-19 years old to increase parents' sense of self-worth, personal empowerment, empathy, bonding and attachment with their child(ren).
- The goals of NPP are to modify beliefs that contribute to abusive parenting behaviors and to enhance parents' skills in supporting attachments, nurturing and healthy parenting.
- In-home coaching sessions help parents apply new parenting behaviors, enhance attachments and support nurturing skills.
- Trained staff provide support and linkages to educational, clinical and family support services.
- Parents will receive support to work on the areas of parenting that are the most difficult for each specific parent/family and will learn strategies for self-care.

Benefits for families:

- Help families develop alternative strategies to harsh disciplinary practices.
- Increase parents' knowledge of age-appropriate developmental expectations.
- Increase parenting skills to improve parents' sense of self-worth and effectiveness.
- Improves parental empathy, bonding and attachment with child(ren).
- Reduce the risk of abuse or neglect.

Duration of services:

- The model calls for 18-23 sessions.
- These sessions can be solely based on individual home-coaching or combine group sessions and individual home-coaching.
- Each group session is 2.5 hours.

What parents need to hear About NPP:

- NPP supports parents and caregivers in order to enhance parenting skills by using relationship-based interventions.
- NPP is an approach that focuses on bonding and attachment between parents and children.
- NPP provides parents with the support they need to address the issues that brought them to the attention of DCFS.
- The group format offers parents the opportunity to work on parenting competencies with other parents who have had similar experiences/challenges.

Multi-Systemic Therapy (MST)

Focus of intervention:

- MST is a community based, family driven intensive therapy. MST serves youth 12-17 years old.
- MST provides interventions for youth involved in the legal system, or who display aggressive behaviors, use substances, are truant and engage in behaviors that prohibits their growth.
- MST relies on highly trained and skilled therapists that work with each youth, their caregivers and other designated members who are a part of the youth's treatment system. This system can include: school personnel, court services, vocational support or other identified supports.
- The therapist provides support 24 hours a day, seven days a week. The therapist and treatment team develop productive solutions and strategies to help get the youth back on track.

Benefits for families:

- Promotes behavioral change by empowering families and caregivers to solve problems in lasting ways.
- Families have access to support ***24 hours a day, seven days a week*** through MST.
- The family works closely with a team who is invested in the best possible outcome for the youth.
- MST clinicians have small caseloads to support focus and give the required attention to youth and families when needed most.

Duration of services:

- The MST therapist begins by observing youth over a 1-3-week period and will then create an individual treatment plan.
- The process includes regular check ins with the family and the youth to see how treatment is progressing and if there are any challenges that need to be addressed.
- MST therapists provide ***1-2-hour sessions, 3-5 times per week***; treatment may continue for up to five months.

What parents need to hear about MST:

- MST sessions are tailored for each family and their schedule.
- MST therapists will meet families wherever necessary in the community (i.e., school).
- The therapist works with the family to develop an individualized plan that includes a structure of rewards and consequences based on behaviors.
- This is a team approach that focuses on increasing pro-social skills and developing strong community supports which increases a youth's success in treatment.

High Fidelity Wraparound (Wraparound)

Focus of intervention:

- The primary emphasis of Wraparound is an individualized, team-based, collaborative process to provide a coordinated services and supports.
- Wraparound supports children and youth ***ages 0-21*** with complex emotional, behavioral or mental health needs and their families who are involved with several child and family-serving systems (e.g., mental health, child welfare, juvenile justice, special education, etc.).
- Wraparound is a process that supports families, providers and key members of the family's social support network to collaborate and build a plan that based on their strengths that responds to the particular needs of the child and family (Suter & Bruns, 2009).
- Team members then implement the plan and continue to meet regularly to monitor progress and adjust the plan as necessary.

Benefits for families:

- Reduction in behavioral, emotional and developmental challenges.
- Increase the family's capacity to develop positive coping strategies.
- Improve family relationships.
- Access to the support of a highly skilled Wraparound coordinator.
- Access to flexible funding to meet the needs identified through the teaming process.
- Empowers the family to identify their goals and work together with their team to meet the needs of the youth and family to achieve their goals.

Duration of services

- Wraparound is delivered in phases that generally require 6-12 months to complete successfully.

What parents need to hear about High Fidelity Wraparound

- Wraparound is a process that empowers you as the caregivers of the youth to identify strengths and needs for your family while working with your team to develop a plan that will help you to achieve your goals.
- The Wraparound process is family-driven. That means you are guiding the process from start to finish.
- Parents will receive the unconditional support of a Wraparound coordinator. The coordinator will work with you and your team to ensure that the plans work for you and your family.
- The team that is developed in the Wraparound process will be an ongoing support to you and your family.

One Step at a Time

In some cases, parents may need to complete, or at least establish, some stability in a critical intervention [i.e. substance abuse or domestic violence] PRIOR to engaging in Family First services in order to stabilize them or help them be more available for the next intervention. Discussing your plan with the family, your supervisor or the family team helps to create a road map for success. Most of us cannot make multiple changes simultaneously successfully.

Learn more about Family First interventions:

- Child Parent Psychotherapy: *https://childparentpsychotherapy.com/*
- Nurturing Parenting Program: *https://www.nurturingparenting.com/*
- Multi-Systemic Therapy: *www.mstservices.com*
- Trauma Focused Cognitive Behavioral Therapy: *https://tfcbt.org/*
- Positive Parenting Program: *www.triplep.net*
- Wraparound: National Wraparound Initiative (NWI) (pdx.edu) – *https://nwi.pdx.edu*

Section 4: Using the provider module to make referrals

Overview

After careful consideration of the family's needs using the CANS and making a plan for an identified intervention, this section will address the steps to making a referral through the department's online system. The referral and all critical accompanying documents [i.e. Release of Information, Integrated Assessment] will be sent to the selected community providers of evidence-based interventions.

Step one: verify case member information in SACWIS

- Names – Verify the spelling of each member's first and last name and that there is only one record in SACWIS for the individual.
- Date of Birth – Verify the DOB of all children.
- Address – Verify address information is correct.
- Person Linkages – Ensure all members are linked to the record for the individual. If multiples are found, request person merges by contacting *SCR.Mailbox@illinois.gov.*
- Family Group Linkages – Ensure the case is opened under the correct family group.
- CYCIS Client IDs – All members receiving services must have a CYCIS Client ID associated to their SACWIS Person ID.

Step two: Using SACWIS to refer a case

SACWIS to the portal instructions:

Under Prevention Planning you will see two options: Provided Services and Recommendations.

- If you see 1 or more unreferred recommendations, put a dot in Recommendations and follow the steps below.
- If there are 0 recommendations, but you still want to make a referral for a specific intervention, put a dot into Provided Services and follow the steps below.

1. Click on the New Prevention Service link.
2. Choose the prevention service that you want.
3. Choose a case member and other participants.
4. Choose add services.
5. Select the target population: Intact and Choose Prevention Strategy.
6. Add comments regarding the referral.
7. Select Send Referral to send the referral to the Portal.
8. The case should now show up on the caseworker's dashboard as unreferred.

When in the portal

1. On the caseworker dashboard click on the referral number.
2. Review the client information.
3. Scroll down to referral details.
4. Click the link to add the provider.
5. Enter the client's address.
6. Click the appropriate provider link.
7. Click on the link at the top right-hand corner to link the provider with the referral.
8. Add the hours.
9. Add Unit Type.
10. Add Start date and end date.
11. Add notes under referral notes if needed.
12. Save.
13. Click submit referral (This will send the referral to the supervisor's dashboard for approval).
14. Supervisor: Click on the referral number, scroll down and click approve.

If the supervisor dashboard is not functioning, you can search the entire database:

1. Go the Provider Portal.
2. Click on Referral List.
3. You will see a drop down beside Provider Accepted Referrals.

4. From the drop down:
    - Select "Unsubmitted" to see which cases the case worker will need to complete the 507 on and submit for approval; OR
    - Select "Unapproved" to see the referrals that the workers have completed a 507 on in the portal, but are awaiting approval.
    - For referrals that are pending approval: Click on the number, scroll down to Review Referral Information and click Approve on the bottom of the page.

How to add a column to filter by worker:

1. Click on Referral List.
2. Choose the appropriate drop down menu (Unsubmitted or Unapproved Referrals choose any other drop down categories as applicable to obtain information that you are seeking).
3. Go to the right-hand corner and click Edit Columns.
4. Click + Columns.
5. Choose Caseworker Name and scroll down to the bottom of the page.
6. Click Close.
7. Click Apply.
8. Click on the Caseworker Name drop down.
9. Choose Filter By.
10. Enter caseworker name in the second box.
11. Click Apply.
12. You should now see if there are any pending referrals for the worker.

To deactivate/cancel a referral:

1. Click on the circle on the left side of the identified referral.
2. Click Deactivate at the top of the portal page.
3. Confirm that you want to deactivate.
4. If you make a mistake, you can retrieve the referral from the deactivated referrals folder.

Reminders!

1. Pin the Provider Portal *https://dcfsdpm.crm9.dynamics.com/* to Chrome or Microsoft Edge.
2. If you do not have access to the portal there is a Provider Portal Access Form you can fill out to request access to the Provider Portal. The form is available from the D-Net homepage -> OITS -> Request Services -> *Request Provider Portal Access*.

Step three: plan for linkage and coordination using best practice

While the portal helps you to begin the referral, you will want to coordinate the care of the family with the provider directly. That contact could help you anticipate a waitlist, or it may help to identify additional materials that the family will need to bring to make their first appointment experience productive. If you do not already know the agency, this communication will be essential to relationship building as you work together on behalf of the family.

Section 5: DCFS home visiting services

SERVICE TYPE	DESCRIPTION
Intact Family Services	Are designed to provide short term voluntary services intended to make reasonable efforts to stabilize, strengthen, enhance and preserve family life by providing services that enable children to remain safely at home.
Erikson DCFS Early Childhood Project	Offers consultation and linkage of early childhood serivces for young chidlren involved in intact family services. Home visiting specialists act as a liaison to connect families involved in child welfare to home visiting.
Home Visiting Services	Is a community resource available for families that is free and voluntary, used by many families whether they are or are not connected to child welfare. It helps parents work to enhance their children's development and strengthen the parent-child relationship.

Background on Home Visiting

The parent-child relationship is one of the most important factors in a young child's development. DCFS recognizes that child welfare involved young children are at increased risk for adverse experiences that can impact their emotional health and development. DCFS also recognizes that there are evidence-based approaches including home visiting services that can support and strengthen the parent-child relationship. Home visiting, when provided in the early years, has been shown to be effective in improving maternal and child outcomes.

In keeping with this knowledge, the Erikson Institute has committed to facilitating effective linkages to home visiting programs for families with children prenatal to 3 years old identified as in need of these home visiting services. As home visiting service availability varies by community, this linkage will occur whenever there is a program the family qualifies for in the service area.

Linkage to home visiting is a partnership

- **Ages prenatal-3:** Case managers should consider home visiting as a possible service for any family with young children, in utero to 3 years old. According to DCFS policy, case managers are to contact DCFS.HomeVisiting@illinois.gov for any family with a new pregnancy to support pregnant parents considering home visiting.
- **Voluntary intervention:** Home visiting is a free, voluntary program. Parents may decline this resource at any point without consequences. Parents need to agree and sign written consent to be linked to a home visiting program.
- **Consultation with caseworkers:** Erikson DCFS Early Childhood Project home visiting specialists will work with case managers to find the programs that can serve the family. They work to reduce the barriers which prevent families from successfully linking to this preventive long-term support. Home visiting specialists are a resource at any point to consult and explain processes as well as advocate to address barriers.

- **Linkage:** Home visiting programs undergo an intake process to enroll families. Home visiting programs will inform home visiting specialists of any barriers/difficulties to enroll family.
- **Things to know:** Home visiting programs do not provide assessment of parenting capacity. With the parent's approval and partnership, home visiting programs can provide an overview of family's engagement, participate in meetings about the child welfare case and support family's completion of their service plan. Home visiting programs can continue to offer parents support for some time after the child welfare case closes.

Please contact *DCFS.HomeVisiting@illinois.gov* with any questions or requests.

Treatment snapshot:

A home visitor first works to build a relationship and understand what the needs and goals are as a parent. The intensity of services is based on the parent's needs, beginning weekly and moving gradually to quarterly home visits as the family becomes more self-sufficient.

What benefits/results are there for clients?

Home visiting services have been found to:

- Strengthen the parent-child relationship.
- Improve birth outcomes (decreased pre-term births and low birthweight) and overall child and maternal health.
- Increase school readiness.
- Reduce incidences of child abuse and neglect.

New DCFS policy for intact family services/home visiting:

Since 2020, modifications to policy 302.388 were made to promote home visiting services for families as early as during pregnancy. DCFS policy requires offering a referral for home visiting services for intact family service cases that meet the following conditions:

- While a parent, caregiver or youth is pregnant or the family composition includes children ages 0-3.
- When a family refuses to consent to intact family services the child protection investigator shall work to link the family to home visiting.
- When a child protection supervisor or an area administrator determines the family is not eligible for intact family services and the family composition includes children ages 0-3, efforts will be made to access home visiting.

Home visiting works the best at supporting families when they are linked during the prenatal period. Please ensure that all intact family cases on your caseload are linked to home visiting when you learn of a pregnancy by contacting *DCFS.HomeVisiting@illinois.gov*.

Home visiting is voluntary. The parent must agree to the service. The policy is designed to make sure efforts are made to offer home visiting and connect parents with young children to a parenting service that can be in their lives after child welfare is gone. If you try, and a family declines the intervention, that is ok. Please document your attempts.

How do I start the home visiting process?

SERVICE TYPE	CONTACT INFO
Home Visiting Services	Phone: 312-893-7181 Email: *DCFS.HomeVisiting@Illinois.gov*
Erikson DCFS Early Childhood Project	Phone: 312-893-7181 Email: *dcfsproject@erikson.edu* Website: *https://www.erikson.edu/services/clinical-practitioner-programs/early-childhood-project/*

Section 6: Motivational Interviewing (MI)

Change is complex and requires motivation, access, supports and capacity. In this section, we will review key ideas in Motivational Interviewing (MI). These are easy ideas to understand but it will take commitment and practice to become skilled in this work. MI is ideally part of everything we do when working with someone no matter what other interventions we are using, the glue that holds it all together, rather than an extra or add-on task to our work. We hope your journey is supported, and we hope you will share your successes and struggles in MI with your team.

What is Motivational Interviewing?

Motivational interviewing (MI) is a method of talking with people about change. It's defined as "a collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller & Rollnick, 2013). In other words, a way of supporting people as they talk themselves into changing!

MI takes the view that people commonly have difficulty changing because they feel two ways about it. They're ambivalent. Part of them wants to change and part of them can think of arguments for not changing – "I know these parenting classes would be helpful, but it's so hard to get started and besides my life is already way too busy."

In MI, once a concern or change goal has been identified, the child welfare professional serves as a guide to assist and support the person as they explore their ambivalence, and more importantly, to elicit the individual's own motivation to change – such as their reasons for considering change, possible benefits, how they might go about making the change in order to be successful, how important or urgent the need is to change, the individual's level of confidence in moving forward, who else could support the change and possible next steps.

Why are we choosing to implement MI?

The concept of Motivational Interviewing (MI) grew out of the experience of providing treatment for problem drinkers and was first described by psychologist, William R. Miller, in an article published in 1983.

Historically, the substance misuse treatment field, especially in the United States, has been characterized by a highly confrontational, shame-based approach believed to break down people's "denial" so they will come to their senses about their need to change. This approach has proven to be mostly ineffective and counterproductive. In general, human beings tend to resist other people's attempts to get them to change, even when those efforts are well intended.

With the publication of William R. Miller and Stephen Rollnick's seminal book, *Motivational Interviewing*, in 1991, child welfare professionals were introduced to an alternative way to engage in "helping conversations" with people misusing substances. The authors described a way of interacting based on a particular conversation style and use of specific communication skills and strategies.

A second edition, *Motivational Interviewing: Preparing People for Change*, was published in 2002. It further refined the MI approach, provided an emerging research base for MI and detailed its spread to other areas beyond substance use disorders including health, behavioral health, corrections and schools.

A third edition, *Motivational Interviewing: Helping People Change*, 2013, expanded on the MI approach and included some new concepts including the four processes of MI conversations (engaging, focusing, evoking and planning) and distinguish between sustain talk and discord. Today, MI has circled the globe, and support and respect for the practice is growing.

The evidence for Motivational Interviewing

A wealth of studies indicate that MI has a statistically significant positive effect on behavior change, with several studies showing that those changes are durable over time. MI remains effective when used as a stand-alone intervention, infused within other approaches to treatment, as well as a precursor to other treatment. Several studies have revealed that individuals defined as "least ready to change" experience the largest MI effect.

Of course, there are variations in MI competency among child welfare professionals and in the quality of the alliance that develops between the child welfare professional and individual. Poor MI promotes poor results. Structural and environmental factors can also affect the success of MI. For example, social instability can hinder efforts to address substance misuse or other concerns on a person's mind. For others, a history of trauma may create obstacles to accessing assistance and support. MI sees people's struggles in the context of their lives and works with them to focus and prioritize.

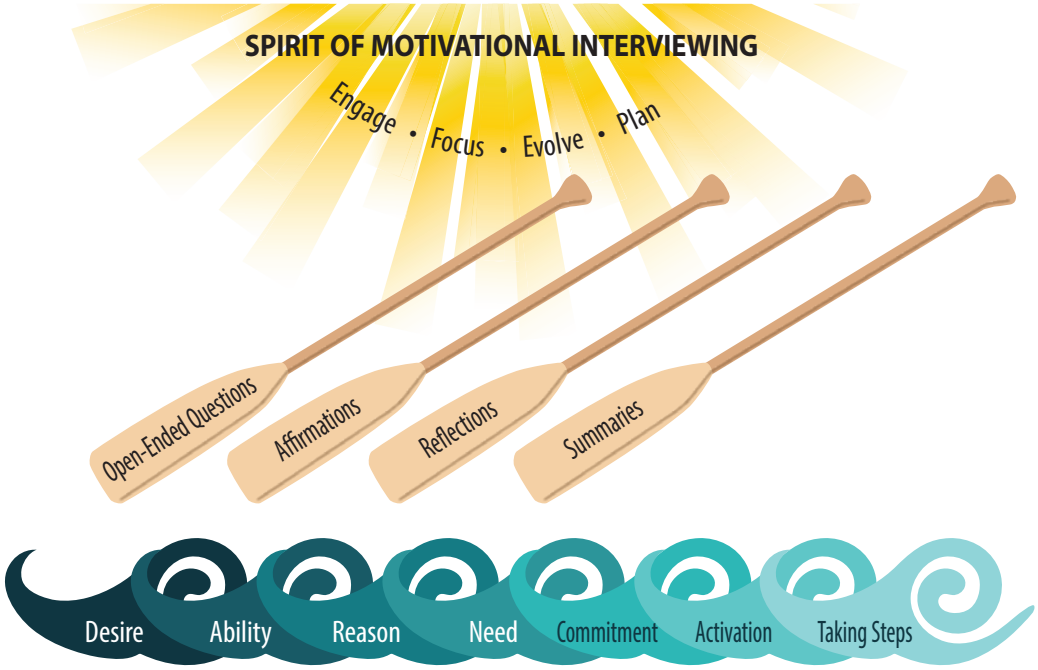
How does Motivational Interviewing work?

Practicing MI requires a healthy sense of humility. It brings us face-to-face with the recognition that we don't have the power to change others. In truth, we can only change ourselves. However, we can have a positive influence on others and their motivation to change – if we are able to engage well with them and support their growth in a way consistent with their values and strengths. As Madeline Hunter says: "they say you can lead a horse to water, but you can't make him drink. But I say, you can salt the oats." The goal of MI is to support individuals as they become "thirsty" for change by skillfully engaging them in an exploratory process to discover, strengthen and act upon their own motivations to change.

MI child welfare professionals seek to create safe, trusting, non-adversarial relationships with individuals. This makes it easier for people to non-defensively examine their lives, particularly in areas where their own behaviors and values are out of sync. If child welfare professionals try to "educate" or convince, people are likely to defend the status quo. When they focus on eliciting the person's own knowledge, experience and inner wisdom in a genuine, empathic manner, change is more likely to happen.

Ongoing practice with accurate feedback and coaching is needed to develop MI skills. Research shows that MI competence requires expert feedback based on observed practice and coaching to support shifts from current practice to MI proficiency. It is important that you continue to learn and grow in your MI practice.

MI consists of the Spirit of Motivational Interviewing, the process, skills and change talk. This manual will walk you through each of these and provide you with additional resources and support.



What is the spirit of Motivational Interviewing?

According to Miller and Rollnick (2013), MI springs from a heart- and a mind-set that brings a "profoundly accepting and compassionate" (p.15) style to our work. As we practice MI, we support people as they change, and we even help ourselves change – becoming more collaborative, accepting and compassionate as human beings. The Spirit of MI is made up of partnership, acceptance, compassion and evocation (PACE).

- **Partnership** requires a true collaboration, a quality of alliance, or working together to move forward.
- **Acceptance** is meeting people "where they're at" without judging them; seeking to understand the "backstory" and conveying genuine empathy and understanding of their perspective; believing in others' intrinsic value and worth; shining a light on the strengths you see in them – not focusing on their deficits – and acknowledging and honoring the person's right to self-determination.
- **Compassion** prioritizes the other's needs and seeks to work with them to alleviate their suffering.
- **Evocation** is to bring forth from the person their own motivations, hopes, options, aims and expertise. This approach tells the other person, "You have what you need and together we will find it," rather than "I have what you need and you need to do it my way."

The goal is to be curious and to humbly recognize that whatever may be in the notes, history or previous records is only a portion of the story that is needed to support the person's change process. We seek to create the conditions under which people are more likely to consider change, draw out and strengthen their motivation to change.

STANDARD APPROACH	MI APPROACH
Focus in fixing problems.	Focus in person's concerns.
Expert-individual relationship.	Collaborative partnership.
Assumes motivation flows from problem awareness and solution identification.	Matches approach with person's level of readiness to change.
Focus on expert's knowledge and skills.	Emphasizes personal choice and autonomy.
Lack of awareness or denial are problems to overcome.	Ambivalence viewed as normal part of the process.
Discord countered with argumentation and facts.	Discord seen as signal to try different approach.

Three communication styles

One thing we know about MI is that there is no one formula that works for every individual and that MI supports each child welfare professional in bringing his/her own strengths and gifts to the session. And along with genuinely collaborating with each individual, we know that there are a variety of communication styles that often are effective in having this conversation about change.

Directing ⟷ Guiding ⟷ Following

For example, if we were to think about a continuum of styles related to conversations about change, we would likely see on one end, a ***directing*** style, or a way of communication where the clinician is telling or giving advice to the individual on what to do or how to move forward. A directing style, at times, may be helpful for someone experiencing a bona-fide emergency.

At the other end of this continuum is a style of ***following***. In MI, there is much focus on listening, asking open-ended questions and using person-centered counseling skills. And it can be easy to resist offering additional material into the session and wanting the individual to trust their own intuition and wisdom.

And in the middle, there is a ***guiding*** style, and this is where MI can be so effective in the conversation about change. It is like being a facilitator or a skillful guide, where one is a good listener and offers support at the appropriate times. This is similar to when a child is learning a new task and we want to offer just the right amount of information and support without doing the task for them.

Below is a sample of verbs offered by Miller and Rollnick associated with the three communication styles, which occur in our everyday lives and in conversations about change:

DIRECTING STYLE	GUIDING STYLE	FOLLOWING STYLE
Administer	Accompany	Allow
Conduct	Assist	Listen
Manage	Collaborate	Observe
Steer	Support	Stay with

The overall style of MI is guiding, but elements of a directing and following style may also be included when appropriate. MI is a conversation about change. The intention of MI is to collaborate with the individual, so they are able to believe in the change they want and that the change is consistent with their own values and goals. People are most influenced by what they hear themselves say and not by what someone else says.

What are the Motivational Interviewing processes?

Motivational conversations have a purpose and direction. They seek to support people as they identify and explore their hopes, values and change goals within the context of an empathic, guiding style. This guiding approach generally moves through four processes over time.

These processes – engaging, focusing, evoking, planning – tend to be sequential in MI conversations, although each can be revisited as needed.

To advance the practice of the four MI processes, definitions and examples are highlighted below:

Engaging – getting to know someone and building trust.

- "It's really good to meet/see you again."
- "What would you like me to know about you and your family?"
- "What would be helpful for you to know about me and my role here?"
- "What's going well in your life? What concerns, if any, do you have?"
- "What are some of your hopes related to your family's well-being?"

Focusing – figuring out together what to talk about and explore.

- "What would you like to focus on in our time together today?"
- "What's on your mind that you'd like to make sure we cover today?"
- "You've mentioned X, Y and Z. Where would you like to start?"
- "It seems like you're feeling a bit stuck. Could we explore that a bit and see which way to go together?"
- "Would it be all right if we took a closer look at your relationship with your kids?'"
- "How might we narrow that down a bit?"

Evoking – exploring ambivalence and drawing out the person's own desire, reasons, ability and need to change *(example: parenting as the focus).*

- "How would you like things to be for you and your kids?"
- "How do angry outbursts impact you and your family?"
- "What concerns, if any, do you have about your shouting at your kids and the impact on them?"
- "If you did decide to attend the parenting classes, why might you want to do that?"
- "What options have you considered so far?"
- "Given everything in your life, how important is it for you to make this change?"
- "How confident are you that you could make this change if you wanted to?"

Planning – developing a specific change plan that the person is willing to put in action.

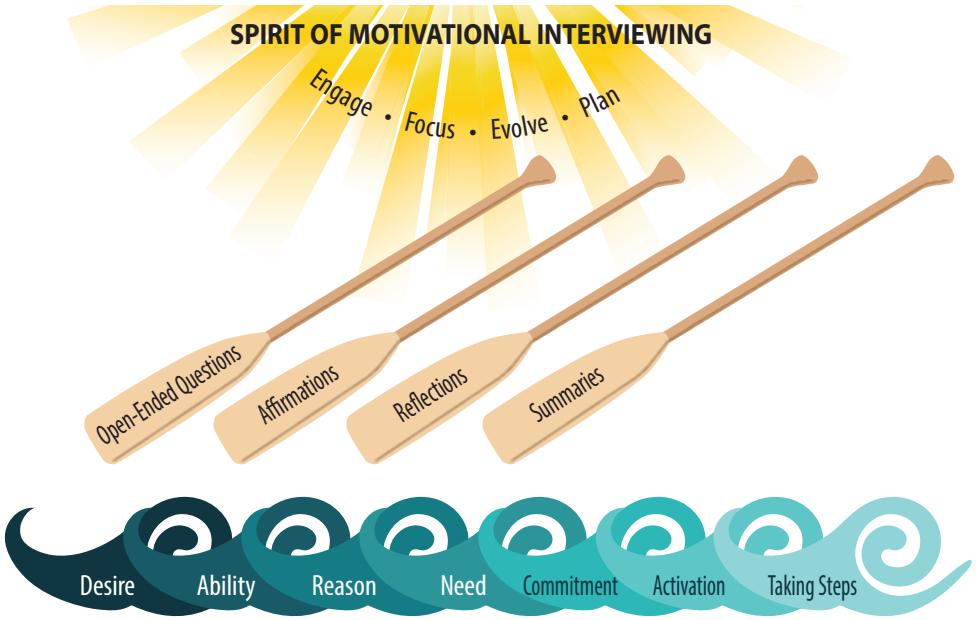
- "What do you think you'll do next?"
- "Who or what could be of support?"
- "How can we start to address what the court is asking of us?"
- "What challenges, if any, do you anticipate in carrying out your plan?"
- "How will you know when your plan is working?"
- "How will you celebrate successes along the way?"

What are the skills of Motivational Interviewing

Motivational Interviewing focuses on building interviewing skills. You likely received training in some of these skills in your professional education. MI calls the skills below the OARS.

SKILLS	DEFINITIONS	EXAMPLES
Open-ended questions	An open-ended question invites the interviewee to tell you part of their story. It is not a yes/ no answer.	Tell me about when you learned that DCFS had been called about your family?
Affirmations	Authentic positive feedback builds understanding and relationship.	I know it was not easy to share your worries about being involved with the department.
Reflections	Restating what you have heard them say, both in content and feeling.	So you've been worried about the children hearing and seeing the fights with your partner, and you've been trying to get them to bed earlier to avoid being awake when he gets home.
Summarize	Pulls together information provided by the interviewee.	I've heard you say you'd like to . . .

These skills take time and practice. When used regularly with intention, they become much more natural and easier to use in conversation.



The decisional balance

Ambivalence refers to a dilemma of being pulled or pushed in opposite directions at the same time. Simply put, ambivalence is feeling two ways about something. This uncertainty is completely normal and occurs as predictably as the sun rises. It is not pathological, nor is it a sign of denial or resistance. Ambivalence is simply a part of the change process – something to be acknowledged and explored in order to support people move through it.

Each time we are presented with a decision at the very least the person is feeling ambivalence: two or more ways about a change. Is this important to me? Even if it is, do I have the confidence to do this? Is this a priority for me and my family? If so, is now the time? Is this the right plan for me? We balance the "pros and cons, the good and not so good of the possibilities within us and in front of us. This is known as "decisional balance" described in the graphic below. This tool can be used with the individual as thy work through their ambivalence toward change talk.

What will I gain if I don't make this change?	**What will I lose if I don't make this change?**
What will I lose if I make this change?	**What will I gain if I make this change?**

Change talk

Change talk is described as "any individual speech that favors movement toward a particular change goal" (Miller & Rollnick, 2013, pp. 406). Change talk is a crucial activating ingredient in the process of change, much like yeast is to dough. As Miller and Rose (2009) note, "The strength of preparatory change talk predicts subsequent strength of commitment, both of which have been shown to predict individual outcomes."

The seven kinds of change talk are important to cultivate. We can think about any change we've ever made in our lives. It started with thinking and talking about what was important to us and what we felt able to do, and we call this "preparatory" change talk. We speak about what we want, whether we believe we can, why it's important to us and what makes it a priority.

Early in the change process, we are likely to hear preparatory change talk in which people are contemplating or "trying on" the possibility of change. This is expressed in statements of wanting to change, being able to change, having reasons to change and having a need or sense of urgency to change.

Over time, preparatory change talk is likely to evolve into mobilizing change talk in which the change is starting to "get legs." Mobilizing change talk is reflected in statements expressing commitment to change, a readiness to act and reporting some initial steps towards implementing change.

With that foundation, we can then begin to speak how we see ourselves moving forward: what we are willing to commit to doing, how we'll prepare to be successful and what steps we see ourselves taking. We call this "mobilizing" change talk, as it puts into motion what we've said is important to us and what we think we can do.

Change talk is speech of any kind that points in the direction of change related to a particular focus. Sustain talk is speech that points towards staying the same or the status quo.

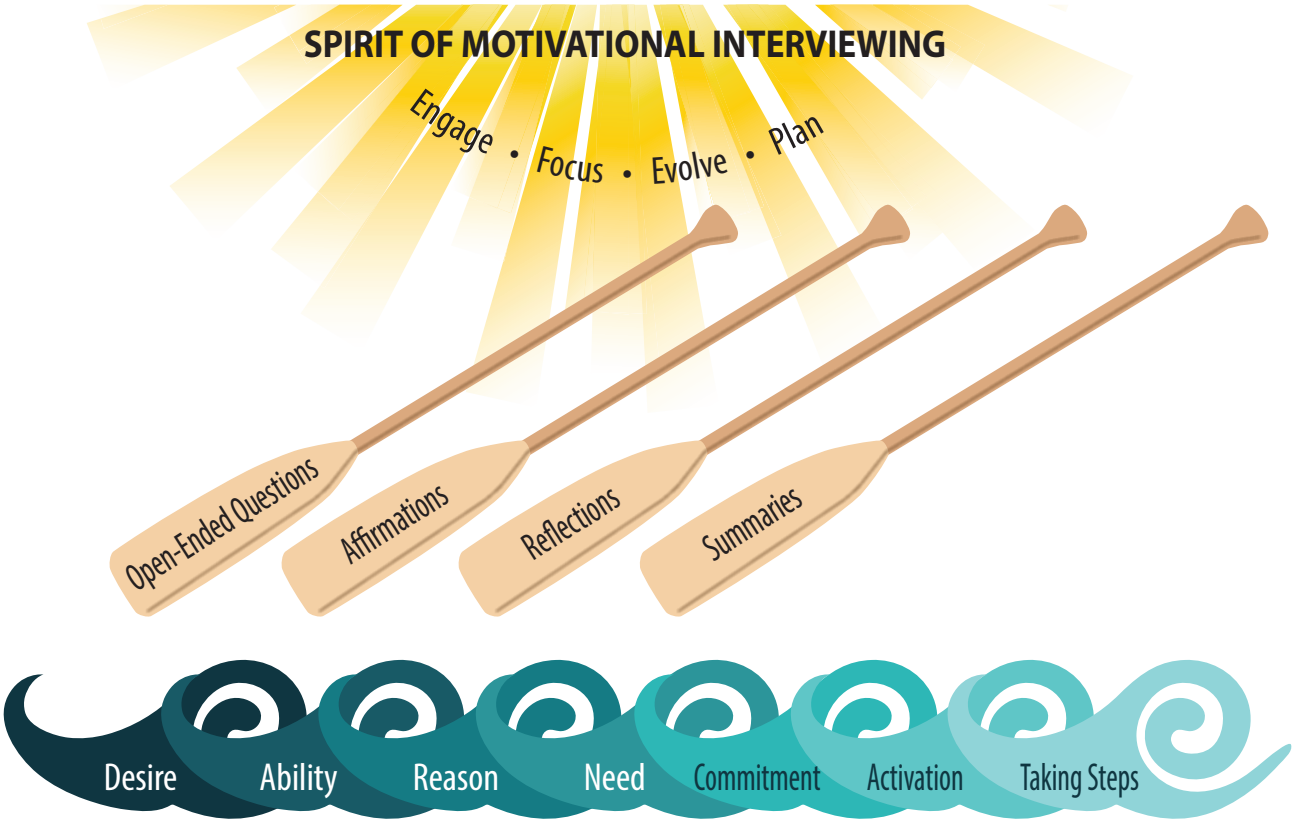
Why is change talk important?

In MI, evoking and focusing on language supporting change supports people as they become more open to change, think positively about it, be willing to think what life would be like if they changed and eventually implement change. MI operates on the research-based principle that the more someone talks meaningfully about changing, the more likely it will occur.

As a person increasingly offers more change talk than sustain talk, the likelihood of change increases. Similarly, the odds of change improve as individuals become less general and more specific about why, when, where and how they might change.

However, change talk is not always easy to evoke or identify. Often, change talk comes attached to language about keeping things the same, or not changing, called sustain talk. When we hear sustain talk, we shouldn't ignore it. Instead, we acknowledge the most important parts of the sustain talk, so the person knows that we understand it. We also strive to make sure we don't increase sustain talk by getting into a confrontational stance.

Often, just acknowledging peoples' sustain talk can elicit the other side of their ambivalence. In other words, it can draw out change talk. In MI, it is generally best to focus most of the attention on the change talk.



Even when someone barely hints at the possibility of change, or expresses only minimal concern about the status quo, it is worth exploring these "mustard seeds" of potential change. A statement such as "I don't worry much about yelling at my kids," still leaves the door open a crack for the possibility of responding with a reflection of: "Every now and then you wonder about how you get through to your kids."

Not surprisingly, people often couple change talk with sustain talk in the same statement – a classic expression of ambivalence. It often sounds like, "I want to change, but…" or "I don't see the point, but maybe…" Any statement that contains some expression of openness to change is regarded as change talk from an MI perspective. Such statements, no matter how non-committal, still leave room for further exploration.

And, what about discord?

In early editions of the MI text, Miller and Rollnick used the word "resistance" to describe a person's speech or movement that was not in the change direction. They had grown increasingly uncomfortable with the word – it placed the locus and responsibility for the phenomenon within the person being served – as though the person was being blamed for being "difficult." It pathologized a person's reluctance (a perfectly normal and natural part of the working through the change process) as well as a person's understandable inter-personal response to the child welfare professional or context.

In 2013, with the third edition of the MI text, Miller and Rollnick introduced words that more accurately described reluctance about change ("sustain talk") and better represented inter-personal disharmony ("discord"). Sustain talk is about the target behavior or change. Discord is about our relationship with the person we are serving.

WHAT AM I HEARING?		
CHANGE TALK	**DISCORD**	**SUSTAIN TALK**
Statements that support change: • I want to . . . • I could change . . . • I need to . . . • I'm ready to . . .	Interpersonal difficulties between helper and client: • Defensiveness • Arguing • Interrupting • Disengaging • Challenging	Statements that support the status quo: • I don't want to . . . • I don't see how I could change . . . • I don't need to . . . • I'm not ready . . .
← "RESISTANCE" DECONSTRUCTED →		

Signs of discord:

- Defending: feeling the need to defend oneself – through blaming, minimizing, justifying and so on – may arise from a perceived threat to one's stated reluctance to change and even their expertise, integrity, autonomy or self-esteem.
- Squaring off, arguing and/or challenging: an oppositional stance shows the person sees us more as an adversary than a partner for change.
- Interrupting: if we are talking over one another, no one is listening and certainly the person is not feeling heard or understood.
- Disengaging: inattention, distraction, ignoring, looking for the emergency exit, not showing up.
- Agreeing: while this can be a more subtle and socially acceptable form of discord, agreeing for the sake of agreeing has the quality of saying yes on the outside and meaning no on the inside; we are not able to be on the on the same page; compliance-only change is another manifestation of this.

Note: Signs of discord are culturally relative; what can signal a rupture in working alliance in one culture or subculture may not be so in another. There may also be cultural differences in expressing discord.

Question for Reflection:

Where have you found this to be true in your own work?

Discord in the four processes of Motivational Interviewing:

- **Discord in engaging:** prior experiences in seeking services (such as coercion, expectations, child welfare professional low-empathy) can impact how a person enters our encounters and may be an immediate challenge to forming an alliance with us; confrontation and other conversational roadblocks; the "expert trap" where we assume we hold the exclusive and necessary expertise to support the person; the "assessment trap" where we prioritize data and fact collection or history gathering over understanding the person; the "question-answer trap" where we put the person into the position of providing answers to our child welfare professional-centered inquiries.
- **Discord in focusing:** disagreements over what to discuss and the target(s) for change; viewing the person only through the lens of the presenting "problem;" the "premature focus trap" where the child welfare professional pushes too soon for a target the person does not yet share.
- **Discord in evoking:** pushing too soon or in a direction for which the person is not ready; the "righting reflex" where the child welfare professional tries to fix the problem or install reasons, solutions, confidence, and so on, into the person.
- **Discord in planning:** taking over the change process; directing instead of guiding; presenting information and solutions without collaboration and autonomy support.

Where there is discord, we will need to be especially attentive to bringing our best and most consistent MI-self to the conversation; it can also be the time we find it most challenging (even difficult) to bring our best. Studies have shown a reciprocal effect between challenging encounters and child welfare professionals' temptation to confront or use other conversational roadblocks.

How to identify change talk

Miller & Rollnick (2013) describe various types of change talk that commonly emerge in MI conversations. Each type represents a different dimension of motivation, some of which have greater strength than others. These dimensions are often described in everyday language as being "ready, willing and able." Based on the research of various linguists, additional dimensions are included in MI that form the acronym: **DARN-CATS**.

Preparatory change talk: DARN

Desire: I want to; I would like to; I wish; I hope.

Ability: I can; I could; I am able to.

Reasons: It would help me; I'd be better off if.

Need: I need to; I have to; Something has to change.

Mobilizing change talk: CATS

Commitment: I will; I promise; I give you my word.

Activation: I'm willing to; I am ready to; I am prepared to.

Taking **S**teps: I signed up for; I avoided; I contacted; I bought; I went.

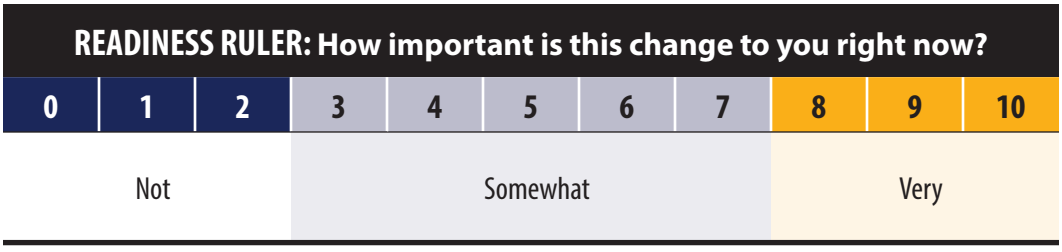
How to evoke change talk

Ask open ended questions:

- What worries you about your current situation?
- Why would you want to make this change?
- How might you go about it, in order to succeed?

Use a ruler:

- Importance example: On a scale of 0 to 10, how important is it for you to make this change?



- Tell me about being at _____compared to (several numbers lower)?
- Confidence example: On a scale of 0 to 10, how confident are you that you can make this change? What would you need to make it a ____ (number higher)

Exploring extremes:

- What concerns you absolutely most about _____ ?
- What are the very best results you could imagine if you made a change?

Looking back:

- Tell me about other difficult things you've been able to do and how you can use some of those skills here?

Looking forward:

- How would you like things to be different in the future regarding _____?

Exploring goals and values:

- What do you value most in life?
- What are your most important reasons for wanting to meet these court conditions?
- How do your current behaviors fit with your most important goals?
- How does this fit with who you want to be as a parent?

Documenting key processes of Motivational Interviewing:

Documentation to capture activities associated with Motivational Interviewing is required in these four process areas:

- Engaging - in a working relationship through listening and understanding.
- Focusing - on a shared purpose about what needs to change.
- Evoking - individuals' ideas and motivations to explore ambivalence and understand their own "why" and "can" of behavior change.
- Planning - for change, led by individuals in a way that highlights their strengths, values and expertise.

When documenting MI process, it is important to include information in the narrative that addresses the following questions.

Engaging

- How comfortable is this person in talking with me?
- How supportive and helpful am I being?
- Do I understand this person's perspective and concerns?
- Does the person seem to feel heard and understood?
- Am I showing the person they matter, that they have absolute worth?
- Am I respecting and emphasizing the person's autonomy?
- How comfortable do I feel in this conversation?

- Does this feel like a collaborative partnership?
- What kind of atmosphere am I making available so this person can share safely with me?
- What are some of the things I am doing well for engaging with this person?

  Engaging narrative example: CWS checked in to see how things were going with mother, Samantha, CWS was open to hearing about the stress and many priorities the mother is experiencing. CWS offered supportive reflections. CWS asked mother how she was managing. She provided examples and CWS reflected those and affirmed her successful navigation of the stress she is experiencing.

Focusing

- What goals for change does this person really have?
- Do I have different aspirations for change for this person?
- Are we working together with a common purpose?
- Does it feel like we are moving together, not in different directions?
- Do I have a clear sense of where we are going?
- Does this feel more like dancing or wrestling?

  Focusing narrative example: Mother, Samantha, had a lot of priorities: transportation, recovery meetings, parenting classes, positive social support, continuing to test negative. All these came out and CWS used a decisional balance to support her in making a decision about where she wanted to start.

Evoking

- What are this person's own reasons for change?
- Is any reluctance more about confidence or importance of change?
- What change talk am I hearing?
- Am I showing the person I hear their change talk?
- Am I encouraging their change talk?
- Am I steering too far or too fast in a particular direction?
- Is the righting reflex pulling me to be the one arguing for change?

  Evoking narrative example: CWS recognized the many changes mother has made. CWS reflected that mother had brought positive people in her life and affirmed her efforts. CWS reflected the reasons she offered for continuing her changes, for making them real and keeping her targets in mind. CWS asked looking back and looking forward questions to evoke mother's reason for change.

Planning

- What would be the person's identified reasonable next step toward change?
- What would be supportive to this person to move forward?
- What ideas does the person have for moving forward?

- If I think information or options would be of support, did I ask permission to offer and to see that the person thinks?
- Am I offering needed or requested information or advice with permission and autonomy support?
- Am I remembering to evoke rather than prescribe a plan?
- Am I retaining a sense of quiet curiosity about what will work best for this person?

Planning narrative example: Mother asked for information about completing her court conditions. CWS offered details about what the judge might be looking for. CWS asked her how she will proceed in the next weeks. This helped her to prioritize. CWS reflected the specific steps mother indicated she was planning to take to start with parenting classes, get the testing done and try to get to recovery meetings. CWS affirmed the things she had already done. She expressed concerns that she couldn't keep on being successful. CWS reflected the reasons and values she said were important to her. CWS asked her to walk through how she'll move ahead before our next meeting.

Note any discord and how it was resolved:

Discord narrative example: Mother, Samantha, was really overwhelmed when she sat down, she seemed angry. CWS was supportive and reflected her frustration and her many priorities. When mother asked for assistance and support, CWS offered ideas that may meet her needs. CWS asked permission to offer her information and get her the bus tickets. CWS affirmed what she had been doing well and supported her autonomy to decide what to talk about which reduced the discord.

Considerations for supervisors

- Encourage participation in regularly scheduled introductory and advanced MI training opportunities (ensuring that participants are assigned to or already a part of an ongoing learning circle).
- Encourage self-initiated learning by providing resources such as MI books, eBooks, articles, training tapes, skill-building exercises and other learning tools.
- Collaborate with other MI trained professionals.
- In supervisory sessions, regularly review staff progress in MI skill-building.
- Include MI skill-building as a professional development goal for all child welfare professionals in their job performance plans.
- Create MI-related visual reminders (posters, signs, buttons, importance and confidence rulers).
- Utilize teams for online MI discussion forum within your agency.

Initiate your own inspired ideas!

Summary

It is important that you as the child welfare professional engage with the individual as an equal partner and refrain from telling them what to do or providing unsolicited advice, confronting, instructing, directing or warning. MI is not a way to "get people to change" or a set of techniques to impose on the conversation. MI takes time and practice, and requires self-awareness and discipline from the clinician. (Miller & Rollnick, 2009)

MI includes a guiding style of communication that lives between following (good listening) and directing (giving information and advice).

The spirit of MI includes:

Partnership. MI is a collaborative process. The MI practitioner is an expert in supporting people as they change; people are the experts of their own lives.

Acceptance. The MI practitioner takes a nonjudgmental stance, seeks to understand the person's perspectives and experiences, expresses empathy, highlights strengths and respects a person's right to make informed choices about changing or not changing.

Compassion. The MI practitioner actively promotes and prioritizes clients' welfare and well-being in a selfless manner.

Evocation. People have within themselves resources and skills needed for change. MI draws out the person's priorities, values and wisdom to explore reasons for change and support success.

The process of MI includes:

Engaging: This is the foundation of MI. The goal is to establish a productive working relationship through careful listening to understand and accurately reflect the person's experience and perspective while affirming strengths and supporting autonomy.

Focusing: In this process an agenda is negotiated that draws on both the client and practitioner expertise to agree on a shared purpose, which gives the clinician permission to move into a directional conversation about change.

Evoking: In this process the clinician gently explores and supports the person as they build their own "why" of change through eliciting the client's ideas and motivations. Ambivalence is normalized, explored without judgement and, as a result, may be resolved. This process requires skillful attention to the person's talk about change.

Planning: Planning explores the "how" of change where the MI practitioner supports the person to consolidate commitment to change and develop a plan based on the person's own insights and expertise. This process is optional and may not be required, but if it is, the timing and readiness of the client for planning is important.

The skills of MI:

Open questions draw out and explore the person's experiences, perspectives and ideas. Evocative questions guide the client to reflect on how change may be meaningful or possible. Information is often offered within a structure of open questions (elicit-provide-elicit) that first explores what the person already knows, then seeks permission to offer what the practitioner knows and then explores the person's response.

Affirmation of strengths, efforts and past successes assist in building the person's hope and confidence in their ability to change.

Reflections are based on careful listening and trying to understand what the person is saying by repeating, rephrasing, or offering a deeper guess about what the person is trying to communicate. This is a foundational skill of MI and how we express empathy.

Summarizing ensures shared understanding and reinforces key points made by the client.

Change talk, sustain talk and ambivalence

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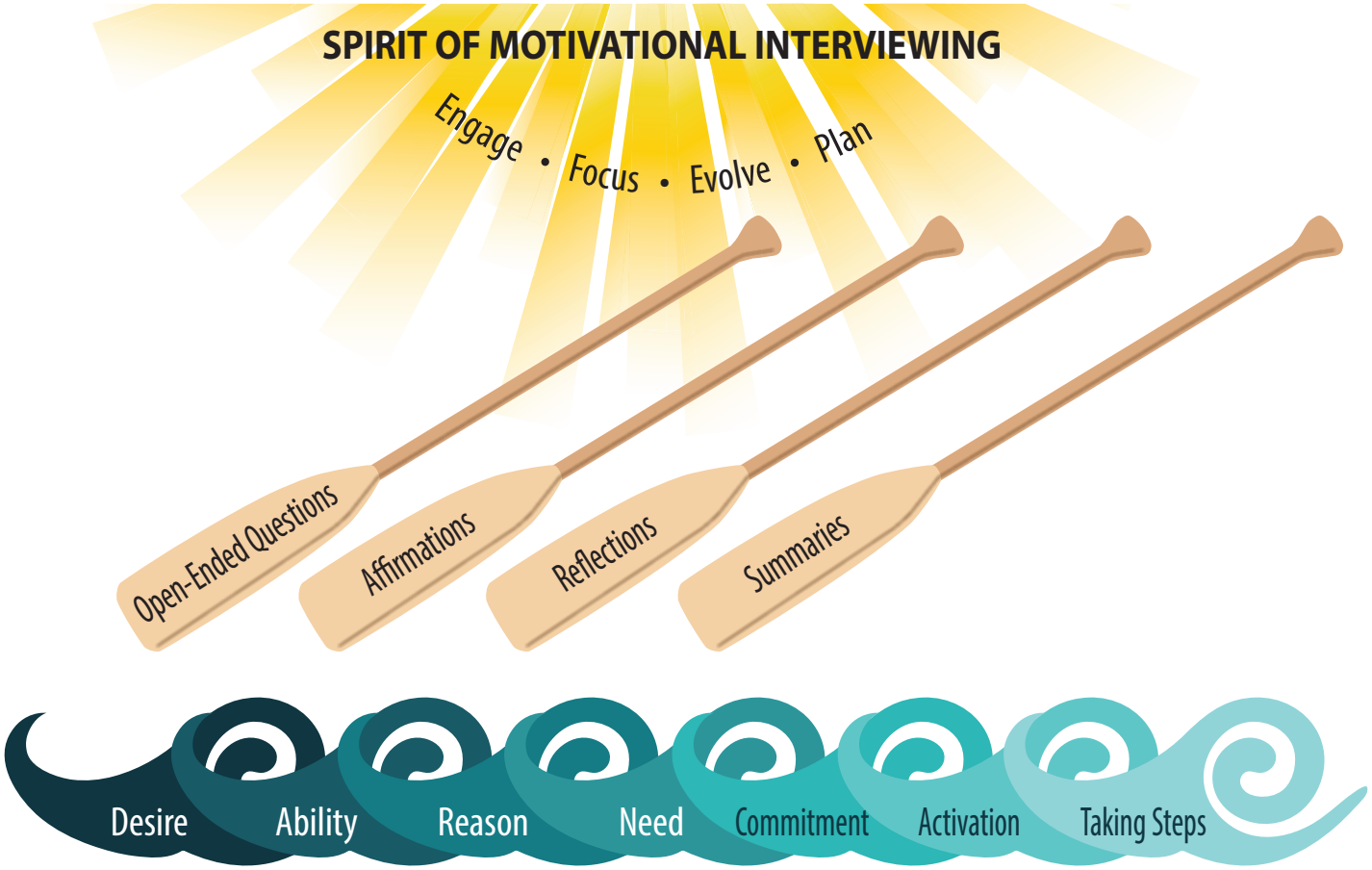

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Section 7: Coordination of care

Overview

Previously, we discussed the lists of needs and interventions that may flow from the assessment process. We know it is critical to plan for these referrals so the family is not overly burdened by the requirements of too many things at the same time. Another core practice that will be essential to the outcomes of the case is the coordination of these interventions, which is best accomplished through Child and Family Team Meetings.

What is the Child and Family Team Meeting (CFTM) process?

Child and Family Team Meetings are an important part of the child welfare process in Illinois' work with families. These meetings provide an opportunity for families and their supports to communicate and work together effectively to meet the needs of the child and family. The CFTM brings together the family, as defined by the family; natural supports like friends, neighbors and church members; and formal resources like therapists, caseworkers and probation officers. The purpose of the CFTM is to address the needs identified by the family, build upon their strengths and develop a plan to accomplish their goals with the support of their team.

Why are Child and Family Team Meetings important?

- CFTMs build on the family's strengths while meeting the family's needs.
- Families are experts on themselves.
- Families deserve to be treated with dignity and respect.
- Families can make well informed decisions about keeping their children safe when supported.
- Outcomes improve when families are involved in decision making.
- A team is often more capable of creative and higher quality decision making than an individual.
- CFTMs help end the need for DCFS involvement.

Who comes to the meeting?

The family will explore who they would like to invite to the CFTM with the support of their child welfare worker. The meeting should involve whomever the family defines as the family. Team members that may be invited include natural supports such as pastors, grandparents, siblings and friends; and formal supports such as therapists, teachers and counselors.

Family First Stakeholders

Casey Family Programs
Dept. of Human Services
Dept. of Public Health
Aunt Martha's
Children's Home and Aid Society
Hephzibah Homes
Illinois Collaboration on Youth (ICOY)
Ounce of Prevention
Lawrence Hall You Services
Allendale For Kids
Caritas Family Solutions
Omni Youth Services
Maryville Academy
Lutheran Child and Family Services
Kaleidoscope
Northwestern University
Chapin Hall
Center for Youth and Family Solutions
Center for Law and Social Work (CLSW)
Office of the Public Guardian
Administrative Office of the Illinois Courts
Judge Valerie Ceckowski
Lake County
Judge Martin Mengarelli Madison County
HealthCare and Family Services
University of Illinois at Champaign
Substance Use Prevention & Recovery (SUPR)
Little City Foundation
Cunningham Children's Home
Let it Be Us
Nexus
Ada S. McKinley
Spero Family Services
UCP Seguin
Thresholds
Garden of Prayer Youth Center
Luther Social Services of Illinois
Chaddock
Easter Seals
Pathways
Hoyleton
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