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Research Brief

Engaging families in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Lessons from Illinois Family First Prevention Services Act Implementation

TF-CBT's focus on addressing trauma symptoms aligns with the needs of many Illinois families receiving Intact Family Services, according to caseworkers and clinicians.

This document summarizes themes from focus groups and interviews conducted in 2023 with child welfare caseworkers and Trauma Focused Cognitive Behavioral Therapy (TF-CBT) providers in Illinois.

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Introduction

The Family First Prevention Services Act (FFPSA) is transformative legislation passed in 2018 that created provisions for state child welfare agencies to use federal funding for foster care prevention services. To enhance the ability of states to connect families to prevention service models that are more likely to be effective in terms of positive child and family outcomes, FFPSA also invests in evidence building. State child welfare agencies are required to employ continuous quality improvement methods (at minimum) or rigorous experimental or quasi-experimental designs to evaluate prevention services that, according to the Prevention Services Clearinghouse, have not demonstrated effectiveness or contributed to improved outcomes. The Illinois Department of Children and Family Services (DCFS) included Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) in their Prevention Plan as a service to be offered to child welfare-involved families who meet their definition of candidacy for prevention services. Chapin Hall is partnering with DCFS to conduct a process evaluation that will inform our understanding of the challenges and facilitators to the successful implementation and service delivery of TF-CBT.

TF-CBT is a joint child and parent psychotherapy model for children experiencing significant emotional and behavioral difficulties due to traumatic life experiences. Treatment includes trauma-sensitive, family-based interventions focusing on cognitive behavioral patterns, which are the connections between thoughts, feelings, and behaviors (National Child Traumatic Stress Network, 2012). The model's goals include improving posttraumatic stress disorder (PTSD) and depressive and anxiety symptoms; improving children's externalizing behavior problems; improving parenting skills and parental support of the child; enhancing parent-child communication, attachment, and ability to maintain safety; improving children's adaptive functioning; and reducing shame and embarrassment related to the trauma event (Cohen et al., 2006). TF-CBT is designed to take place over 12–16 sessions, though the duration of treatment is flexible depending on the child's needs. Additionally, TF-CBT focuses on building children's and parents' education and skills related to coping with trauma (Ramirez de Arellano et al., 2014).

There are currently five private child welfare contributing agencies (CWCAs) on contract with DCFS to provide TF-CBT services. These agencies serve three of the four administrative regions in Illinois: Northern, Southern, and Cook (they do not serve the Central region). Over the past 3 years, DCFS has strategized and worked through multiple administrative and practice considerations to enhance FFPSA implementation. Administrative components have included building the infrastructure to facilitate a smooth and complete referral process. Practice components have included building a decision support tool to help caseworkers identify the appropriate prevention services for families.

The goal of the process evaluation is to assess TF-CBT implementation to date and to ensure that implementation continuously meets required standards for fidelity. Without appraisal of the extent to which a treatment is implemented as intended, it is not possible to attribute intervention outcomes with confidence. The process evaluation includes objectives in the areas of fidelity to eligibility and referral processes between DCFS and TF-CBT providers, child and family service use and experiences, clinician fidelity to the TF-CBT treatment model, and observation of implementation strengths and challenges. The component of the process evaluation discussed in this brief used structured interviews and focus groups to obtain the perspectives of DCFS staff, TF-CBT providers, and TF-CBT administrators on selection and referral, implementation facilitators, challenges, potential solutions, and support and resources needed. Key implications and recommendations for ongoing implementation of TF-CBT as part of Illinois's FFPSA Prevention Plan are discussed.

Study Methods

This study used qualitative methods to examine the statewide implementation of TF-CBT from multiple vantage points: caseworkers referring families to TF-CBT services, clinicians providing TF-CBT to families, and administrators providing clinician supervision and supporting referral and linkage, data entry, and billing processes.[1]

Caseworker interviews. To capture caseworker experiences with TF-CBT, we conducted 45-minute virtual interviews with nine caseworkers. Topics included: the referral process, family engagement, and how TF-CBT

[1] The administrator interviews were conceptualized by the research team at Juvenile Protective Association/University of North Carolina evaluating other Family First prevention services and re-analyzed for the purposes of this study. Interviews with families are planned in a future phase of this study.

connected to child welfare safety and permanency goals. We first used DCFS administrative data to identify caseworkers that had made at least one referral to TF-CBT in the past year. We then recruited from this sample, selecting potential participants to ensure perspectives from DCFS Intact Family Services caseworkers and private CWCAs providing Intact Family Services, and from each of the four DCFS administrative regions, were represented. While TF-CBT is technically only available in three regions, our initial sampling included caseworkers from all four regions with referrals to TF-CBT in the past year. This is likely due to caseworkers providing virtual services or serving families in a different region than their assigned region. We contacted 35 caseworkers and completed nine virtual interviews. Most nonparticipants (*n*=14) did not respond to multiple emails or telephone recruitment attempts while others declined for various reasons including a change in their role (*n*=3) and lack of interest (*n*=1). Of the nine caseworkers interviewed, 44% were employed by DCFS and 56% were employed by private CWCAs. Forty-four percent served the Northern region, 33% served the Southern region, 11% served the Cook region, and 11% served the Central region.

Clinician focus groups. To understand clinician experiences with TF-CBT, we conducted five, 1-hour virtual focus groups with participants (*n* =11) organized by provider agency. Topics included: TF-CBT fidelity and adaptation, the referral process, family engagement, and coordination with caseworkers. We coordinated with the lead for each agency contracted for TF-CBT to find a convenient time for the virtual focus group and to update our list of clinicians providing this model. We invited all clinicians currently providing services, facilitated the focus group at the time recommended by the lead, and offered a $25 gift card incentive to each participant.

Administrator interviews. To understand experiences with TF-CBT from an agency perspective, we conducted three 1-hour virtual interviews. Topics included motivation for becoming a Family First provider and implementation successes and challenges as they relate to referral process and fit, reimbursement, and staffing. We recruited agency leads as part of the sample developed for a larger project that aimed to engage providers offering all of the prevention services making up the Illinois Family First service array. We contacted four leads and ultimately completed three virtual interviews.

Table 1. Nearly All Interview and Focus Group Participants Were Female and Most Had a Master's Degree or Higher

Data Source	n	Master's Degree or Higher	Female	White	African American/ Black	Hispanic/ Latino	Biracial
Nine individual caseworker interviews	9	67%	100%	44%	33%	11%	11%
Five clinician focus groups	11	100%	90%	40%	40%	20%	0%

Note. Demographic characteristics of the TF-CBT administrators who participated in interviews are not described here because demographic information was not collected during interviews.

For each data source, we transcribed the interviews and the focus groups, created a set of codes based on the interview and focus group guides, and then applied those codes to the transcripts.

Findings

> "One of the things that I always assess for is the safety of my clients. So, if they're in the home and they're feeling unsafe, I work to take care of that first." — Clinician

We highlight five implementation lessons drawn from across the experiences of caseworkers, TF-CBT clinicians, and community-based provider administrators providing Family First prevention services to Illinois families.

Finding 1. TF-CBT goals and strategies strongly align with trauma-related needs of many families receiving Intact Family Services.

Caseworkers and clinicians consistently reported that TF-CBT's focus on addressing trauma symptoms and building coping skills to more effectively manage stressors aligned with the needs of many Illinois families receiving Intact Family Services. A caseworker explained that what made TF-CBT attractive was "the whole idea of addressing the trauma piece. Everybody's got trauma, it's just the degree. And I think a lot of the families we're working with have more than most." Another caseworker observed:

> **The percentage of families that we see with children and parents who've experienced some trauma, some of the parents are DCFS foster youth alumni. . . I understand how trauma. . . affects people, and when it's not tended to or you don't heal from that trauma, how it impacts you as an adult. I really feel that's an important thing for us to have available to our families.**

Caseworkers also indicated the value of TF-CBT's family-based emphasis. The model's attention to supporting primary caregivers to develop their own coping skills as part of supporting their child aligns particularly well with the multigenerational experience of trauma they observe among families involved with the child welfare system. One clinician observed that many types of therapy did not include this crucial caregiver component. They said TF-CBT's family-based approach creates "an environment that is working towards that progression in terms of being able to understand trauma and its effects not just with the child, but how it affects everyone within the home." Caseworkers using the Decision Support Tool[2] also reported that the recommendations for evidence-based interventions generated by the Tool generally aligned with their own assessment of family needs.

Clinicians described the value of the model's explicit focus on coping skills and strategies for addressing trauma-related needs experienced by many children and families. For example, developing a safety plan that can be returned to and addressed throughout TF-CBT delivery. One clinician explained, "One of the things that I always assess for is the safety of my clients. So, if they're in the home and they're feeling unsafe, I work to take care of that first." Clinicians also described the value of the model's flexibility in being able to go out of order or return to prescribed phases to be responsive to a client's needs. One clinician said, "Sometimes they're comfortable in one area, but they still maybe need to discuss their trauma narrative or we need to do something else like safety first just because there's an emergency or crisis. . . things definitely change from different situations that arise within their lives, so we have to address them as such."

[2] The Decision Support Tool was developed by DCFS to use information gathered in the Child and Adolescent Needs and Strengths (CANS) assessment to generate FFPSA service recommendations.

Caseworkers noted that families may feel uncomfortable with TF-CBT's focus on trauma, especially when the caregiver is the perpetrator or has also experienced the trauma, like interpersonal violence.

Despite the benefits of TF-CBT for addressing trauma-related needs, many families receiving Intact Family Services still face challenges (such as transportation challenges) that contribute to missed sessions and uneven attendance. Clinicians reported that, particularly because TF-CBT is intended to be a brief therapy model, missing sessions can slow progress considerably. Clinical progress can also be nonlinear when a child does not recall the traumatic experience or when trauma is complex or ongoing.

Finding 2. Caseworkers and clinicians report significant challenges engaging families in TF-CBT, such as material hardship, negative experiences with the child welfare system, and families' incomplete understanding of how traumatic events can impact children.

Caseworkers, clinicians, and provider administrators reported greater challenges engaging families receiving Intact Family Services in TF-CBT than families referred through other non-DCFS sources. Common challenges affecting family engagement included: (1) families' ongoing material hardship and related stressors, (2) families' often negative experiences with the child welfare system, particularly the child maltreatment investigation, and (3) TF-CBT's emphasis on trauma. For example, some families receiving Intact Family Services face urgent material hardships, such as being unhoused or not having enough food, or ongoing stabilization challenges that make it difficult to prioritize weekly therapy sessions. In cases where a family's primary challenges are not directly related to parenting or trauma, caseworkers also described prioritizing progress on other concerns over engaging families in TF-CBT or other Family First services.

Caseworkers also cited challenges engaging families specifically due to TF-CBT referrals coming through the child welfare system. One challenge is how experiences with investigations colored family interest in prevention service referrals. A caseworker said, "When their initial engagement with DCFS is bad, it doesn't matter what service it is. [Families] would not want to engage." For another, the fact that TF-CBT referrals are voluntary—that they were not court-ordered—also contributed to there being less interest in the referral. Some families are also simply reluctant to participate in therapy or TF-CBT due to previous personal experiences or fears of feeling shame or guilt. Caseworkers also indicated that families are sometimes uncomfortable with TF-CBT's explicit focus on trauma and trauma exposure, particularly when the caregiver is the perpetrator of a child's trauma or when the caregiver had also experienced the traumatic events, such as interpersonal violence. This was particularly true if the traumatic events were not the reason for involvement with the child welfare system.

From clinicians' perspective, families generally came to TF-CBT with limited understanding of trauma or the model. This affected family engagement. One clinician observed, "Sometimes it's kind of hard to get the parents and the child to both want to participate. And also some of the patients, they're not ready to talk to someone, so that's been hard to try to get them to participate because even if they're present, sometimes it's difficult to get them involved in the sessions. I've seen that happen sometimes because of trauma or what they've experienced prior." Another clinician said,

> **We have to explain a little bit what we're doing so that they can understand…[and] be educated on what's happening too. So the psychoeducation of it may need to be explained a little bit…it's trauma and it's related to what they're going through. For [families], it's still part of what they're experiencing, it's not over…we have to link them.**

Finding 3. Caseworkers and clinicians are actively supporting family uptake of TF-CBT referrals by carefully choosing when the TF-CBT referral is offered, articulating the benefits of TF-CBT, and providing psychoeducation to families.

Carefully choosing when the TF-CBT referral is offered. Recognizing challenges related to material hardship and ongoing stabilization, caseworkers offered resources available through the child welfare system to address basic needs, such as gas cards and help with utility payments. Caseworkers also reported that they might wait until a family experienced progress addressing housing instability, food insecurity, and other similar concerns before offering the TF-CBT referral. One caseworker said, "We try to monitor them a little bit closely and try to help them get stabilized as much as possible. . . . 'Where you're going to be at? Are you guys safe? Are the kids safe? Have they eaten?' . . .at that point we can't just be like, 'Oh yeah, you need to do this and this.'" Clinicians also reported that they or an intake coordinator assessed the family's needs. They would offer families gift cards to buy food and reach out to caseworkers to alert them to identified needs.

Communicating the benefits of TF-CBT. Caseworkers and clinicians also highlighted the need to effectively convey the benefits of TF-CBT to families to make them more receptive to this voluntary referral. Some caseworkers described getting the family's go-ahead before making a referral; others described deciding to put a referral in before discussing why they believed the family would find it helpful. One caseworker explained, "I would suggest to them, 'Hey, I really think that this will be a good idea for the kids or for the family as a whole. Are you interested in participating in the service?' And then I just tell them the reason as to why I would recommend it. And then I. . . go ahead and refer it." Another caseworker said they introduce the concept

> **in a way that is *not* telling them, 'You have to do this because. . . '. I'm saying, 'Maybe some things have happened that I can recognize and it's my belief that these things will help. And in my experience, and we have these resources and because DCFS was involved and you now have an Intact case, you have access to these resources.'"**

These conversations scaffold a psychoeducation process—educating families on trauma, normalizing trauma responses, and conveying the benefits of treatment—so that families recognize that they could benefit from TF-CBT (National Child Traumatic Stress Network, 2012). One caseworker underscored this information as being important because families may or may not identify some past or ongoing experiences as traumatic.

> The challenging aspects of the work being done at TF-CBT sessions (for example, discussing traumatic experiences) negatively influenced buy-in and interest in completing the model.

Providing psychoeducation to families. Whether caseworkers discussed trauma and TF-CBT specifically with families varied somewhat. Caseworkers with a longer tenure as a caseworker for Intact Family Services or those with clinical backgrounds were more likely to provide psychoeducation to families about trauma and TF-CBT prior to referring them to services. In line with these reports, clinicians indicated that families were sometimes unaware that they had been referred to TF-CBT by their caseworkers and often were not familiar with the model's goals and structure. They reported using "pretreatment" sessions to build rapport with families and provide crucial psychoeducation about the TF-CBT model. These pretreatment sessions had been added to the TF-CBT provider contract with DCFS in 2022. Clinicians underscored the value of this additional time for enhancing assessment of family needs and establishing trusting relationships and buy-in that are important for this family-based, brief therapy model. Families were often not familiar with the concept of trauma or the multiple impacts that traumatic life events can have, such as difficulties with depression, anxiety, behavioral problems, and trust. Clinicians emphasized the importance of pretreatment sessions to define what trauma is and connect it to a child's behaviors, particularly for families that were referred to TF-CBT but had a limited understanding of the goals and expectations for TF-CBT and how it is different from general therapy.

Finding 4. Providers are reducing barriers to completing TF-CBT by offering multiple service modalities and reaching out to caseworkers.

To reduce barriers to starting and completing TF-CBT, community-based agencies offer TF-CBT using different modalities. They also reported spending more time and effort over the course of treatment to keep Intact Family Services families engaged in TF-CBT compared to families from other referral sources.

Multiple service modalities. To reduce barriers to access, clinicians offer the model via multiple modalities. The modalities are determined in partnership with their community-based agency that is contracted to provide TF-CBT. In addition to traditional in-office sessions, community-based agencies provided TF-CBT through in-home, in-community, school-based, and virtual modalities. While the specific modalities supported by each community-based agency differ, clinicians observed distinct pros and cons based on their experiences offering the different modalities. For example, clinicians noted that while various in-community and virtual modalities addressed the issue of transportation, they had limited ability to ensure a controlled environment with access to supplies for play and other therapies. This included coordination with school or library staff to limit interruptions and to protect their client's privacy. Similarly, while virtual sessions offered convenience, sessions could be interrupted by phone calls or texts or by clients not having printed out worksheets ahead of time.

Table 2. Clinicians Feel That Different Service Modalities Address Different Barriers

Primary Barriers Addressed				
Service Modalities	**Transportation to Sessions**	**Family Work and Childcare Schedule**	**Private and Safe space**	**Active Participation by Primary Caregiver**
Office			⬢	⬢
In-home	⬢	⬢		⬢
At school	⬢	⬢	⬢	
In-community (Library, Park)	⬢	⬢		⬢
Virtual	⬢	⬢		⬢

Caseworker and clinician coordination. Clinicians reported that families receiving Intact Family Services, as opposed to families from other, non-DCFS referral sources, were more likely to miss or reschedule sessions. Therefore, ongoing engagement efforts are critical, especially for families receiving Intact Family Services. Clinicians noted that families missed or rescheduled sessions due to circumstances and concerns that had led to their involvement with the child welfare system. It was also the case that, for some families, the challenging aspects of the work being done at TF-CBT sessions (for example, discussing traumatic experiences) negatively influenced buy-in and interest in completing the model.

Caseworkers cited that current policy calls for at least monthly outreach to TF-CBT clinicians serving families on their caseload, but they also described reaching out weekly for higher risk families. When families are just starting TF-CBT or other services, caseworkers described primarily checking in on attendance and participation:

> **At the beginning, I just want to make sure that they're engaged and that they're showing up. But as we get further into services, then I'm saying [to the clinician], "I would like to have a progress update. Is there anything I can do to encourage the work that you're doing? Are there insights that you think that I can help with?" Or the conversation sometimes goes the other way and I'm reaching out and I'm saying, "Hey, I'm hitting a wall with this person. Is there something in your treatment plan that you feel like you can help pinpoint so that we can move past this barrier that I'm seeing when I visit with them every week?"**

Caseworkers also asked families directly about their service experience to understand potential engagement challenges, in addition to reviewing notes and reports submitted by clinicians. One caseworker said, "Every visit I talk to families about services and then I follow up with the service providers. . . ...I like to check in once a week because this is high risk." Another explained that they ask families if they are finding TF-CBT to be beneficial, what level of service they are receiving, and if they like the provider.

Finding 5. Waitlists and gaps in regional TF-CBT availability, as well as cases being closed mid-treatment, are ongoing, statewide challenges to TF-CBT access.

> "The issue everywhere is trying to find therapists– therapists who can meet kids on their actual hours, not in the middle of the day while they're at school." – Caseworker

Waitlists and gaps in TF-CBT availability. TF-CBT is not yet available through FFPSA at any private CWCAs serving Illinois's Central region nor at multiple counties in other regions. One caseworker said, "The only option for that service right now is this one agency that's virtual. . . unless a family wants to private pay." Caseworkers overall indicated more families were interested in this service than could be served; there were instances of families being waitlisted for months or not being able to start before case closure. Caseworkers reported that the information available to them about the agencies contracted for TF-CBT was not always up to date. They mentioned taking steps such as contacting the agency to confirm they served a particular catchment area and to ask if the agency could accommodate a referral immediately to reduce the time families spent waiting to start services. Agency administrators also indicated they faced challenges with recruiting and retaining clinicians, which limited the number of clients they could support at a given moment in time. A caseworker noted, "The issue everywhere is just trying to find therapists, trying to find therapists who can meet kids, trying to find a therapist who can meet kids on their actual hours, not in the middle of the day while they're at school or something else, trying to get a parent to continue to take them for these services."

Cases being closed midtreatment. Caseworkers and clinicians indicated the importance of coordination to bolstering family engagement and progress through TF-CBT treatment. Nevertheless, they also identified as an ongoing challenge that DCFS Intact Family Services cases were being closed before treatment was completed. Caseworkers reported pressures to close cases – stemming from administrative demands to manage caseloads and policy directives to close cases when families completed service plan requirements—even if TF-CBT treatment was still underway. Clinicians, on the other hand, discovered that some families' cases had been closed without their knowledge, disrupting treatment and billing processes.

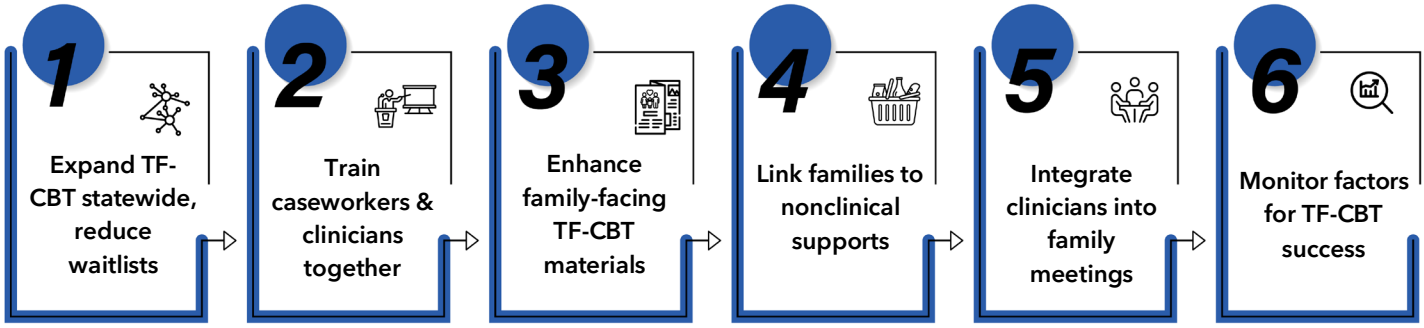
At the time of data collection, DCFS policy specified that Intact cases receiving TF-CBT or other Family First services should be kept open until treatment is completed. In 2023, the time that a referral was available had also been lengthened from 6 months to 1 year. Despite these policies, the tension remained as caseworkers and clinicians navigated the complexities of case closures impacting ongoing treatment. For example, caseworkers described instances where a family was unable to start TF-CBT before their case closed or wanted to continue TF-CBT (but could not). One caseworker explained, "It's not helpful for families that if we're closing their case and they don't need us to monitor them, but they want to continue in a service, that they would have to start paying [for the service]." Clinicians also described working with families only to find out that their case had been closed weeks or months earlier, which meant that the agency could not bill for these sessions. Some clinicians reported actively advocating with a caseworker for a family's case to remain

open until treatment could be completed. Some caseworkers also described connecting families to other community-based agencies so the family could choose to start receiving services independently, outside of a referral through the child welfare system.

For sources of information about family progress in TF-CBT treatment, caseworkers described consulting monthly and quarterly reports on family progress provided by clinicians and reaching out to clinicians by email and phone. Caseworkers also indicated that they invited providers to a family's Child and Family Team Meeting based on the family's preferences. However, few clinicians indicated that they had ever been invited to join a family's team meeting.

Facilitating factors associated with a family's successful completion of TF-CBT. Clinicians reported that the appropriateness of referrals had been improving over time. Caseworkers also said they had been developing relationships with agencies providing TF-CBT (some of which they had not been aware of previously). These connections, along with positive family feedback about TF-CBT and individual clinicians, helped them feel more confident when offering families these referrals. However, clinicians reported that, particularly for families facing ongoing stabilization challenges, they sometimes needed to pivot to general therapeutic techniques. Even when a child met TF-CBT's eligibility requirements, TF-CBT's brief approach and design that focuses on past traumatic events (rather than ongoing traumatic experiences) might be less appropriate for some families, especially when the ongoing trauma is likely a contributing factor to the family's involvement with Intact Family Services. As such, the factors that facilitate successful referral to and successful engagement with TF-CBT for families should be documented and monitored and implementation should adjust accordingly.

Recommendations



The following recommendations were identified after carefully analyzing and synthesizing the experiences and perspectives described above. Overall, TF-CBT has multiple strengths and there are positive perceptions of the service and its usefulness for families identified as candidates for Family First prevention services because of their risk of foster care involvement. However, there are also multiple opportunities to improve the referral process, improve engagement and communication between caseworkers and TF-CBT providers, and improve families' engagement with TF-CBT. In the next phase of the process evaluation, we will interview families to understand their firsthand experiences with TF-CBT when they are referred by Intact Family Services. This perspective will help further inform ongoing implementation of TF-CBT as part of Illinois's FFPSA Prevention Plan.

Recommendation 1. Continue pursuing the expansion of TF-CBT across the state. Illinois' Department of Children and Family Services has already been working diligently to expand the availability of prevention services, including TF-CBT. The findings described in this brief confirm that expanding access to TF-CBT would be valuable for children and families. Caseworkers and clinicians reported strong alignment between family needs and the goals of this model, but they highlighted gaps in family access due to waitlists and local availability. Strategies like leveraging virtual services as an option for families where this model is not offered locally, streamlining caseworker access to up-to-date information about clinician availability and waitlists, and aligning staffing of clinicians with the demand for TF-CBT would help enhance families' access to TF-CBT.

Recommendation 2. Bolster implementation of updated policies by training caseworkers and clinicians together. Caseworkers and clinicians can benefit from better coordination to minimize gaps in opportunities for families to become aware of, receive, and engage with TF-CBT. Conducting routine check-ins or dialogues between caseworkers and clinicians to discuss current referral and case closure policies in the same meetings or trainings will reinforce consistency in their practice and messaging of TF-CBT, aid in identifying emerging implementation challenges, and further foster collaboration between caseworkers and clinicians.

Recommendation 3. Strengthen initial family engagement with TF-CBT by supporting caseworkers to introduce the TF-CBT model and benefits, through enhanced family-facing materials and consistent messaging. Caseworkers indicated that they relied primarily on DCFS's internal-facing documents in discussing TF-CBT with families. Enhancing existing materials with plain language for sharing the value and goals of TF-CBT with families (for example, the brochure) will provide information that can help increase caseworkers' familiarity with the service and provide a consistent set of messages that clinicians can later build upon. This would also likely help with family engagement with TF-CBT when first contacted by a clinician to offer services.

Recommendation 4. Familiarize providers with concrete support resources Intact caseworkers can offer families to support families' basic needs not addressed by TF-CBT and improve initial and ongoing family engagement with TF-CBT. Most community-based agencies providing TF-CBT have not traditionally served families receiving DCFS Intact Family Services. This meant providers were not necessarily aware of the types of resources that caseworkers can access to address a family's basic needs, such as food. Helping provider agencies develop this familiarity with nonclinical services and supports available to families through Intact Family Services will support them to more effectively collaborate with caseworkers to address more immediate risk factors. (These might include material hardship, housing stability, or navigating community systems.) In addition, this help can be offered to families even before the family is ready to address their trauma and clinical needs through TF-CBT. This may also help clinicians in identifying when to offer a direct link to community resources.

Recommendation 5. Support ongoing family engagement with TF-CBT by more consistently integrating clinicians into existing family engagement practices, such as Child and Family Team Meetings and early meetings with a family and their caseworker. Clinicians reported DCFS Intact Family Services cases were being closed before families successfully completed TF-CBT. Clinicians also experienced other practice challenges that limited the benefits of the model for families. Stronger coordination between caseworkers and clinicians is critical to developing a more comprehensive planning process, identifying emerging opportunities to support families, and avoiding case closure before families can make progress in treatment.

Recommendation 6. Identify and monitor facilitating factors associated with successful completion of TF-CBT to support strong family engagement. TF-CBT's specific eligibility criteria related to traumatic experiences and trauma symptomology defines a specific target population experiencing significant, and potentially ongoing, trauma. However, as clinicians noted, even among those families that meet the trauma indicators that necessitate a referral, TF-CBT may not be the most appropriate therapeutic approach given the circumstances a family faces, including ongoing trauma. To further inform appropriate referrals and service delivery, it will be important to ask families what helped them decide to accept the referral and participate in treatment (or factors that made it difficult to continue treatment). This will aid DCFS in prioritizing key supports and changes in service identification and referrals that may maximize the ability of families to benefit from TF-CBT as a voluntary prevention service.

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The opinions, findings, and recommendations expressed in this publication are solely those of the authors and do not necessarily reflect those of DCFS, University of North Carolina, Juvenile Protection Association, or our clinic partners.

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