MOTIVATIONAL INTERVIEWING

A Guide to Family First Implementation

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Motivational Interviewing: A Transformational Opportunity

Motivational Interviewing (MI) is an evidence-based practice (EBP) with the potential to change the way child welfare professionals work with families. By providing a framework for workers and clinicians to reach, engage, and empower families, it creates affirming and transformative service experiences—replacing the reactive or punitive interactions that have characterized child welfare for too long.

Delivered as an integrated component of case practice, MI represents more than a clinical intervention: it can be a radically different approach to partnering with families. While many EBPs attempt to modify or direct a participant's behavior, MI is a nondirective approach that supports individuals to clarify their own intrinsic motivation for behavior change. MI's empowering approach dovetails with child welfare's increasing commitment to racial equity and community-centered prevention approaches. In light of new opportunities under Family First, many child welfare systems will implement MI across their service continuum, altering day-to-day interactions between workers and families and changing how they carry out their mission for generations. Other jurisdictions will need to take a more prescribed or incremental approach to implementing MI over time, knowing that they will get out what they put in.

Unlike other evidence-based models prevalent in child welfare, MI is not a manualized intervention with prescriptive structure, sequencing, and tasks to guide practice. In fact, its developers call it a "counseling approach."[1] Moreover, methods for implementing MI in the child welfare context are not articulated. For this reason, as well as the long history of successful and creative adaption of the approach in a wide variety of contexts, jurisdictions considering MI should approach its implementation in a planful and intentional manner.

Chapin Hall and Public Consulting Group (PCG) have developed this guide to share key considerations at each step of the planning and implementation process to boost impact of MI practice. Quality implementation is essential for realizing the potential impact of EBPs. Therefore, Chapin Hall and PCG are dedicated to supporting child welfare systems and their partners throughout the planning, implementation, and claiming of MI so that jurisdictions across the country do not miss this opportunity.

This guide provides a roadmap through the MI planning and implementation process as follows:

- **Planning and Readiness.** The planning and readiness section begins with an overview of the model, reviews the historical context and current policymaking environment, and provides a summary of key benefits of the approach for child welfare systems. The planning section concludes with guidance for developing an implementation strategy and drafting an implementation plan.
- **Implementation and Change Management.** The implementation and change management section of the guide provides an in-depth exploration of considerations and approaches for two core components of MI implementation: supporting workforce capacity and claiming. Each of these implementation components is thoroughly reviewed, highlighting current practice and well as opportunities.
- **Continuous Quality Improvement.** This section provides a step-by step-guide for developing an approach to continuous quality improvement (CQI) for Motivational Interviewing. Fidelity monitoring methods and instruments explored in depth, and key MI outcomes are identified.

Within each section, the guide presents key decisions and actions that must be addressed by jurisdictions implementing MI, which are marked with ✓ symbols.

Planning and Readiness

Explore and Understand the Model

Motivational Interviewing is a person-centered approach designed to address the common challenge of ambivalence to change. Rather than being presented as an intervention per se, MI is framed as a method of communication that can be used on its own or in combination with other treatment approaches.[2]

OVERVIEW OF MOTIVATIONAL INTERVIEWING

According to clinical psychologists William R. Miller and Stephen Rollnick, who are recognized as the lead developers of the approach, "MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."[3]

The MI principles of engagement are:

- An authentic partnership between the practitioner and the client.
- A nonjudgmental and respectful approach to signal the practitioner's acceptance of the client.
- Compassion for and prioritizing the client's needs and their well-being. Evocation of the client's own desire to work toward change.

While it is commonly said that MI is simply "good social work practice," the approach is defined by a core set of skills and fundamental processes. These core skills are abbreviated by the acronym OARS, which stands for the following:

- **Open questions** to elicit and explore the person's experiences, perspectives, and ideas.
- **Affirmations** of successes and strengths to foster the person's confidence in their ability to change.
- **Reflections** based on attentive listening and understanding what the person is expressing, by repeating, rephrasing, or connecting with a deeper level of meaning the person is expressing.
- **Summarizing** to ensure a shared understanding and reinforce a person's key points.

The fundamental processes of Motivational Interviewing are:

- **Engaging** in a working relationship through listening and understanding.
- **Focusing** on a shared purpose or agenda.
- **Evoking** clients' ideas and motivations to explore ambivalence and understand their own "why" of behavior change, as well as the skills and strengths they would bring to it.
- **Planning** for change, led by clients in a way that highlights their strengths and expertise.[4]

MI's core skills and fundamental processes are "observable practice behaviors" that can be empirically measured to provide clinicians with objective feedback.[5] The approach was originally used with adults experiencing substance use issues[6] and has since been applied in many contexts and settings with many different populations.[7] Research studies have found that MI is more effective than traditional advice giving to treat a broad array of behavioral and physiological illness.[8]

When thoughtfully adopted, MI can be a potent tool for empowering families, securing engagement, and eliciting behavioral change by resolving ambivalence and addressing barriers to change. As jurisdictions adapt to Family First and align service plans to be more family driven and prevention oriented, MI strategies can help the child welfare workforce more effectively partner with families. After multiple generations of child welfare involvement, families have come to expect punitive, demanding treatment from child welfare agencies and family courts; ambivalence toward "the system" appears at both the case and system levels. Although child welfare staff may find safety concerns to be evident and pressing, families experiencing child welfare involvement may not follow through with service plans due to unanticipated setbacks, low motivation, competing priorities, or lack of personal agency in service planning. MI has the potential to address these barriers, whether it is implemented in preventive (family preservation) services or any other part of the child welfare continuum. Addressing these barriers through MI can lead to more meaningful and realistic case goals and strategies and increase the chance that families will attain the goals in their service plans.

HISTORICAL CONTEXT AND CURRENT STATE OF MOTIVATIONAL INTERVIEWING IN CHILD WELFARE

Emergence and Growth in the Field

Interest in the use of evidence-based practices (EBPs) in child welfare has grown significantly over the past two decades, accelerating in the late 2010s with the prominence of EBPs in many Title IV-E Waiver demonstrations. Still, relatively few evidence-based programs have been effectively implemented for use with child welfare populations to date.[9] The California Evidence-Based Clearinghouse for Child Welfare (CEBC), the first child welfare-focused clearinghouse with significant national prominence, aims to advance the effective implementation of such EBPs for

children and families involved with the child welfare system. The CEBC first added Motivational Interviewing to its registry in 2006.[10] It rates MI with a score of one on a 5-point scale, with one being the highest rating, "Well-Supported by Research Evidence."[11]

While MI is a commonly used approach with a significant presence in some human services fields, particularly criminal justice and welfare-to-work settings, its use in child welfare has been limited. When used in child welfare, MI has been applied across a range of contexts, including with caregivers and adolescents.[12] Jurisdictions have developed and delivered MI training to both their agency staff and contracted provider agency staff. These trainings have included homegrown training developed by agencies themselves, as well as training delivered by Motivational Interviewing Network of Trainers (MINT)[13] members and other external clinicians. Motivational Interviewing has demonstrated effectiveness in helping clients to build their motivation for completing child welfare services and enhancing their readiness to change.[14]

Current Policymaking Environment

The Family First Prevention Services Act (Family First or FFPSA) was passed in 2018, representing the most significant child welfare legislation in more than a decade. At the center of the legislation is a new opportunity for jurisdictions to claim Title IV-E funds for evidence-based preventive services delivered to "candidates for foster care"[15] and their caregivers, as well as to pregnant and parenting youth in foster care. Family First brought unprecedented federal funds not only to preventive services but specifically to evidence-based practice, spurring new interest and investment in preventive EBPs in child welfare nationwide. The legislation established the Title IV-E Prevention Services Clearinghouse (the Clearinghouse) to systematically review available research on programs and services intended to support children and families and prevent entry into foster care.

The Clearinghouse reviews programs for Title IV-E prevention funding in three discrete areas: mental health, substance abuse prevention and treatment, and in-home parent skill-based programs.

Motivational Interviewing was one of the first 12 programs identified for systematic review by the Clearinghouse.[16] It was reviewed as a prevention service for substance abuse and was given the Clearinghouse's highest evidentiary rating of "well-supported."[17] MI's well-supported rating enables jurisdictions to include the intervention in their Title IV-E Prevention Plan and request a waiver of the requirement to undertake a well-designed and rigorous evaluation.[18]

A pivotal milestone in the prominence of Motivational Interviewing as a Family First prevention service occurred in September 2020, when Washington, DC, received approval for its Title IV-E Prevention Plan.[19] While MI had been approved in the Clearinghouse solely as a substance abuse intervention, Washington, DC's plan proposed its use as an integrated component of case management practice to address needs related to substance use, mental health, and parenting. Under the plan, both community-based providers and agency in-home caseworkers will deliver MI across all cases as both a distinct treatment modality intended to motivate change and adherence to case goals, and as a "bundled program,"[20] delivered alongside other evidence-based programs to enhance their uptake and effectiveness.[21] Washington, DC anticipates MI will result in better achievement of case goals and outcomes for children, youth, and families.[22]

Other jurisdictions have since followed the District's lead in proposing to use MI more broadly than as a substance abuse intervention. Like Washington, DC, most propose using it in a manner integrated with casework practice, often as an integral component of the jurisdiction's practice model. Considerations related to the scope of MI implementation are discussed in depth in the section below, "Supporting Change in Child Welfare Practice."

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Key Benefits to Child Welfare Systems

The implementation of Motivational Interviewing under Family First confers multiple benefits to jurisdictions. Most importantly, allowing jurisdictions to deliver the model by integration with case practice provides a clear pathway to widespread practice improvement. This integration fundamentally changes the ways child welfare practitioners engage and partner with families. In addition, the ability to flexibly apply MI with all Title IV-E prevention cases allows jurisdictions to offer EBP services and claim for more children under Family First—sometimes for entire programmatic areas (such as Family Preservation or In-Home Services).[23] Lastly, the broad application of MI provides jurisdictions with a mechanism to meet the Family First requirement that at least 50% of reimbursable costs be for interventions rated "well-supported" on the Title IV-E Clearinghouse.[24] A jurisdiction making investments in "supported" and "promising" EBPs benefits from the ability to count its MI spending in its calculation of "well-supported" EBPs, thus enabling more claiming on EBPs with lower evidentiary ratings—a benefit that is covered further in the "Claiming for MI" section of this guide. Collectively, these advantages have significantly elevated MI's prominence in the field since the passage of Family First.[25, 26]

While individual contexts vary, key aspects of the MI approach align well with the child welfare context, and many jurisdictions' practice models already contain OARS skills. MI is well-regarded for its broad applicability as well as its intuitive appeal and accessibility, making it a good fit for a wide range of child welfare and provider workforces. Both clinical and nonclinical practitioners can be trained and coached to use MI effectively. While ongoing learning, consultation, and practice are necessary to continue increasing skillfulness and mastery of MI methods, practitioners can gain an understanding of the method and some initial experience delivering it with approximately 16 to 24 hours of training.[27] As the approach is in the public domain, cost barriers are lower for MI than for many other evidence-based practices.

The increasing application of MI in the field of child welfare has corresponded to a concurrent increase in evidence of its effectiveness for improving child welfare-related outcomes. Available evidence suggests that Motivational Interviewing has a small but statistically significant effect on client engagement and intention to change.[28] Since the initial CEBC review, further reviews have demonstrated MI training can yield positive impacts on child welfare workers' empathy and self-efficacy.[29] When MI is used as a standalone intervention, evidence suggests that participants' subsequent engagement in substance use treatment and intensive family preservation programs increases.[30] As an adjunctive intervention—when used in tandem with another treatment modality—MI is correlated with improved outcomes for families receiving Parent-Child Interaction Therapy (PCIT), Multisystemic Therapy (MST), Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT), and the Parents Raising Safe Kids program.[31] In light of these favorable results, expansion of MI as both a primary practice and an adjunctive intervention holds promise in child welfare settings.

However, jurisdictions considering MI implementation should bear in mind that not all studies have found favorable results; the Title IV-E Clearinghouse reviewed a wide range

Key Benefits of MI in Child Welfare

- MI can lead to widespread practice improvement, changing how practitioners engage and partner with families.
- Stronger partnerships with families may lead to more consistent engagement in preventive services and achievement of family goals.
- Implementing MI broadly allows jurisdictions to offer EBP services and claim for more children under Family First—sometimes entire programmatic areas.
- Claiming for MI contributes to meeting the Family First requirement that 50% of reimbursable costs be for interventions rated "well-supported," thus enabling more claiming on EBPs with lower evidentiary ratings.

of available research to identify 109 findings. Of these, 16 showed "Favorable" effects, 91 showed no effect, and 2 showed "Unfavorable" effects. No evidence-based practice is a silver bullet, and in exploring an MI-based strategy, the strengths of the intervention should closely align with the policy goals it is meant to support. Moreover, sustaining improvements in MI skills requires quality implementation, integration within the unique system and context, and meaningful investment in workforce supports.

APPLYING MOTIVATIONAL INTERVIEWING WITH DIVERSE POPULATIONS

When selecting and implementing EBPs, it is essential to consider each model's fit and effectiveness with a jurisdiction's specific racial, ethnic, and cultural subgroups. Although a small number of MI studies has examined race, ethnicity, and culture, MI's effectiveness with clients from a variety of backgrounds has not been demonstrated conclusively. Nonetheless, these research findings combined with early work on cultural adaptations of MI, yield important insights. At the writing of this Guide, most culturally-specific adaptations of MI are in early stages of development and building evidence. Jurisdictions considering Motivational Interviewing may wish to explore emerging adaptations to ensure appropriate and effective services for those most impacted by systemic racism and disproportionate child welfare system involvement.

While one prominent meta-analysis shows that Motivational Interviewing may be more effective with racial, ethnic, and cultural minorities in general compared to white clients,[32] findings for African American and Hispanic clients are mixed.[33,34,35] Moreover, preliminary evidence suggests that a culturally adapted version of MI may be more effective for Hispanic individuals.[36] Very limited research exists on MI's effectiveness with Asian Americans,[37] though culturally-tailored MI adaptations for Nepali[38] and South Asian[39] clients have been explored. MI is often described as well-aligned with American Indian/Alaskan Native culture and communication styles,[40] and a Motivational Interviewing manual has been developed for use with American Indian/Alaskan Native populations.[41] The manual reflects a promising contribution to the field, and early research suggests that culturally adapted versions of MI may be more effective with American Indian/Alaskan Native individuals.[42]

Ensure Alignment with Organizational Goals and Develop a Theory of Change

Once a jurisdiction has reviewed the historical and current policy making context and determined that the key benefits of MI are aligned with its Family First vision, it is ready to begin implementation planning.

As the jurisdiction begins its effort to integrate MI into its prevention strategy broadly and its Family First prevention plan specifically, the jurisdiction's agency should articulate the agency's goals, objectives, and theory of change vis-à-vis Motivational Interviewing and deliberately set aside team time to clarify these critical inputs to the jurisdiction's implementation strategy. MI promises to transform the ways in which child welfare practitioners partner with children, youth, and families. A clear and intentional implementation strategy is required to support and ensure the success of this fundamental shift.

Jurisdictional goals and objectives for MI implementation should be identified at the individual, group, organization, and community levels. While goals are high-level and aspirational in nature, objectives are more concrete components of broader goals. Objectives are specific measurements of success; they can be process- or outcome-oriented and short- or long-term.

A *theory of change*[43] is a useful tool to help structure and logically depict an intended change process. It presents a roadmap from an identified issue or interrelated set of issues to the intended long-term outcomes, depicting the change that occurs along the way. A theory of change is a critical tool for identifying interventions in alignment with intended impacts. A jurisdiction should review its Family First theory of change to confirm the appropriateness of MI as an intervention.

Once goals and desired objectives are clearly identified and the expected change processes are understood, a *logic model*[44] can be a powerful planning tool to inform a logically consistent MI implementation approach. It will also serve as the basis for developing research questions and measures to fuel the continuous quality improvement (CQI) or evaluation process.

Develop an Implementation Strategy and Plan

An *implementation strategy*[45] is the culmination of a jurisdiction's planning process.

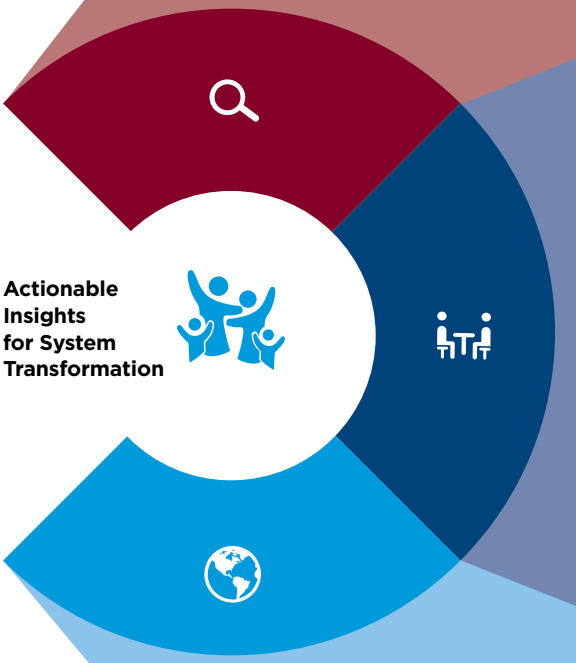
Conceptually mapping out the phases or components of the implementation process clarifies what activities need to be accomplished, the methods or approaches that will be used, and what milestones will determine success. An implementation strategy also considers practice installation and sequencing, including which activities can occur in parallel, what must be phased in, and how outdated processes will be transitioned to the new.

Once an implementation strategy has been conceptualized, a jurisdiction is ready to develop its implementation plan. An *implementation plan*[46] is a project management tool that guides the implementation by identifying all the activities that need to occur, who needs to be involved, for how long, and at what level of effort. It clarifies the resources needed and the interdependencies among the various activities and tasks.

Figure 1 shows the implementation phases and offers an overview of key activities that a jurisdiction may undertake throughout the implementation process.

Although the phases and tasks will differ between jurisdictions and organizations depending on the depth to which MI will be applied, a well-structured and -sequenced approach to implementation is essential to ensure the success of any new practice—especially MI, which can have deep implications for the day-to-day work of child welfare practitioners.

Figure 1. Phases and Key Activities in the Implementation Process



Planning and Readiness

- Understand the historical and current policymaking environment
- Consider the benefits of the MI model and how they align with jurisdictional goals and theory of change
- Define desired change and logic model for MI
- Determine scope of MI implementation across staff levels and types
- Assess alignment with the jurisdiction's practice model, EBP continuum, & workforce development goals to identify needed implementation supports for integration
- Identify key MI implementation drivers[47]
- Define implementation strategy and plan
- Form a partnership of agencies, providers, and stakeholders across the human services system to implement MI

Implementation and Change Management

- Revise policy changes to support MI implementation
- Develop communications plan
- Deliver initial training and coaching
- Develop claiming strategy and submit cost allocation plan amendment if needed
- Adapt data systems to capture MI claiming, reporting, and CQI data elements
- Update business processes and practices to support implementation and documentation needs
- Procure and contract for MI if delivered by a provider
- Monitor and manage implementation drivers

Evaluating & Improving Quality

- Implement key fidelity and capacity measures early to monitor and improve implementation
- Identify tools for CQI and fidelity monitoring
- Establish methods and infrastructure for capturing, storing, analyzing, and reporting CQI data Integrate MI CQI within the broader Family First CQI framework
- Form a Family First CQI team including MI experts and practitioners
- Initiate CQI cycles of improvement to monitor and improve fidelity and outcomes
- Provide ongoing coaching and workforce supports to promote consistent practice

Implementation and Change Management

Supporting Change in the Child Welfare Workforce

As a jurisdiction develops an implementation strategy, the manner in which Motivational Interviewing will be integrated into the jurisdiction's child welfare practice is of central importance in determining other aspects of implementation, including training, continuous quality improvement, and claiming. MI offers inherent flexibility in the manner and degree to which the approach is integrated into a jurisdiction's practice, and jurisdictions must determine their own scope and goals prior to planning implementation. Depending on the scope of implementation, workforce development and training strategies may require significant planning and coordination. By incorporating frontline staff and agency partners who will be impacted into the planning and readiness phase, a smoother implementation can be ensured.

Determine the Scope of Implementation

Each jurisdiction has unique constraints, strengths, and priorities for practice improvement. Given this, each jurisdiction should explore and determine where within agency and partner operations MI will be the most feasible and impactful.

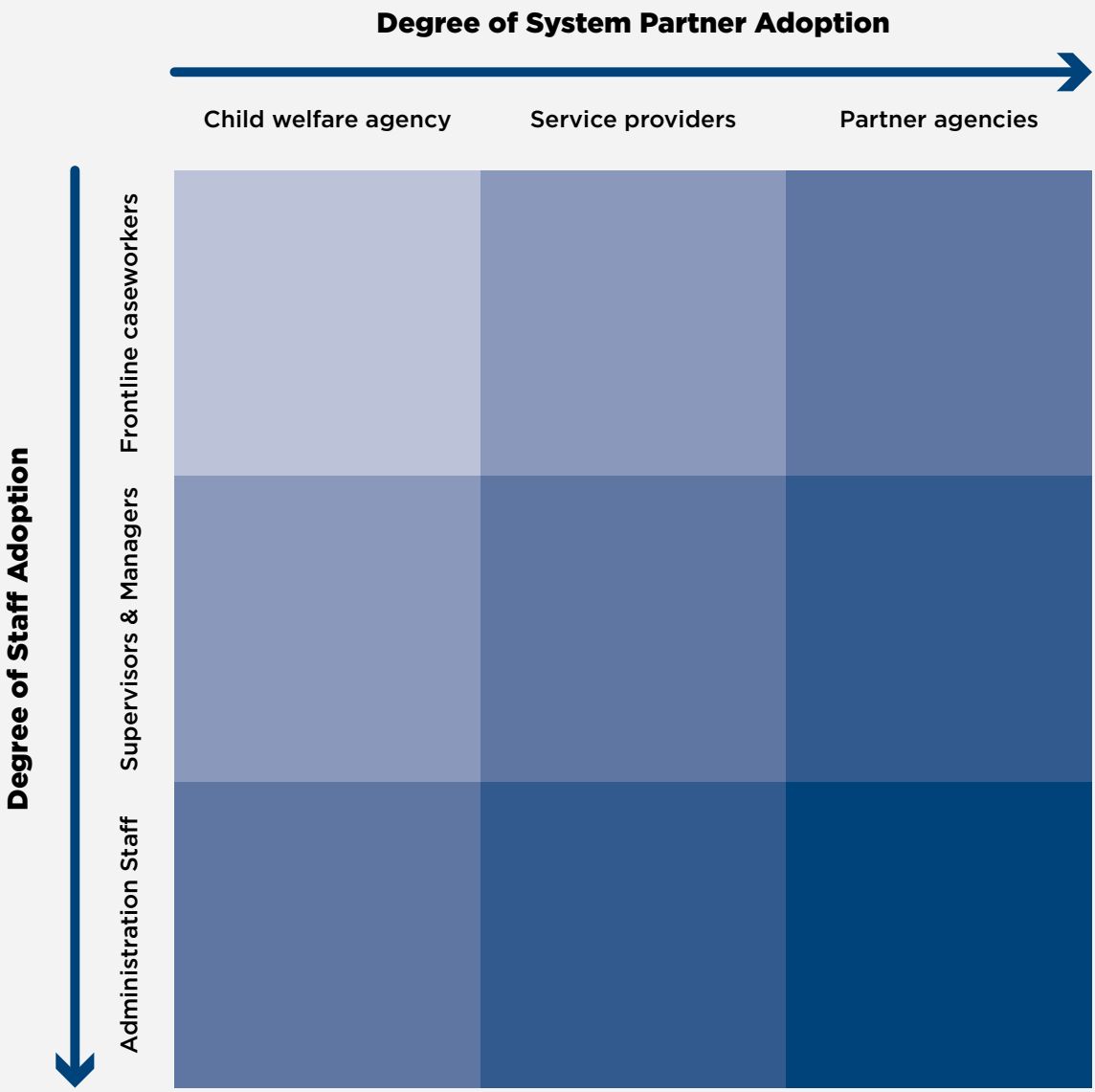
Implementation will be strengthened if jurisdictions take a broad, comprehensive approach. This entails implementing MI not only across the child welfare continuum, but also across the broader human services system by engaging partners early in planning and implementation. Offering MI training and support to partner agencies and Family Courts benefits families in multiple ways. First, model fidelity will be higher when training is consistent across the service continuum. Second, caseworkers working with high-risk families can be assured that a shift to MI-infused practice (as opposed to more traditional, directive approaches) will be supported by Family Courts and agency managers. Third, families will experience coherence in case management strategies across their involvement with child welfare. With continuum-wide training, a CPS caseworker, a preventive services worker, and a judge will all reinforce the values of MI and a parent's agency in addressing safety concerns. Partner agencies charged with assessing eligibility and referring families to Family First EBPs could be trained in MI to promote the same strong family engagement skills.

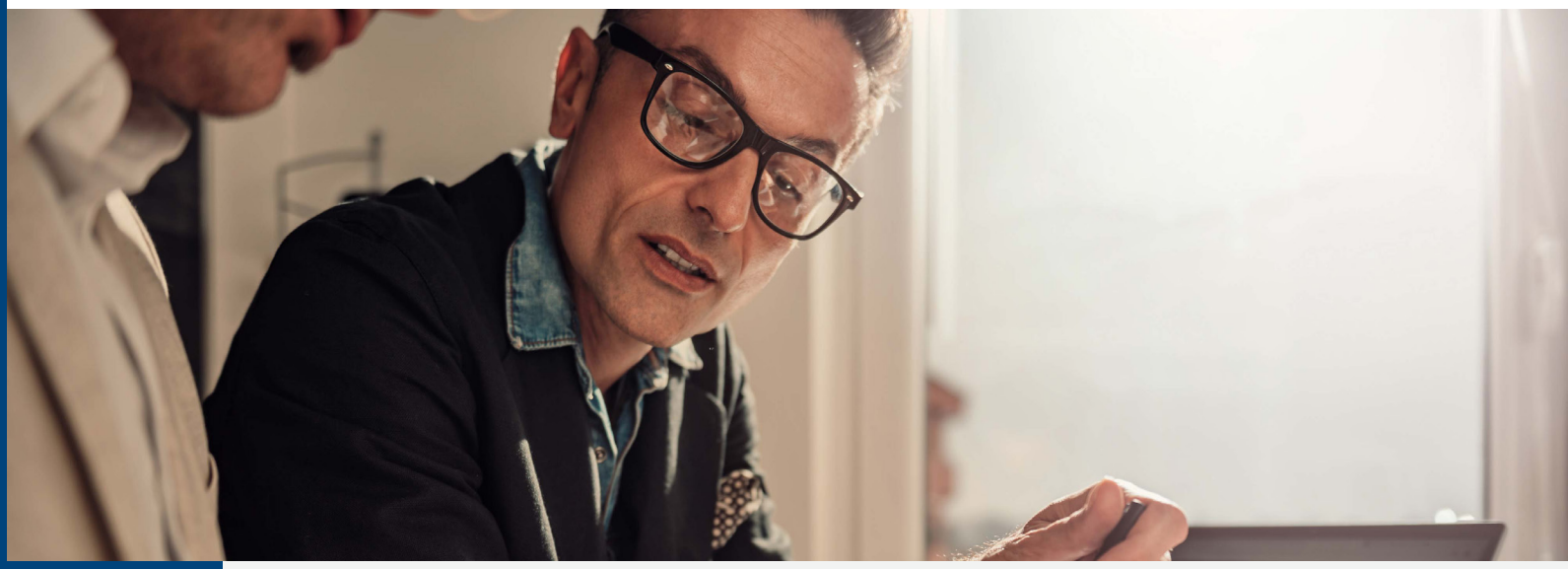
In light of families' prior experience with child welfare, this last point is especially important. MI seeks to deepen trust with caregivers in distress. If the legal system or other service partners do not reinforce the validating, growth perspective of Motivational Interviewing—or worse, undermine or discredit it—families may perceive the practice as disingenuous or even harmful. Agencies and jurisdictions that use MI as described by Miller and Rollnick—a style of engagement infused throughout an agency's practice that fosters growth, respect, and empowerment—are likely to see meaningful shifts in child and family well-being, no matter how the family arrives at the attention of child welfare.

Lastly, while practice with families is usually an agency's primary focus, the benefits of infusing MI into agency-wide administrative and managerial operations should not be overlooked. MI-infused coaching and supervision supports staff growth and commitment in a way that is both cost effective and impactful. Soliciting change talk from staff who are not frontline workers can spur novel, creative problem solving for agency operations and imbue staff with a sense of being heard and valued. These outcomes benefit the agency by opening up new avenues for innovation. They can also potentially reduce attrition and turnover by improving the quality of communication and supervision.[48]

The following matrix illustrates a jurisdiction's cumulative depth of MI implementation across two dimensions: degree of adoption across agency and system partners, and degree of adoption across staff roles. Jurisdictions should start with a level of implementation that aligns with identified goals and readiness, and may wish to consider planning a phased approach to expanding implementation over time.

Figure 2: Dimensions of MI Implementation





Deepen Implementation through Administrative Infrastructure, Policies, and Protocols

Learning and integrating Motivational Interviewing involves shifts in practitioner perspectives and behaviors because MI typically requires new ways of thinking and communicating.

Such change rarely occurs overnight and must be supported and nurtured by implementing agencies, allowing full implementation to unfold over time. Successful practitioner implementation requires an organization to allocate the necessary finances, resources, and time to support change. Experts indicate that if implementation is done well and with deep investment in supporting shifts in practice, an organization can achieve full implementation into services within 2 to 4 years.[49] More often than not, an agency's training or workforce development arm will have a significant role in the implementation of MI. As described in the "Training and Support for the Workforce" section to follow, the effectiveness of acquisition of MI skills can be impacted by the chosen training model (one-off, ongoing, with or without coaching).

Successful practitioner implementation requires an organization to allocate the necessary finances, resources, and time to support change.

How an agency incorporates MI into its existing policy infrastructure will vary depending on the vision for infusing MI into child welfare operations. Leaders should consider whether implementation will solely focus on frontline workers and supervisors or if administrative and managerial staff will also adopt MI practices. Based on these decisions, policies will then need to be reviewed and updated to reflect the expectation that MI is employed in key interactions. The goal is to integrate MI into everyday, routine practice.

Integrating MI into Administrative Infrastructure

While some EBPs require new business processes and workflows, MI can be readily integrated into existing procedures, protocols, and services, such as:

- Position descriptions for caseworkers, supervisors, and managers
- Protocols for CPS investigation and service initiation practices
- Policies guiding family and child assessments and service planning
- Policies outlining training requirements and expectations
- Competencies measured in employee performance reviews

Training and Support for the Workforce

MI training is not standardized or manualized by its developers; relying on a prefabricated approach can lead to disappointing outcomes.

OVERVIEW OF POSSIBLE APPROACHES FOR MI TRAINING

MI training is meant to be tailored and personalized to a variety of audiences.[50] Jurisdictions, therefore, have tremendous flexibility to determine what training will meet the needs of their workforce. However, fidelity tools that measure and provide

data for coaching to MI require more prescriptive training to ensure consistency in practice, delivery, and CQI measurements.

An initial exploration of MI implementation should consider existing MI trainings the agency already offers. As part of an agency's practice model, components of MI may be included in existing trainings for the workforce, or in preservice training. One-off trainings may suffice as an overview of MI information, though recurring training, training with ongoing coaching, and training with booster sessions are more likely to result in actual skill acquisition.[51] This points to the difference between learning *about* MI and the ability to actually demonstrate MI with fidelity, so that families can experience positive outcomes. Training alone will not be as impactful as ongoing reinforcement of MI practice through ongoing supervision and coaching (see items 4 and 5 in "Tailor Training and Capacity-building to Support Implementation Goals").

> Jurisdictions … have tremendous flexibility to determine what training will meet the needs of their workforce.

Building an MI Training Plan

A well-developed MI training plan is responsive to the unique context of the implementing agency and system, and can be accomplished in three phases:

1. Inventory the agency's existing MI capacity, trainings, and workforce needs
2. Identify an ideal training plan based on the scope and type of planned implementation
3. Adjust the plan based on feasibility and contextual factors as implementation rolls out

Consider Building Internal Capacity through MINT Membership

In order to maximize successful implementation of MI, jurisdictions or agencies may want to consider supporting one or more staff applying for MINT membership.

Typical criteria for a successful application include extensive prior and ongoing training, extensive supervision and feedback about work samples, the opportunity to use or train on MI going forward, and exceeding competence in a standard patient/client MI demonstration. Individuals may also be interested in seeking guidance and coaching from a qualified MINT member to meet application criteria. Resources for high-quality self-paced training modules and self-study and learning community resources can be found in Appendix A.

Tailor Training and Capacity-Building to Support Implementation Goals

The following descriptions outline typical MI training and capacity-building approaches and identify learning objectives for each. They could be used independently or in combination, building on each other to deepen and increase fidelity of MI practice.

1. Introductory level (typically 2 full days): Providers learn about MI generally and may begin to feel a difference in heartset and mindset about working with others. in addition to provider training, all staff who have any contact with clients (including reception, telephone reminders, and scheduling personnel as well as overnight, kitchen, transportation, medical, and similar staff in residential settings) can benefit from learning about "MI spirit" in a 2- to 3-hour workshop and will more effectively support the organization's overall mission.

2. Intermediate or advancing skills level (typically 2 full days): Focusing on intensive skills practice, students may see a difference in their ability to use MI relationally and technically. Trainer will offer sessions that address and allow students to practice skills for specific challenges they face in their work.

3. Practitioners' playground/community of practice/learning community (ongoing): Emphasizes keeping learning alive through deliberate, interactive practice. Organizations can also connect some of their key staff MI champions to external communities of practice to keep ideas flowing in.

4. Supervision or learning coding/coaching tools (typically three to four full days): Students learn about evaluating motivational conversations and helping others improve in MI. They learn ideas for forming communities of practice or learning communities, continuing and sustaining development, integrating MI into service delivery, supporting organizational implementation, and gaining these capacities to help organizations sustain their MI investment and work toward self-sufficiency in MI implementation. Coding and coaching are also useful functions for QA staff; learning to use a coding instrument with fidelity will help jurisdictions toward self-sufficiency and enhance positive outcomes.

5. Personalized and individualized feedback (ongoing): A skilled coach (internal or external to the organization) trained in one or more coding/evaluation techniques facilitates planning for change by reviewing objective criteria about what staff are doing well and ideas about how to strengthen their MI abilities. In Family First implementation, this kind of feedback should be paired with the use of objectively rated fidelity results. This is a fast and effective way for a staff member to get better at MI. Initially, feedback every 3 to 4 weeks is optimal; some individuals will be able to meet competence by their third work sample, and it is recommended that feedback continue for up to six sessions and at least twice annually thereafter to reduce skill drift.

6. Training for MI in groups or for blending EBPs (varies): Workshops for MI in groups and blending EBPs are specialized topics. Agencies will want to explore their training needs with potential trainers to generate an experience tailored to their particular goals.

7. Individual study and self-training (varies): Perhaps the most common method by which clinicians explore MI is to study print materials and view training videotapes. Although this can provide some understanding of the basic approach, research by Miller and colleagues found that assigned self-training was not effective in improving clinical skillfulness in MI (see Appendix A for list of resources for individual study and self-training).[52]

Claiming for Motivational Interviewing

As noted above, Family First provides federal funding for evidence-based practices that prevent placement into foster care. Federal funding is available through the Title IV-E Prevention Services Program for Prevention Services and related administration costs. Each category has its own set of rules for submitting claims to the federal Administration for Children and Families (ACF) using the CB-496 form.[53]

The categories for claiming include:

- **Prevention Services:** Funding for the services delivered as evidence-based programs that are approved by the Clearinghouse and included in the jurisdiction's approved 5-year Prevention Plan, when the services are delivered to a child who meets all Title IV-E Prevention Program child-specific eligibility requirements.
- **Prevention Services Administration:** Funding for costs incurred by the state agency responsible for administering the Title IV-E Prevention Program, as well as any other public agency that has an agreement with the Title IV-E agency, when delivered on behalf of a child who meets the Title IV-E Prevention Program child-specific eligibility requirements, as detailed below. Administration costs include activities such as case management, supervision, and training, as defined in 45 CFR 1356.60.[54]

Costs associated with delivering an MI service can fall in either of these categories. This section explores methods for capturing and claiming costs associated with delivering MI under an approved Prevention Plan.

Definition of an Eligible Child

Claiming under the Title IV-E Prevention Services program requires that the child or youth receiving the service meet the eligibility requirements for the program. These requirements include:

- The child meets the definition of "candidate" in the jurisdiction's approved Prevention Plan, or is a pregnant or parenting foster youth;
- If the child is a candidate, the child's candidacy is documented in their child-specific prevention plan; and
- MI is listed as a strategy to prevent placement into foster care in their prevention plan.

In this section, "eligible child" refers to a child who meets all the criteria listed above for the Prevention Services Program and those detailed in federal guidance.[55]

Where to Start: Claiming Under Prevention Services or Prevention Services Administration

MI is approved on the Clearinghouse as a prevention service and can be integrated into case management practice.

Case management is an allowable Title IV-E administration cost. When **integrated with case management**, MI is both a prevention service and an allowable administration cost, so jurisdictions must decide whether to claim MI costs under the rules governing claiming for Prevention Services or under the rules governing administration. Depending on which method a jurisdiction selects, they will follow guidance found under "Methods for Claiming MI as a Preventive Service" or "Methods for Claiming MI Under Title IV-E Administration."

When MI is incorporated into case management, it can be added to every prevention candidate's prevention plan as part of the strategy to prevent placement into foster care, even when the family needs no other approved Family First

service. Jurisdictions can begin claiming for Prevention Services and for Prevention Services Administration costs when a child's prevention plan begins, provided all other eligibility requirements are met.[56]

As of the publication of this guide, ACF has not provided specific guidance on claiming allowable child-specific administrative costs under the rules for Prevention Services Administration. However, because MI is an approved Title IV-E prevention service, listing Motivational Interviewing in a prevention candidate's prevention plan should allow the jurisdiction to claim the costs, regardless of whether the specific costs associated with Motivational Interviewing are claimed under Prevention Services or under Prevention Services Administration. This provides a financial benefit to integrating MI into case management practice, because Prevention Services Administration covers allowable administration costs "without regard to whether the child would be eligible for Title IV-E foster care maintenance payments."[57] In other words, jurisdictions need not apply a Title IV-E foster care eligibility rate to administration costs claimed as Prevention Services Administration.

By comparison, prior to Family First, jurisdictions were only able to claim administrative costs for children who had been defined as candidates for foster care under section 472(i) of the Social Security Act. This category of candidates is referred to as "traditional candidates" and has different claiming rules than prevention candidates, which are defined under section 475(13) of the Social Security Act.[58] Jurisdictions can claim allowable child-specific administration costs for traditional candidates who would be "potentially eligible" for Title IV-E foster care maintenance payments. The federal guidance for traditional candidates states, "The determination of those children who are candidates for Title IV-E foster care must be made either through individual child determinations or through use of an allocation method for determining potential Title IV-E eligibility such as application of a Title IV-E foster care participation rate."[59] With the passage of Family First, jurisdictions can now determine whether to apply traditional or prevention candidacy for a candidate who meets both definitions.

The advantage of claiming "allowable child-specific" administration costs under Prevention Services Administration is that there is no requirement that a prevention services candidate also be "potentially eligible" for any other Title IV-E program, such as the Title IV-E foster care program, which has extensive eligibility requirements. The following table provides a comparison for claiming allowable child-specific administration costs under each program.

Table 1. Allowable Child-specific Administration Costs Example State

Program	Spending on Allowable Title IV-E Administration Activities	Eligibility Rate for Title IV-E Foster Care Payments*	Federal Financial Participation Rate	Revenue
Traditional candidates	$10,000,000	60%	50%	$3,000,000
Prevention Services candidates	$10,000,000	n/a	50%	$5,000,000

*varies from state to state underneath.

When MI is included as an evidence-based practice in the jurisdiction's approved 5-year Title IV-E Prevention Program Plan and integrated into case management practice, the following table compares the benefits and challenges of claiming MI as a Prevention Service or as an Administration cost.[60]

Table 2. Claiming Options When MI is Integrated in Case Management Practice

Type of Claiming	Benefits	Challenges
Prevention Service	• MI is a well-supported evidence-based practice. Beginning in FFY 2024, at least 50% of the expenditures for provision of Prevention Services and programs in each FFY must be for those that meet the "well-supported" practice criteria in accordance with Section 474(a)(6)(A)(ii) of the Social Security Act. Spending on MI services contributes to the percentage of spending on well-supported services, which in turn could increase the amount of spending on supported and promising practices that can be claimed to Title IV-E, as detailed further below. • Starting in federal fiscal year 2027, jurisdictions will receive reimbursement at the federal medical assistance percentage (FMAP) rate for services, which for many jurisdictions is higher than 50%.	• Documentation of the delivery of an MI service must be child specific. • Salaries for staff are usually allocated to Title IV-E administration and other funding sources through a cost allocation plan and a time study. To claim staff salaries and associated overhead as a service, the jurisdiction would need to adjust their processes for administrative claiming and achieve federal approvals.
Administration	• If MI is integrated into ongoing case management practice, then a jurisdiction can calculate claimable administrative costs using existing processes, such as a caseworker time study.	• Administration is reimbursed at 50% regardless of a jurisdiction's FMAP rate. • The requirement that the jurisdiction spends 50% of their claimable Prevention Services funds on well-supported practices is calculated based on spending on **services**. If MI is claimed as an administrative cost as part of ongoing case management, it may not be included in the calculation of spending on well-supported services.

As noted in the Table 2, when spending on MI services is included in the calculation of the percentage of spending on well-supported services, the amount of spending on supported and promising practices that can be claimed to Title IV-E will likely increase. A jurisdiction investing in supported and promising practices would benefit from including spending on MI in their calculation of well-supported practices. For jurisdictions that wish to maximize the calculation of their spending on well-supported services, claiming MI as a service provides a financial advantage. Figure 2 illustrates the advantage of including a higher amount of well-supported practice costs in order to be able to claim more costs for supported and promising practices:

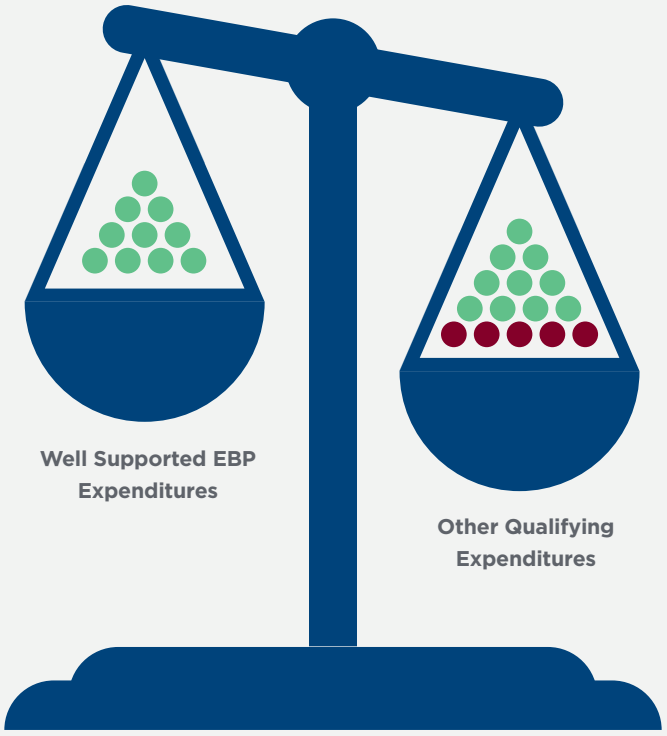
Figure 2. Including MI in Well-Supported Practices Calculation Provides Financial Advantage

FFPSA Requirements:

50% of all prevention EBP expenditures must be spent on 'well supported' EBPs

Well Supported EBP expenditures	$1.5MM
Other Qualifying EBP expenditures	$1MM
TOTAL EBP EXPENDITURES	$2.5MM
● **TITLE IV-E CLAIMABLE DOLLARS**	**$2.5MM**
● **UNCLAIMABLE DOLLARS**	**N/A**

More than 50% of Total EBP dollars were Well Supported EBP dollars, so ALL Other Qualifying EBP dollarsare claimable to Title IV-E



Well Supported EBP expenditures	$1MM
Other Qualifying EBP expenditures	$1.5MM
TOTAL EBP EXPENDITURES	$2.5MM
● **TITLE IV-E CLAIMABLE DOLLARS**	**$2MM**
● **UNCLAIMABLE DOLLARS**	**$500,000**

More than 50% of Total EBP dollars were Well Supported EBP dollars, so ALL Other Qualifying EBP dollarsare claimable to Title IV-E

Define Methods for Claiming MI

CLAIMING MI AS A PREVENTION SERVICE

The Children's Bureau has not issued guidance specific to claiming for MI costs. In the section below, we describe some options for how to identify and claim costs associated with delivering an MI service to a child who is eligible for Title IV-E Prevention Services. In each option, claiming must be in accordance with the jurisdiction's cost allocation plan and the jurisdiction's approved Title IV-E Plan that includes a Prevention Services and Programs 5-year plan.

To claim for the costs associated with MI as a prevention **service**, regardless of whether it is integrated with case management, the jurisdiction must have information to calculate the claim[61] and meet reporting requirements[62] (see Table 3 on next page):

Claiming when Motivational Interviewing is Integrated into Case Management

When state, territorial, Tribal, local, or contracted caseworkers deliver MI services as part of case management, the jurisdiction can consider how to isolate costs associated with MI and claim those costs as a Title IV-E Prevention Service, in accordance with an approved five-year Title IV-E Prevention Program Plan.

We have provided some options for capturing information associated with the steps below; each jurisdiction should consider how they are implementing MI and consider which options, or combinations of options, are compatible with how caseworkers document services and the capability of the jurisdiction's data systems to collect information to support a claim. ACF has not provided guidance as to how costs associated with case management can be claimed as a prevention service. Therefore, each state should enter into a dialogue with their ACF regional office to confirm their planned method for claiming and documenting the child-specific service data that will support their claim. In addition, jurisdictions should submit updated cost allocation plans (CAP) to federal approval authorities as necessary and claim costs in accordance with their CAP.

Table 3. Documentation Required to Calculate Claims and Meet Reporting Requirements

FFPSA Claiming Requirement	Documentation
An MI service was delivered	Definition of a unit of service Documentation that a unit of service was delivered
How much the service cost	A rate associated with a unit of service
Child(ren) benefitting from the service[63]	Documentation of who received the service Documentation of the child(ren) benefiting from the service
The child is identified as a prevention candidate in a child-specific prevention plan	Documentation in the child's prevention plan of candidacy on or before the date of the service
The service is identified as a strategy in a child-specific prevention plan	Documentation that MI is listed as a strategy in the child's prevention plan
When the public expenditure was made	The date the jurisdiction paid for the service (for example, check date of payment to provider or date of payroll if service provided by a public agency employee)

Below we lay out the steps the jurisdiction should take to produce the information required for claiming. For some steps, we have provided examples or options for how to implement the step.

1. **Define a unit of service.** The jurisdiction must define what an MI service includes in a service standard and calculate or establish the amount of time it takes to deliver the service. Considerations for how to define a unit of service include:
    a. Defining what types of activities are included in an MI service. For example:
        i. An MI service could be defined as conducting certain types of MI activities (empathic listening, open-ended questions, presenting options, etc.) when engaged with a caregiver, or
        ii. An MI service could be defined as being consistently embedded in certain types of interactions with caregivers (for example, home visits).
    b. Defining the time it takes to deliver an MI service. **Options** can include:
        i. Defining an increment of time for an MI session. For example, the Clearinghouse notes a typical duration for an MI session is 30 to 50 minutes.
        ii. Based on the jurisdiction's specific practice, studying the time it takes to deliver the service and calculating an average length of time for a unit of service.
        iii. Using an existing random moment time study (RMTS) to capture the time a worker spends delivering MI services or performing activities in which MI is consistently embedded.

2. **Assign a cost to the unit of service.** The jurisdiction calculates a rate for the unit of service that includes the salary and fringe associated with the caseworker's time and a proportionate amount of overhead costs.

3. **Document when a unit of service has been delivered.** The caseworker who is delivering the MI service documents that a unit of MI was delivered. **Options** for documenting could include:

    - The caseworker can document when they use MI in an interaction with a caregiver. For example, the jurisdiction could update its data system screens to include a description of MI and a question related to its use. This would enable the worker to document the use of MI during caregiver contacts, home visits, etc.
    - If MI is defined as a practice that is consistently used and delivered in certain types of face-to-face interactions, the caseworker can document when those interactions occur.
    - The prevention plan could indicate the date that MI services began and the date MI services ended. This information, combined with other data sources—such as random moment time study results and fidelity monitoring practices—can confirm the use of MI through the life of a case.

4. **Associate the children who benefited from the unit of service with the individual who received the service**. For example, if a parent of three Title IV-E prevention-eligible children with active cases receives an MI service, the three children can be identified in the case record as having benefited from the service. Ideally, this association can be automated in the jurisdiction's data system, rather than manually entered by the caseworker.

5. **Confirm that the children benefiting from the service meet eligibility requirements** for the Title IV-E prevention program on the day the service was delivered.

6. **Identify the date the public expenditure was made**. For public agency staff, this will be the date of payroll associated with the date the service was delivered.

7. **Calculate claimable service costs for each quarter**. The claim amount will be equal to the unit(s) of service times the cost of service for each day for which an eligible child received the service. The jurisdiction will report the claimable amount in the quarter that the public expenditure was made.

Claiming Motivational Interviewing Costs Under Title IV-E Prevention Administration

Each state or jurisdiction has existing practices to allocate case management-related costs under traditional Title IV-E. When MI is integrated into case management for prevention candidates there are two options for allocating these costs. One option is to capture those services in the existing processes to develop the Title IV-E Prevention Program Administration claim. The second option is to capture those services using the existing processes for traditional Title IV-E in order to develop the Title IV-E Prevention Program Administration claim. Existing practices, often a random moment time study, can be used to identify time spent on case management activities and to claim costs associated with allowable activities to Title IV-E Prevention Administration. The primary task for the state or jurisdiction would be to differentiate administrative activities and costs on behalf of prevention candidates from those on behalf of other populations (for example, traditional candidates, noncandidates, or children in another program, such as foster care).

Cost Allocation Plan Amendment

Regardless of a jurisdiction's claiming methodology, the jurisdiction may need to amend their cost allocation plan in order to claim MI-related expenditures. For example:

- If claiming MI as a prevention service, a jurisdiction may need a CAP amendment to establish one or more **new cost pools specifically for Prevention Services.** This would allow costs to be moved from a caseworker cost pool into a Prevention Services cost pool to prevent duplicate claiming.
- A CAP amendment may be needed to **update time study activities** or other related changes to the time study. This update may be needed to isolate time associated with conducting MI, or to assure that there is no duplication of claiming when MI is claimed as a prevention service.
- If incorporating MI into existing administrative claiming of case management with no changes to the current process, then a CAP amendment is not necessary.

Continuous Quality Improvement

The Family First requirement for a formal evaluation may be waived for EBPs that have been rated by the Title IV-E Prevention Services Clearinghouse as "well-supported." Because MI is rated "well-supported," most jurisdictions will not conduct a formal evaluation of the intervention. However, Family First also requires jurisdictions to conduct program-specific CQI for all Family First EBPs, with particular emphasis on well-supported EBPs for which an evaluation waiver has been approved. CQI promises to promote strong implementation and improved outcomes for the evidence-based practices at the center of Family First, including MI.

Align MI with Family First CQI Framework

CQI for MI should be aligned with a broader approach to Family First CQI. Chapin Hall's Family First CQI framework (Table 4)[64] describes four categories of measures that typically fall into a well-developed Family First CQI framework: capacity, reach, fidelity, and outcomes.

Of these categories, fidelity measures and a subset of outcome measures (specifically proximal, or short-term, outcomes) tend to be specific to individual EBPs, while capacity, reach, and distal outcome measures are more likely to be consistent across the entire service continuum. Therefore, this guide addresses methods and approaches for assessing and monitoring MI fidelity and outcomes through CQI.

Table 4. Components of a Well-Developed Family First CQI Measurement Framework

Capacity	Reach	Fidelity	Outcomes
• **Agency capacity** refers to the resources the agency devotes to the broader work and staff to support its implementation of preventive services. • **Capacity measures** that assess the degree to which the agency devoted the necessary resources to support its implementation of preventive services	• **Reach** refers to the degree to which the service is reaching the target population through referrals, eligibility determinations, and service uptake. • **Reach measures** relate to children and families referred to services, outcomes of those referrals, and service uptake and completion.	• **Fidelity** is the extent to which the service is carried out with adherence to the intended approach and can be assessed by measuring the degree to which capacity, process, and quality requirements are met. • **Fidelity measures** assess the degree to which the service was carried out with fidelity according to capacity, process, and quality requirements.	• **Outcomes** gauge the extent to which the services are achieving desired child and family outcomes. • **Outcome measures** assess the impact of the service on child and family outcomes.

Define a Fidelity Monitoring Approach and Methods

As with all EBPs, it is essential to implement MI as intended—with fidelity—in order to realize the model's potential benefits for practice and client outcomes.

Jurisdictions implementing MI under Family First must monitor fidelity both to ensure that the practice is delivered with quality according to the model and to meet model-specific CQI requirements within the Family First legislation and guidance. While neither the Family First legislation and guidance nor the MI developer offer formal guidance on establishing MI fidelity monitoring systems, many MINT trainers are available to provide customized consultation and guidance as jurisdictions undertake fidelity monitoring. Agencies can only experience the benefits of MI when it is delivered with fidelity and integrated into routine practice—a level of implementation that will only be reached through dedicated support including strong fidelity monitoring.

In this section, we outline key steps for a jurisdiction to take as it formulates its approach to MI fidelity monitoring. The steps are listed in the sequence in which they should occur, though some variation may exist across jurisdictions and organizations.

> Agencies can only experience the benefits of MI when it is delivered with fidelity and integrated into routine practice—a level of implementation that will only be reached through dedicated support including strong fidelity monitoring.

1. **Identify internal or external staff to conduct fidelity monitoring.** Jurisdictions may wish to determine who will conduct MI fidelity monitoring prior to selecting a fidelity monitoring instrument and determining other aspects of methodology. Staff time, capacity, and skills required may shape the rest of the approach. For example, because instruments vary in complexity and can require different skills, knowing staff skillsets (such as clinical, research, or supervisory) ahead of time would be helpful. In addition, knowing how much time staff have available could inform instrument selection as well as scoring and sampling methodology. First, agencies must determine whether they will build internal capacity to monitor fidelity or leverage support from an external partner.
    a. **Building internal capacity to monitor MI fidelity.** Child welfare organizations wishing to build internal capacity to monitor fidelity generally must choose between assigning this responsibility to CQI staff or to casework supervisors. An advantage of having CQI staff conduct fidelity monitoring is that their roles will be focused on consistent application of the instrument and production of results. This could make intercoder reliability more attainable and ensure more consistent and timely data collection and reporting. On the other hand, some jurisdictions may prefer to have supervisors conduct fidelity monitoring to ensure integration of results into supervision and coaching.
    b. **Leveraging an external partnership.** An external partner, such as a university partner or fidelity tool developer, could be charged with scoring recordings of MI sessions. This partner could utilize any selected MI fidelity monitoring tool and may also be assigned adjunctive responsibilities, such as aggregating and reporting results, integrating findings with broader CQI data, or coaching staff to improve practice.
    c. **Using artificial intelligence technology.** A related option is to employ software utilizing artificial intelligence, such as Lyssn, to assess and score MI skills. Artificial intelligence (AI) solutions are discussed further below. Note that if a jurisdiction decides to use AI, this may obviate the selection of an instrument, as certain instruments are embedded within AI fidelity monitoring platforms.
2. **Select fidelity monitoring instrument**. Nearly a dozen MI fidelity monitoring instruments exist, reflecting a range of characteristics, levels of complexity, and relative advantages. Figures A and B, later in this section, crosswalk of the MI fidelity monitoring instruments that are most likely to meet the needs of jurisdictions and their contracted partners implementing MI under Family First. We discuss selecting fidelity monitoring instruments in more detail in the next section.

3. **Define data collection methods, including sample and periodicity**. Sample size and composition should be determined collectively by programmatic and research staff with an eye to maximizing representativeness while balancing capacity and available staff time. An individual or entity with expertise in sampling methodology should be engaged to inform this decision. Developers of fidelity instruments should be consulted regarding sample size requirements (such as a number or percentage of overall cases) for documenting intercoder reliability and fidelity.

4. **Establish strategy and infrastructure for capturing, storing, analyzing, and reporting fidelity data**. While the selected fidelity tool will determine what MI constructs, dimensions, and behaviors will be captured, jurisdictions must determine where fidelity data will be inputted and stored, and how it will be analyzed and reported. Some AI tools address these considerations by receiving, storing, and transcribing uploaded audio recordings and generating output for each individual session as well as analytics at the level of individual staff and the organization. Other tools require development of a data entry shell and database, including solutions such as Qualtrics, Microsoft Access, or REDCap. If an external or university partner has been engaged to code recorded MI sessions, that entity may be able to assist with development and maintenance of the associated database. Consideration should be given to legal and civil service implications associated with recording sessions, as recording requires both client and practitioner consent.

5. **Define training and capacity-building strategies to promote quality fidelity monitoring**. Just as frontline staff and supervisors must be trained to deliver MI, individuals responsible for monitoring fidelity must be trained accordingly—to fidelity—as well. Moreover, training for frontline staff should incorporate information about the role of fidelity monitoring in improving practice as well as an overview of the fidelity monitoring dimensions, process schedule, and any expectations for skill development.

   To ensure that fidelity monitoring results are accurate and consistent, jurisdictions must ensure a sufficient level of intercoder reliability within the pool of raters or with expert raters. Intercoder reliability refers to the degree of consistency among ratings across raters. Jurisdictions must select a desired threshold for intercoder reliability. They must also establish processes for ensuring that all raters achieve this target both prior to the start of formal rating and periodically throughout the rating period to minimize skill drift and ensure consistent ratings.

6. **Define an approach to leveraging fidelity data to promote practice improvement**. To ensure that fidelity data are used as intended, agencies must define an approach for leveraging results that promotes practice improvement and improves model fidelity among practitioners. For example, supervisors or managers may be trained to review and coach workers on fidelity monitoring results, or an external consultant or university partner could be engaged to coach staff. If aggregate results show specific areas where staff across an organization or team are struggling, agencies may wish to target these practice areas to support staff while making the most effective use of time and resources. Agencies may benefit from establishing a community of practice focused on specific skill improvement dimensions or offer booster trainings.[65] Within communities of practice, individual- or team-level fidelity data could be reviewed to spark reflection and focus attention on results.

7. **Promote integration of fidelity data within broader CQI processes, including Family First CQI**. Fidelity data should be reported and used as part of a broader CQI measurement framework to understand the implementation and effectiveness of MI and to verify that the jurisdiction's logic model is being effectuated. Fidelity data help an agency and its partners determine the extent to which MI is being carried out with fidelity to the model. Practice with fidelity, in turn, is more likely to yield the positive outcomes for caregivers and families that are demonstrated through the literature, thus realizing the promise of MI as an evidence-based practice.

> Jurisdictions may wish to consider whether each tool can be integrated with existing practice model fidelity instruments or practice checklists, reflecting a comprehensive and integrated assessment of practice and eliminating the need for multiple fidelity tools.

Select a Fidelity Monitoring Instrument

As noted above, nearly a dozen MI fidelity monitoring instruments exist. Due to MI's broad international application with diverse target populations in a range of contexts, the tools are likewise diverse, and only a subset of these instruments is likely to align with the needs of child welfare agencies.

Tables 5 and 6 cross-walk five MI fidelity monitoring instruments that are most prevalent in the field among MI practitioners or are most likely to meet the needs of child welfare agencies and their contracted partners implementing MI under Family First. These five tools and their manuals are publicly available and can be downloaded online, though specialized training is required to use them. Table 5 describes profiles of the instruments, including components and scoring, while Table 6 provides a framework and key considerations for selecting an instrument.[66]

When selecting a fidelity monitoring instrument, jurisdictions should carefully consider each tool's fit and feasibility within the organizational context of the child welfare agency and partners who will use it. To assess fit, jurisdictions may examine alignment with specific organizational goals and programmatic context as well as available research. In particular, jurisdictions may wish to consider whether each tool can be integrated with existing practice model fidelity instruments or practice checklists, reflecting a comprehensive and integrated assessment of practice and eliminating the need for multiple fidelity tools. To assess feasibility, jurisdictions may consider resources, capacity, and staffing. In addition to reviewing these tables, jurisdictions are strongly encouraged to review tools and manuals to gain first-hand familiarity before selecting an instrument.

The five instruments described in Tables 5 and 6 are the most likely to be considered for MI fidelity monitoring purposes under Family First. Additional instruments, listed in Appendix B, either have a limited track record but should be explored for potential fit in the Family First context or can be used as learning supports.

Table 5. Profiles of Motivational Interviewing Fidelity Monitoring Instruments

Tool	Overview	Components	Scoring
Motivational Interviewing Treatment Integrity (MITI) version 4.2.1	The MITI measures both **practitioner adherence and competence**. It identifies behaviors used in MI and inconsistent with MI. It does not assess interactions or flow of conversation.	• *Practitioner global ratings:* Four global ratings reflecting practitioner competence, each rated on 5-point scale: cultivating change talk, softening sustain talk, partnership, and empathy. • *Behavioral counts:* Captures practitioner adherence to core MI behaviors across ten MI-consistent and -inconsistent behaviors including: giving information, persuade, persuade with permission, question, simple reflection, complex reflection, affirm, seeking collaboration, emphasizing autonomy, confront.	• *Does not provide a composite or overall score.*
Motivational Interviewing Competency Assessment (MICA) version 3.2[67]	The MICA primarily **measures practitioner competence and flow of conversation between practitioner and client**, rather than prioritizing tracking the raw number of MI skill utterances. It **identifies behaviors used in MI and highlights those inconsistent with MI**. Note that a streamlined version of this instrument, the Abbreviated MICA (A-MICA) is also available.[68]	• *Microskills counts*. Counts of two microskills (reflections and questions) captured. • *MI strategies & intention competence ratings*. Captures practitioner competence for two MI strategies (strategically responding to change talk, and strategically responding to sustain talk) and five MI intentions (evoking, expressing empathy, guiding, partnering, and supporting autonomy and activation). Each MI strategy and intention is rated for practitioner competence on a 5-point scale, allowing for .5 differential ratings.	• *MICA Summary scores:* › *Question-to-reflection ratio* based on microskill counts. › *MICA composite score reflecting* the average of the two strategies added to the average of the five intentions.
Motivational Interviewing Skills Code 2.1 (MISC)	The MISC assesses practitioner adherence, **practitioner competence, client behavior, and provider-client interaction**. It identifies both behaviors used in MI and inconsistent with MI.	• *Practitioner global ratings:* Six global ratings reflecting practitioner competence, each rated on 5-point scale: acceptance, empathy, direction, autonomy support, collaboration, evocation. • *Practitioner adherence:* Captures counts of 15 practitioner behaviors: affirm, confront, direct, emphasize control, facilitate, filler, giving information, question, raise concern, reflect, reframe, support, structure, warn. Subcodes must be completed for four of these. • *Client behavior counts:* Client utterances are coded to reflect *change talk or sustain talk*. Change talk utterances are further coded among five subcodes: reason, other, taking steps, commitment, follow/neutral. Subcodes must be completed for one of these.	• *MISC summary scores:* › Practitioner reflection-to-question ratio › Practitioner percent open questions › Practitioner percent complex reflections › Count of practitioner MI-consistent responses › Count of practitioner MI-inconsistent responses › Percent practitioner MI-consistent responses › Percent client change talk • *Does not provide a composite or overall score.*

Table 5 Continued. Profiles of Motivational Interviewing Fidelity Monitoring Instruments

Tool	Overview	Components	Scoring
Behavior Change Counselling Index (BECCI)	The BECCI assesses the **content of the practitioner-client discussion** rather than the frequency of practitioner behaviors/skills. It is designed primarily **to help learners self-evaluate skills acquired in training**.	• *Practitioner behavior ratings*. Indicate the extent the learner perceives themselves to be using 11 core MI-consistent practices to promote behavior change were utilized using a 5-point scale. • *Practitioner speaking time rating* the amount of time the practitioner spoke during the session via a single item using a 3-point scale.	• *Total score* aggregating ratings across the 11 items. • *Practitioner speaking time score* (based on a single ordinal rating).
Motivational Interviewing Assessment-Supervisory Tools for Enhancing Proficiency (MIA-STEP)	The MIA-STEP is a **collection of supervisory tools for mentoring workers and supporting skills development and supervision in MI**. The comprehensive package includes an Assessment of MI Adherence and Competence, which captures **counts and ratings of extensiveness and skill for MI consistent and inconsistent behaviors**.	• *MI adherence and competence* on 16 behaviors, including MI-consistent items and MI-inconsistent items. MI-consistent and -inconsistent items are rated on 7-point scales. Items include: › *MI-consistent:* MI spirit, open-ended questions, affirmation of strengths and change efforts, reflective statements, fostering collaborative atmosphere, discussing motivation to change, developing discrepancies, exploring pros/ cons/ ambivalence, change-planning discussion, client-centered problem discussion. › *MI-inconsistent:* Unsolicited advice, direction giving, emphasis on abstinence, direct confrontation, powerlessness and loss of control, asserting authority, closed-ended questions	• *Does not provide a composite or overall score.*

Table 6. Selecting a Motivational Interviewing Fidelity Tools for Family First

Tool	FIT		FEASIBILITY	
	Intended Use & Application	Languages	Length & Level of Complexity	Coder Preparation & Inter-Coder Consistency Feasibility
Motivational Interviewing Treatment Integrity (MITI) version 4.2.1	• **The MITI is designed to assess how well an advanced clinical practitioner is using MI and provide feedback to increase MI skill**.[69] The MITI is most likely to be used in clinical settings but is also successfully **used in many community or human services settings typical of child welfare** service delivery. • MITI dimensions are **derived from the MISC**, though the overall tool is shorter and more focused on capturing information that is most relevant for informing clinical practice.[70] • **Results are relatively understandable** for end users and actionable for skill improvement relative to the MISC.	**8 languages** English, Spanish, Danish, Dutch, German, Norwegian, Japanese, and Korean. *The MITI 2.0 is also available in French and Swedish*	**Moderate/High** • The MITI contains fewer items than the MISC and more than the other instruments summarized in this table. The need for two passes increases the overall level of effort required for completion, though it is feasible in a human services setting. • **Two passes are required to complete coding** (*Pass 1:* Global scores; *Pass 2:* Behavior counts).	**Moderate** • Shows strong reliability in multiple research studies examining usage by clinicians and researchers.[71] Reliability could vary depending on coder skills and preparation, though adequate preparation is feasible in child welfare settings with appropriate investment. • Due to the moderate complexity of the tool, moderate effort is required for coders to master the tool and achieve intercoder consistency. • Scales and criteria are **well-defined and clear**. • Approximate training required for self-sufficiency: **40 hours**.
Motivational Interviewing Competency Assessment (MICA) version 3.2[72]	• The purpose of the MICA is to provide **practical feedback to practitioners in multiple service fields on adherence to MI practice and how to build their skillset**. It is well-suited to child welfare practice and can be used to assess basic competence or move practitioners from basic to more advanced MI skill levels.[73] • **Results tend to be relatively understandable** for end users and actionable for skill improvement relative to other tools.	**6 languages** English, Spanish, Dutch, Polish, Japanese, and Chinese	**Moderate** • The MICA is slightly less complex than the MITI and requires only one pass to code. • **One pass is required to complete coding.**	**High** • Reliability and validity testing shows good internal consistency, high correlation between related MICA and MITI scores, and strong intercoder reliability.[74] • The MICA is a less complex tool and more feasible to master than the MITI and MISC. • Scales and criteria are **well-defined and clear**. • Approximate training required for self-sufficiency: **20 hours**.
Motivational Interviewing Skills Code 2.1 (MISC)	• **The MISC can be used for teaching and practice monitoring but is more complex than necessary for these purposes.**[75] The MISC is particularly useful for **researching complex and dynamic processes inherent to MI interactions**. (For example, examining psychotherapy processes and relationships between counselor and client responses, generating new knowledge about the mechanisms of MI efficacy).[76] • **Results tend to be less readily understandable by end users** than those from other tools due to the complexity of findings, and **findings capture complex processes more relevant to research than practice improvement**.	**2 languages** English and Spanish	**Very High** • The MISC is highly comprehensive and comes with a relatively high administrative burden given the number of passes required and total number of items and subitems that require coding. • **Three passes**[77] **are required to complete coding** (*Pass 1:* Global ratings; *Pass 2:* Practitioner behavior codes; *Pass 3:* Client behavior codes).	**Low** • Shows strong reliability in multiple research studies examining usage by clinicians and researchers.[78] Reliability could vary significantly depending on coder skills and preparation, which could be more challenging to achieve in some child welfare settings. • Scales and criteria are **well-defined and clear**. • Due to the tool's high degree of complexity, significant effort is required for coders to master the tool and achieve intercoder consistency. • Approximate training required for coder self-sufficiency:[79] **60 hours**.

Table 6 Continued. Selecting a Motivational Interviewing Fidelity Tools for Family First

Tool	FIT		FEASIBILITY	
	Intended Use & Application	Languages	Length & Level of Complexity	Coder Preparation & Inter-Coder Consistency Feasibility
Behavior Change Counselling Index (BECCI)	• **Assesses perceived fidelity to Behavior Change Counseling (BCC)**, which is a brief MI intervention designed for health care settings. BCC is described in Rollnick et al. (2002).[80] It entails using a wider range of clinical skills and behaviors than for brief advice, but not as wide as those involved when using MI as described in Miller & Rollnick (2013). While agencies may choose to use the BECCI to capture MI practice, the degree of alignment between MI and BCC should be considered. • Results are **well-suited for understanding practitioner skill at a relatively generalized level** and can be used as a prompt or checklist to remind practitioners of core components of MI practice. Results are **less suited for in-depth coaching and rigorous monitoring of organizational practice change**.	**2 languages** English and Spanish	**Low** • The BECCI is a less complex instrument and has fewer items than the MICA, MITI, MISC, and MIA-STEP. • **One pass is required to complete coding**.	**High** • Has been tested for reliability primarily on simulated consultations and a minimal number of real consultations. Results suggest BECCI's reliability and point to similar results between simulated and real sessions. However, testing on real cases is too limited to draw conclusions. • The BECCI is a less complex tool and more feasible to master than the MICA, MITI, and MISC. Minimum training requirements include independent reading and reviewing simulation videos. • Scales are defined generally, but **rating guidance is less specific** for individual items than MICA, MITI, or MISC. • Approximate training required for self-sufficiency: **15 hours**.
Motivational Interviewing Assessment-Supervisory Tools for Enhancing Proficiency (MIA-STEP)	• The MIA-STEP is a comprehensive **collection of supervisory tools for mentoring workers and supporting skills development and supervision in MI**. The comprehensive package includes training materials, research findings, supervisory teaching tools, a self-assessment, a tool for rating MI adherence and competence, and sample rating sheets and transcripts. • While the adherence and competence tool **can be used for practice improvement, it is generally less well-suited for rigorously tracking and reporting individual or organizational progress** on MI practice. • The MIA-STEP adherence and competence tool requires raters to note the **frequency and depth of MI behaviors and skill level**. The tool does not capture or support reduction of MI-inconsistent behaviors. • The MIA-STEP **yields detailed results that are not aggregated**. The tool for rating MI adherence and competence is accompanied by guidance for supervisors on using results and improvement planning tools.	**2 languages** English and Spanish	**Moderate** • The MIA-STEP comprises fewer overall items than the MITI and MISC. Some complexity arises from the fact that it requires coders to capture frequency as well as rate practitioner behaviors on two dimensions: extensiveness and skill level. • **One pass is required to complete coding.**	**Low** • Little evidence exists suggesting that the MIA-STEP adherence and competence tool is conductive to inter-coder consistency. It is primarily intended for practice improvement rather than rigorous fidelity monitoring. • Scales and criteria are defined in the manual but are **less clear** than the MITI and MICA, including fewer samples. Because guidance on rating to fidelity is low, inter-coder reliability can be hard to attain. • **Approximate training required for self-sufficiency: 40 hours.**

Artificial Intelligence

As noted on the previous page, artificial intelligence (AI) technology solutions have been developed to assess practitioner fidelity and competence in MI. The solution with the greatest presence in human services and child welfare is **Lyssn**,[81] which uses underlying algorithms based on a combination of the MISC and MITI. Counselling sessions are livestreamed or recorded and uploaded to a secure platform and then encrypted, transcribed, and coded. For each session, users can view and search videos and full-text transcripts. A feedback report featuring fidelity metrics is automatically generated for each session. Lyssn produces automated summary reports for tracking and analyzing individual as well as organizational progress on MI practice. All reports are user-friendly and easy for a range of practitioners to understand. Lyssn is designed primarily to assess how well a clinician is using MI and yields feedback that can be used to increase clinical skill, making it well-suited for the needs of many child welfare agencies. As with outsourcing coding to an external partner, AI presents the advantage that agency staff are not required to monitor and code MI sessions.

AI's known limitations should also be explored. At the writing of this guide, Lyssn is available only for sessions conducted in English, though Spanish language is being added. AI's transcription quality can be lower quality if the program is not familiar with participants' particular accent or dialect. Notably, transcription quality may improve rapidly as the technology evolves. Additionally, some MI practitioners point out that AI may miss factors that impact the conversation's relational fabric, including inflection and contextual variables such as connected silence and supportive presence. Last, some workers and families may not be comfortable with livestreaming or recording case-related conversations for AI transcription and coding. These potential limitations of AI should be examined alongside its advantages when jurisdictions consider this solution.

Lyssn is designed primarily to assess how well a clinician is using MI and yields feedback that can be used to increase clinical skill, making it well-suited for the needs of many child welfare agencies.

Define MI Outcome Measures

Research has shown Motivational Interviewing to be effective in bringing about a diverse range of behavior changes and client outcomes across health and human services domains, including, but not limited to, child welfare.[82]

The Title IV-E Clearinghouse indicates that MI has been found effective for improving adult substance use outcomes—though the primary developers of MI, Miller and Rollick, have demonstrated that it can be flexibly and effectively used to bring about a far wider range of client outcomes.[83]

Child welfare systems may use MI to bring about a range of proximal and distal outcomes. The outcomes targeted will vary depending on the jurisdiction's specific logic model, as described in the "Planning for Implementation" section above. For jurisdictions that are implementing MI integrated with case practice, intended proximal outcomes may include:

- Increased caregiver engagement and motivation to progress toward case goals and
- Increased caregiver service participation—including uptake and sustained participation.

Progress toward case goals could be measured through capture of case and service planning documentation over time or case participant interviews, and service participation is reflected in Family First reach measures noted at the beginning of this section (see Table 4).[84]

These proximal outcomes could in theory lead to improvement on a range of caregiver outcomes targeted through case goals or services. In the Family First context, an MI logic model may include caregiver outcomes aligned with the scope of the Family First legislation:

- Improved caregiver substance use and mental health outcomes
- Improved parenting skills and practices

Distal outcomes are likely to apply across the child welfare prevention continuum and will not be unique to Motivational Interviewing. These may include, but are not limited to, reduced maltreatment, reduced foster care entry, improved well-being, and increased protective factors.

Appendix A

Resources for Self-directed Training and Skill Development

Sources for High Quality Self-Paced Training Modules:

C4 Innovations: c4innovates.com

The Centre for Collaboration, Motivation and Innovation: centrecmi.ca

Self-Study Resources and Learning Community Materials:

Website dedicated to group MI for teens: groupMIforteens.org

Lifting the Burden in MI—the Guiding Style: youtube.com/watch?v=SsNgZ47o2I4

The Four Processes in MI: youtube.com/watch?v=4Hrz9tLUlUw

William Miller offering information on Change Talk within the leadership context: youtube.com/watch?v=YIhMsTdZMVM&t=399s

William Miller on the Righting Reflex: vimeo.com/18469694

William Miller on What Makes Helpers Helpful: vimeo.com/506809278

MI Demonstration with People Experiencing Intimate Partner Violence: youtube.com/watch?v=P3JUXQ4kkHs&t=4s

Compare/Contrast MI Demonstrations, Variety of Contexts: youtube.com/user/MerloLab

Change Talk app (available for download): go.kognito.com/changetalk

MI implementation resource from the Office of Head Start. Facilitating relationships and change: eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/interviewing-viewers-guide.pdf

William Miller discussing "Listening Well:" youtube.com/watch?v=HWvYeX6Heqk

Miller, W. R. (2018). *Listening well: The art of empathic understanding.* Wipf and Stock.

Miller, W. R. & Rollnick, S. (2013). *Motivational interviewing: Helping people Change* (3rd Ed.) Guilford.

Rosengren, D. R. (2018). *Building motivational interviewing skills.* Guilford.

Frey, J., & Hall, A. (2021). *Motivational interviewing for mental health practitioners- A toolkit for skills enhancement.* PESI Media.

MI Demonstrations, Adolescents: psychotherapy.net/video/mi-adolescents

Appendix B

Additional Fidelity and Practice Support Tools

Helpful Responses Questionnaire (HRQ).

The HRQ is a brief, written test of practitioner responses to several challenging client statements. It can be used to evaluate empathy, the use of roadblocks to listening, training outcomes, practitioner skills, or as a hiring screening tool. It is intended for assessing performance in a test format in response to mock statements. It is not primarily intended for use in assessing fidelity of actual MI practice.

Video Assessment of Simulated Encounters-Revised (VASE-R).

The VASE-R is a video-based method for assessing respondent skill in MI. It consists of a video presentation of a series of vignettes in which actors portray active substance users. Respondents are prompted to identify or generate written responses consistent with MI principles. Because it assesses performance in a simulated format, it is best suited for assessing MI skill or training assessment and is not primarily intended for use in assessing fidelity of actual MI practice. The VASE-R also uses some terminology and references that not fully consistent with current descriptions of MI.

Motivational Interviewing Evaluation Rubric (MIER).

The MIER was developed to be a concise and user-friendly tool for evaluating MI skills in supervision and practice in community-based settings with youth and families. The MIER is designed to be applicable for measuring MI skills, processes, and principles across a range of encounter types, such as intake assessments, very brief check-ins, or crisis intervention. The MIER contains 16 items rated on a three-point Likert scale. The measure includes three sub-dimensions targeting MI Spirit (four items), MI Process (six items), and MI Skills (six items), and produces an overall and sub-dimension scores. It should be noted that MIER was developed in 2020 and has a limited track record, but it should be explored for potential fit in the Family First context.

Sequential Code for Observing Process Exchanges (SCOPE).

The SCOPE was developed to encode recorded MI interactions between a therapist and an individual client, with a particular focus on the sequential information contained in the exchange between the parties. The instrument was developed to investigate the relationships between theoretical constructs important to MI, therapy process more generally, and client outcomes. The instrument is used in conjunction with software that analyzes sequentially entered codes, automatically identifying relationships between MI-consistent or -inconsistent therapist behaviors and resulting client speech. The SCOPE is designed primarily for use in research and to capture underlying mechanisms for MI's effectiveness rather than assessing fidelity or improving practice.

Motivational Interviewing-Coach Rating System (MI-CRS).

The MI-CRS is an evidence-based coding tool that evaluates practitioner competency and behaviors. It uses proprietary standard patient interactions with written feedback. Practitioners can apply the tool or submit recordings for feedback. Users must purchase the tool from the vendor, who is solely licensed for the product. The MI-CRS may be suited for fidelity monitoring by child welfare agencies, but public information about the MI-CRS is limited due to its proprietary nature.[85]

Abbreviated Motivational Interviewing Competency Assessment (A-MICA).

The Abbreviated-Motivational Interviewing Competency Assessment (A-MICA) is a condensed and composite version of the MICA that fuses rating of MI strategies and intentions. The A-MICA has a limited track record, but it should be explored for potential fit in the Family First context. For more information about the A-MICA, jurisdictions may contact the MICA developer.

Endnotes

1 Miller and Rollnick (2013) Motivational Interviewing: Helping people to change (3rd edition).
2 motivationalinterviewing.org/understanding-motivational-interviewing
3 Miller and Rollnick (2013) Motivational Interviewing: Helping people to change (3rd edition); p. 29
4 motivationalinterviewing.org/understanding-motivational-interviewing
5 motivationalinterviewing.org/understanding-motivational-interviewing
6 Miller, W. (1983). Motivational Interviewing with Problem Drinkers. *Behavioural Psychotherapy, 11*(2), 147-172.
7 See motivationalinterviewing.org/sites/default/files/mi_controlled_trials_2020_nov.pdf for a list of controlled clinical trials of Motivational Interviewing that is current as of November 2020
8 pubmed.ncbi.nlm.nih.gov/15826439/
9 ncbi.nlm.nih.gov/pmc/articles/PMC3814165/
10 cebc4cw.org/program/motivational-interviewing/
11 cebc4cw.org/ratings/scientific-rating-scale/
12 childwelfare.gov/pubPDFs/motivational_interviewing.pdf
13 Motivational Interviewing Network of Trainers (motivationalinterviewing.org)
14 cebc4cw.org/program/motivational-interviewing/
15 Per the Family First legislation and guidance, a "candidate for foster care" is a child identified in a prevention plan as being at imminent risk of entering foster care, but who can remain safely in their home or kinship placement as long as services or programs are provided to prevent the entry of the child into foster care.
16 acf.hhs.gov/sites/default/files/documents/cb/pi1809.pdf
17 preventionservices.abtsites.com/programs/256/show
18 acf.hhs.gov/sites/default/files/documents/cb/pi1809.pdf
19 cwla.org/district-of-columbia-receives-family-first-approval-to-broadly-implement-and-claim-for-motivational-interviewing/
20 "Bundled program" is the language used by the Children's Bureau in feedback to multiple jurisdictional IV-E Prevention Plans and has been used in subsequent plans to describe implementation of MI alongside other EBPs.
21 cwla.org/district-of-columbia-receives-family-first-approval-to-broadly-implement-and-claim-for-motivational-interviewing/
22 cfsa.dc.gov/publication/dc-cfsa-family-first-prevention-plan
23 Examples include DC, where all children receiving or stepping down from In-Home Services are candidates and eligible and receive MI, as well as Illinois, where all children being served by: a) Intact Family Services, b) Intact Family Recovery Services, or c) the Extended Family Support Program (EFSP) are candidates and eligible to receive MI. Moreover, in these jurisdictions, child welfare staff across the continuum are being trained to carry out MI as part of casework as a strategy to promote broad practice improvement, even beyond Title-IV-E prevention cases.
24 According to Family First legislation and guidance, "at least 50 percent of the amount paid to the state in any FY must be for prevention services that meet the *well-supported* practice criteria" (acf.hhs.gov/sites/default/files/documents/cb/im1802.pdf).
25 cwla.org/motivational-interviewing-for-case-management-in-dc/
26 cwla.org/district-of-columbia-receives-family-first-approval-to-broadly-implement-and-claim-for-motivational-interviewing/
27 motivationalinterviewing.org/training-expectations
28 Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice, 20*(2), 137–160.
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43 See assets.aecf.org/m/resourcedoc/aecf-theoryofchange-2004.pdf

44 wkkf.org/resource-directory/resources/2004/01/logic-model-development-guide

45 impsciuw.org/implementation-science/research/implementation-strategies/

46 codot.gov/business/process-improvement/self-service/tools/solve-guide/part4/implementation-plan

47 "Implementation Drivers are the components of infrastructure needed to develop, improve and sustain the ability of teachers and staff to implement an innovation as intended as well as create an enabling context for the new ways of work." (nirn.fpg.unc.edu/)

48 phoenixsinclairinquiry.ca/pdf/exhibitk_cheryl_regehr.pdf

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55 Includes the definition of "eligible child" included in ACYF-PI-20-09, Attachment C: Instruction for Completion of Form CB-496, pp. 14–15

56 When costs associated with MI are claimed as a prevention service, the costs would be reported on the federal CB-496 form under "Line 38. Prevention Services Provision – Well Supported Practices." When costs associated with MI are claimed as prevention program administration, the costs would be reported under "Line 40. Prevention Services Administrative Costs – Prevention Planning and Agency Management."

57 ACYF-PI-20-09, Attachment C: Instruction for Completion of Form CB-496, page 14.

58 Administration costs for traditional candidates are reported on the federal CB496 form under "Line 10a. Title IV-E Foster Care Candidate Administrative Costs – Case Planning and Management."

59 ACYF-PI-20-09, Attachment C: Instruction for Completion of Form CB-496, page 12.

60 Funding under the Title IV-E Prevention Program is available after the state has met a maintenance of effort (MOE) requirement. FFPSA requires the state child welfare agency "to maintain at least the same level of 'state foster care prevention expenditures' each FY as the amount the agency spent in FY 2014 (section 471(e)(7) of the Act). States with a population of children less than 200,000 in FY 2014 (as determined by the Bureau of the Census) may elect to use FY 2015 or FY 2016 instead of FY 2014 for this purpose (section 471(e)(7)(A) of the Act)." ACYF-CB-PI-18-09.

61 See ACYF-CB-PI-18-12, Attachment C: Instruction for Completion of Form CB-496, for detailed claiming instructions.

62 See Technical Bulletin #1: Title IV-E Prevention Program Data Elements, revised August 10, 2021.

63 States will want to consider procedures for how to document and claim services that benefit multiple children, noting that there may be cases in which all children are prevention candidates and others in which some children are prevention candidates and some are not.

64 chapinhall.org/project/family-first-toolkit-part-3/

65 See resources in Appendix A to guide community of practice exercises.

66 A subset of MINT trainers can train on the tools below. Coding sessions using any of these tools requires knowledge of MI.

67 In addition, the Abbreviated-Motivational Interviewing Competency Assessment (A-MICA), a condensed and composite version of the MICA that fuses rating of MI strategies and intentions, was recently developed and is being used on a limited basis in human services fields outside of child welfare. Initial feedback on the tool is positive, but limited documentation about the tool is available due to its newness. For more information about the A-MICA, jurisdictions may contact the MICA developer.

68 The Abbreviated-Motivational Interviewing Competency Assessment (A-MICA) is a condensed and composite version of the MICA that fuses rating of MI strategies and intentions. Please see Appendix B for more information about the A-MICA and other tools with an emerging presence in human services.

69 Moyers, T.B., Manuel, J.K., & Ernst, D. (2014). *Motivational Interviewing Treatment Integrity Coding Manual 4.1*. Unpublished manual.

70 Moyers, T.B., Manuel, J.K., & Ernst, D. (2014). *Motivational Interviewing Treatment Integrity Coding Manual 4.1*. Unpublished manual.

71 Moyers, T. B., Rowell, L. N., Manuel, J. K., Ernst, D., & Houck, J. M. (2016). The Motivational Interviewing Treatment Integrity Code (MITI 4): Rationale, preliminary reliability and validity. *Journal of Substance Abuse Treatment*, 65, 36–42. Forsberg, L., Källmén, H., Hermansson, U., Berman, A. H., & Helgason, Á. R. (2007). Coding Counsellor Behaviour in Motivational Interviewing Sessions: Inter- rater reliability for the Swedish Motivational Interviewing Treatment Integrity Code (MITI). *Cognitive Behaviour Therapy, 36*(3), 162–169.

72 In addition, the Abbreviated-Motivational Interviewing Competency Assessment (A-MICA), a condensed and composite version of the MICA that fuses rating of MI strategies and intentions, was recently developed and is being used on a limited basis in human services fields outside of child welfare. Initial feedback on the tool is positive, but limited documentation about the tool is available due to its newness. For more information about the A-MICA, jurisdictions may contact the MICA developer.

73 Jackson, C., Butterworth, S., Hall, A., Gilbert, J. (2015) *Motivational Interviewing Competency Assessment (MICA)*. Unpublished manual.

74 Vossen, J., Burduli, E., Barbosa-Leiker, C. (2018) Reliability and Validity Testing. Washington State University. Motivational Interviewing Competency Assessment (MICA).

75 De Jonge, J. M., Schippers, G. M., & Schaap, C. P. (2005). The motivational interviewing skill code: Reliability and a critical appraisal. *Behavioural and Cognitive Psychotherapy, 33*(3), 285-298.

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77 The number of times a session must be observed to complete the fidelity tool. This information, combined with an understanding of the tool length and complexity (described in *Components & Scoring*), provides a sense of the overall level of effort required to complete the tool.

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79 Estimated time required for formal training with an expert in the tool and model. Estimate could vary depending on individual training approaches and preparation of trainees.

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82 See, for example: Martins, R. K., & McNeil, D. W. (2009). Review of motivational interviewing in promoting health behaviors. *Clinical Psychology Review, 29*(4), 283–293; Kistenmacher, B. R., & Weiss, R. L. (2008). Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. *Violence and Victims, 23*(5), 558–570; Song, D., Xu, T. Z., & Sun, Q. H. (2014). Effect of motivational interviewing on self-management in patients with type 2 diabetes mellitus: A meta-analysis. *International Journal of Nursing Sciences,* 1(3), 291–297; Clair-Michaud, M., Martin, R. A., Stein, L. A., Bassett, S., Lebeau, R., & Golembeske, C. (2016). The impact of motivational interviewing on delinquent behaviors in incarcerated adolescents. *Journal of Substance Abuse Treatment, 65*, 13–19.

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84 *Reach* refers to the degree to which the service is reaching the target population through referrals, eligibility determinations, and service uptake.

85 The developer did not respond to e-mailed informational requests during development of this guide.

Additional Support

Working with Chapin Hall and PCG

As jurisdictions pursue the use of MI as a prevention service under Family First, **Chapin Hall at the University of Chicago** is well-positioned to support its planning, implementation, and sustainment.

As a trusted advisor and implementation partner to child welfare agencies across the nation, Chapin Hall provides support to design, plan, install, monitor, and evaluate evidence-based programs in alignment with the research literature and best practice.

Chapin Hall's team of policy experts, implementation scientists, and researchers can guide a jurisdiction through exploration of the evidence of Motivational Interviewing's effectiveness and the key target populations in the literature to determine relevance to the jurisdiction's population subgroups identified in its Family First prevention planning.

Chapin Hall can also guide assessment of fit and feasibility to determine the ease with which MI can be integrated into existing training, practice, and continuous quality improvement. As a jurisdiction moves forward with implementation, Chapin Hall can support alignment with the existing practice model, as well as other system-change efforts and improvement efforts including the Child and Family Services Plan (CFSP), Annual Progress and Services Report (APSR), and Child and Family Services Review Program Improvement Plan (CFSR PIP) processes. When specialized outside expertise is needed, the Chapin Hall team is able to connect an agency with implementation partners who understand child welfare and its unique opportunities and challenges.

The implementation experts at Chapin Hall can guide the thoughtful and strategic rollout of MI across a jurisdiction, considering whether a single or multistage rollout is most advisable. During installation and full implementation, the team proactively identifies project opportunities and risks and provides guidance to effectively hurdle and sequence implementation activities.

As a jurisdiction considers Motivational Interviewing as a part of its Family First Prevention Plan, Chapin Hall at the University of Chicago is prepared to be a committed partner every step of the way.

Public Consulting Group (PCG) is a nationally recognized firm delivering consulting services and operational excellence to state and local governments. Public Consulting Group has been working closely with states as they plan for and implement Family First.

As an active and trusted voice in Family First program design and financing, PCG can support state and local jurisdictions with the implementation of Motivational Interviewing as a part of a foster care prevention strategy. PCG can develop Title IV-E claiming methodologies for Title IV-E agencies to accurately capture MI service and case management costs. PCG works with states to optimize federal funding by shifting appropriate prevention service costs to Title IV-E while managing other funding streams that may support child and family services, like Medicaid, Transitional Aid to Needy Families, Social Security Block Grant and Title IV-B. PCG can assist in developing a claiming methodology that meets all federal requirements, minimizes burden on caseworkers, and provides a reliable funding stream that is sustainable. In addition, PCG can support the training of the workforce with expert MINT trainers who deliver training to caseworkers, supervisors, and manager, with additional reinforcements through coaching and learning groups.

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