



QIC•AG

ILLINOIS IMPLEMENTATION MANUAL

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION
AND THERAPY

CHAPTER 1

INTRODUCTION USING THE IMPLEMENTATION MANUAL

The Implementation Manual provides detailed information a child welfare system/agency would need to implement one of seven interventions that were implemented and evaluated as part of the Quality Improvement Center for Adoption/Guardianship Support and Preservation (QIC-AG). All of these interventions are geared for children and families who are moving toward adoption or guardianship or children and families who have already achieved permanence through adoption or guardianship.

The Implementation Manual provides a roadmap for using a structured process to 1) determine if an intervention is the “right” intervention for your site and 2) implement the intervention with integrity. The manual will assist with the following:

- » Conducting a system assessment to identify the problem that needs to be addressed and the target population that has the need;
- » Developing a Theory of Change that explains why the change is proposed and the steps needed to achieve the desired outcome;
- » Ensuring the intervention meets the identified need by assessing fit, available resources, expected outcomes, and system readiness and capacity for implementation;
- » Developing a plan to implement the intervention;
- » Identifying and operationalizing supports necessary for implementation;
- » Testing the process to ensure that the intervention is implemented as intended.

Implementing a new intervention will require significant time and resources, and accordingly the manuals that describe the implementation are necessarily detailed. Each chapter contains practical considerations for implementation as well as lessons learned from the pilot sites. You can stop reading the manual if at any point you determine the intervention is not the right intervention for your site.

The manual chapters are as follows:

CHAPTER 2: OVERVIEW OF THE INTERVENTION:

This chapter provides a brief introduction to the intervention including core components, or key elements. In addition, the chapter identifies the supports needed to successfully implement the intervention with special attention to those supports that are most critical.

CHAPTER 3: CORE COMPONENTS:

Only read chapter 3, if after reading chapter 2 you would like to have a more in depth understanding of the intervention. Building on the overview in Chapter 2, core components are further defined and operationalized. Additionally, important considerations or tasks needed to develop or implement each component are provided to fully inform and guide replication. Site-specific strategies and examples are given.

CHAPTER 4: CHOOSING THE RIGHT INTERVENTION

Once you understand the intervention, it is important to determine if it meets the needs of your clients and system. This chapter guides the reader through the **Identify and Explore** phase of implementation, helping to determine if the intervention is right for their system/agency. This chapter includes methodology and tools to identify 1) the problem in need of attention, 2) the target population, and 3) whether the named intervention can be implemented to meet the needs of the target population. Important considerations or tasks needed to develop or implement each component are provided to fully inform and guide replication. Site-specific strategies and examples are given. If the intervention seems like a good fit then move on to chapter 5. If the intervention is not a good fit consider some of the other interventions implemented by the QIC-AG.

CHAPTER 5: PLANNING TO IMPLEMENT

This chapter takes the reader through the critical steps of **Implementation Planning**, focusing on the components critical to support implementation. These components include: 1) research considerations 2) what must be done to ready a system to support high quality implementation, and 3) teaming and communication structures. This chapter also includes a discussion of the structural and functional changes to the system that may be needed to ensure that the intervention can be implemented (installation phase). Important considerations or tasks needed to develop or implement each component are provided to fully inform and guide replication. Site-specific strategies and examples are given.

CHAPTER 6: ASSESSING READINESS: USABILITY TESTING

Usability testing is a process used during the ***Initial Implementation*** phase to ensure the intervention can and is being implemented as intended. This testing period allows for adjustments to be made before full implementation begins. Site-specific strategies and examples of usability testing are given.

CHAPTER 7: TRACKING PROGRESS THROUGH WORK PLANS

Establishing and documenting time frames and responsible parties ensures the project stays on track and progresses as planned. This chapter includes a discussion of the key elements needed in a work plan to effectively track the progress of activities over time and by implementation phase, as well as the benefit of documentation and periodic review.

POST PERMANENCY STRATEGIES

The QIC-AG is a five-year project that worked with sites across the United States to implement evidence-based interventions or develop and test promising practices, which, if proven effective, could be replicated or adapted in other child welfare jurisdictions. The following interventions were implemented:

PATHWAYS TO PERMANENCE 2: PARENTING CHILDREN WHO HAVE EXPERIENCED TRAUMA - TEXAS

The Texas site team implemented Pathways to Permanence 2: Parenting Children Who Have Experienced Trauma and Loss, hereafter, referred to as Pathways 2, developed by the nonprofit Kinship Center a member of the Seneca Family of Agencies in California. The Pathways 2 program uses a seven-session group format to guide adoptive parents, foster parents, kinship caregivers, and guardians through robust discussion and activities designed to strengthen their family. Participation in Pathways 2 is limited to “active caregivers” who are either temporary or permanent caregivers for a child living in the home, or an adult who is engaged with the child through visitation, phone calls, or therapy and is willing to have the child return to the home.

FAMILY GROUP DECISION MAKING - THE WINNEBAGO TRIBE OF NEBRASKA

The Winnebago Team adapted and implemented Family Group Decision Making (FGDM) a practice model that honors the inherent value of involving family groups in decisions about children who need protection or care. As opposed to decisions, approaches, and interventions that are handed down to families, FGDM is designed as a deliberate practice where families lead the decision-making process, and agencies agree to support family plans that adequately address child welfare concerns. A trained FGDM coordinator supports the family throughout the process.

THE VERMONT PERMANENCY SURVEY - VERMONT

The Vermont site team implemented the Vermont Permanency Survey. The survey consisted of validated measures and questions identified by the Vermont site team that fell into the following categories:

- » Family well-being: To better understand the factors that can impact the family’s safety, permanency, and stability.
- » Child well-being: To identify and understand the strengths and challenges of children and youth who were adopted or are being cared for through guardianship.

- » Caregiver well-being: To identify and understand the strengths and experiences of caregivers who have adopted or assumed guardianship of a child.
- » Community services: To identify and rate the level of helpfulness of the preparation services families used prior to adoption or guardianship and family support services available after achieving permanence.

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY – ILLINOIS

Trauma Affect Regulation: Guide for Education and Therapy (TARGET) is designed to serve youth ages 10 years and older who have experienced trauma and adverse childhood experiences. TARGET uses a strengths-based, psycho-educational approach and teaches youth about the effects trauma can have on human cognition; emotional, behavioral, and relational processes; and how thinking and memory systems can be impeded when the brain's stress (alarm) system is stuck in survival mode. The target population was a child between 11 and 16 years old living with an adoptive parent or guardian and youth over 10 years of age, living in families who finalized private domestic or inter-country adoptions.

TUNING IN TO TEENS - NEW JERSEY

Developed at the Mindful Centre for Training and Research in Developmental Health at the University of Melbourne, Australia and implemented by the New Jersey Team, Tuning in to Teens (TINT) © is an emotion-coaching program designed for parents of youth ages 10 to 18 years. The program equips parents with strategies for not only responding empathically to their adolescent's emotions but also helping their teens develop skills to self-regulate their emotions.

ADOPTION AND GUARDIANSHIP ENHANCED SUPPORT - WISCONSIN

The Wisconsin Team created a new intervention, Adoption and Guardianship Enhanced Support (AGES), an enhanced case management model. Designed with the goal of responding to families who expressed feelings of being unprepared, ill-equipped, or unsupported in trying to meet the emerging needs of their children after adoption or guardianship permanence was finalized. An AGES worker assesses the family's strengths and needs and with the family develops a support plan, covering critical areas such as social supports, case management, parenting-skills development, education, and other capacity-building activities. The intervention was implemented in the Northeast Region of Wisconsin.

The development of AGES was informed by two post-adoption programs: Pennsylvania SWAN and Success Coach in Catawba County, North Carolina.

THE NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT) - TENNESSEE

The Neurosequential Model of Therapeutics developed by the Child Trauma Academy, is a developmentally informed, biologically respectful approach to working with at-risk children. NMT is not a specific therapeutic technique or intervention, rather NMT provides a set of assessment tools (NMT metrics) that help clinicians organize a child's developmental history and assess current functioning to inform their clinical decision-making and treatment planning process. NMT integrates principles from neurodevelopment, developmental psychology, trauma-informed services, as well as other disciplines to enable the clinician to develop a comprehensive understanding of the child, the family, and their environment. The NMT model has three key components: (a) training/capacity building, (b) assessment, and (c) specific recommendations for selecting and sequencing therapeutic, educational, and enrichment activities matched with the needs and strengths of the individual.

CHAPTER 2

OVERVIEW OF THE INTERVENTION

The Trauma Affect Regulation: Guide for Education and Therapy © (TARGET) intervention was implemented by a team of child welfare professionals from the Illinois Department of Children and Family Services, Illinois Adoption Support and Preservation agencies, and the QIC-AG site consultants and evaluators, collectively referred to as the Illinois Team or the Team. Based on data and feedback the Illinois Team collected from stakeholders, the Team identified adolescence as a high-risk period for adoptive and guardianship families. Given this knowledge, the Illinois Team concluded that proactively equipping families of pre-adolescents or adolescent youth with coping tools might alleviate some stressors that arise during this developmental stage. TARGET was selected because it is a skills-based, short-term intervention that is preventative in nature and uses a strength-based perspective to provide youth and their families with information on trauma and the long-term impact of traumatic experiences. Additionally, Illinois had used TARGET in conjunction with another grant-funded project, and thus had experienced staff who were certified by the TARGET purveyor to conduct the TARGET training and act as coaches.

This chapter provides an introduction to the intervention and an overview of the core components, or key elements that define an intervention. In addition, the chapter identifies the supports needed to successfully implement the intervention with special attention to those supports critical.

I.

OVERVIEW

The TARGET intervention is designed to serve youth 10 years and older affected by trauma and adverse childhood experiences. TARGET uses a strengths-based, psychoeducational approach to teach youth about the impact of trauma on human cognition; the emotional, behavioral, and relational processes; and how the brain's stress or alarm system — when stuck in survival mode — can impede thinking and memory processes. During TARGET sessions, a trained facilitator uses “FREEDOM Steps” (**F**ocus, **R**ecognize triggers, **E**motion self-check, **E**valuate thoughts, **D**efine goals, **O**ptions, and **M**ake a contribution), a 7-step skill sequence that addresses trauma-related feelings and reactions commonly experienced among youth living in adoptive and guardianship families.

Additional information about TARGET is available from the following websites:

- » <http://www.advancedtrauma.com>
- » http://resources.childhealthcare.org/resources/target_general2012.pdf



II.

INTERVENTION CORE COMPONENTS

The various elements making up the interventions vary widely but some core components are critical to the identity and aim of each intervention. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “core components are the most essential and indispensable components of an intervention, practice or program.” TARGET is comprised of four core components:

1. **Learning to manage affect dysregulation**
2. **Understanding the body’s stress response systems**
3. **Using the FREEDOM Steps**
4. **Family participation in TARGET**

CORE COMPONENTS 1 TO 3: LEARNING TO MANAGE AFFECT REGULATION; UNDERSTANDING THE BODY’S STRESS RESPONSE SYSTEMS; AND USING THE FREEDOM STEPS

TARGET teaches youth how to recognize and understand their stress triggers so they can regulate overwhelming feelings (or prevent feelings from becoming overwhelming), enabling them to make and to achieve their goals. Learning to manage affect is a skill that helps participating youth not only understand their reactions to stress but also regulate their emotions and behaviors.

TARGET uses non-technical language to explain the difference between normal stress and extreme stress (i.e., trauma). Extreme stress causes alarm reactions in the brain that activate the body’s fight/flight reaction, which short-circuits normal thinking processes. TARGET shows how people of all ages who have experienced extreme stress can use seven skills or steps to gain freedom from their reactions to that extreme stress. TARGET facilitators teach these skills (known as the FREEDOM steps) as a method for recognizing and processing unfinished emotional business that arises in current life experiences. Each of the seven

letters in the FREEDOM acronym represents a unique step that “turns down the brain’s alarm”¹ : **F**ocus, **R**ecognize triggers, **E**motion self-check, **E**valuate thoughts, **D**efine goals, **O**ptions, and **M**ake a contribution.

TARGET can be delivered in a group setting or in an individual session. It is a manualized intervention that includes semi-scripted session notes and corresponding materials such as worksheets and other hand-outs that are used as part of the session process. Sessions are delivered in sequential order. The TARGET purveyor provides the materials used in sessions, which also include posters, flash cards, wrist bands, and other tools that help facilitators teach TARGET concepts.

Given the nature of the TARGET program—teaching skills for processing and managing trauma-related reactions to stressful situations—youth with the following characteristics are unlikely to benefit from the intervention:

- » An IQ lower than 70
- » Significant symptoms or functional impairment
- » Severe autism
- » Untreated substance abuse
- » Significant developmental disabilities

CORE COMPONENT 4: FAMILY PARTICIPATION IN TARGET

TARGET supports a family-centered approach to therapy. The developer of TARGET, Dr. Julian Ford, has indicated that parent participation in TARGET is a significant factor in successful outcomes. According to the TARGET Family Manual, the goal of the intervention “is to enable family members to process the emotional, somatic (physical body), and cognitive information that was not fully processed at the time of trauma exposure rather than intensifying intrusive re-experiencing by suggesting that the focus should be on the objective traumatic events.”²

¹ Retrieved from: www.advancedtrauma.com/Services.html

² Advanced Trauma Solutions, 2015, p. 18



GETTING YOUR SYSTEM READY: IMPLEMENTATION SUPPORTS

The term *implementation supports* refers to the infrastructure developed to facilitate the successful implementation of an intervention, which also helps to ensure the stability of the intervention over time. Without implementation supports, the system will not have the capacity to support the delivery of the intervention to the target population. Because implementation supports facilitate intervention delivery, assessing these supports is crucial.

The following provides some basic information about the infrastructure that is needed to support TARGET.

- » Leadership
- » System partners and community linkages

1. Staffing

TARGET can be taught to and delivered by persons from a wide variety of cultural and educational backgrounds and professions including, but not limited to, mental or behavioral health, counseling, medicine, nursing, education, social work, marriage and family therapy, addiction recovery, personal coaching, and human resources professionals. While the purveyor prefers to train professionals with a master's degree, if an agency wishes to use the model with bachelor-level professionals, the purveyor will work with the agency to make appropriate adaptations to the instructional and coaching tasks associated with implementation to ensure the right level of support is provided to staff.³

2. Training, Coaching, and Supervision

Initial training for TARGET therapists/facilitators is referred to as Level 1 training and consists of 4 days of training (i.e., 3 full days of training on TARGET content and a fourth day of training on the fidelity and coaching requirements for therapists). Each training cohort is limited to no more than 20 facilitators. Level 1 training teaches therapists how to deliver TARGET in an individual service delivery model, referred to as the TARGET Individual/Family Manual. The first 3 days of the training provide an overview of the following topics: Impact of traumatic stress on the brain; social and emotional development and ability to regulate affect; the neurobiology of stress and coping; and use of the manual to provide TARGET. Day 4 of the training provides therapists with an overview of the fidelity monitoring and on-going coaching requirements for TARGET facilitators,

³ https://www.nctsn.org/sites/default/files/interventions/target_training_guidelines.pdf

including the steps to achieving certification status. Supervisors and program directors from the agencies where TARGET therapists were located were offered a half-day orientation in TARGET. Supervisors were also invited to attend Day 4 of the Level 1 training to familiarize them with the TARGET fidelity monitoring and coaching requirements.

Immediately following the Level 1 training, therapists began individual and group coaching provided by a purveyor-certified TARGET coach. The coaching sessions were used to reinforce content learned in training and served as a mechanism to help facilitators prepare for their initial sessions with families assigned to the intervention group. Once therapists began meeting with their assigned families, the coaching sessions were used to discuss specific case situations and the application of TARGET in each case. This high level of involvement and follow up was intended to ensure the core components of the intervention were established and maintained over time.

3. Fidelity

TARGET uses a well-developed and well-defined fidelity system complimented by individual and group coaching. The specific elements of this system include:

- » Use of videotaping with validated fidelity monitoring
- » One individual coaching session per month, per therapist
- » Two group coaching sessions per month

To assure the TARGET model is being delivered as intended by the developers, all TARGET sessions are recorded (with the camera focused on the facilitator only to protect the identity of participants). Facilitators submit recordings of every session conducted and receive feedback on a sample of these sessions from their fidelity coach. Through this process, facilitators can work toward proficiency and certification statuses (described below). Facilitators explain the purpose of the recording but families have the option to not have sessions recorded.

Sessions with the assigned fidelity coach begin prior to the first clients receiving the intervention. This forum is used to support facilitator preparation for first clients and to ask any intervention-specific questions. When sessions with clients begin, coaching sessions are focused on development of the necessary skills to successfully implement TARGET with active clients. The coaching sessions provided by TARGET coaches were not intended to replace clinical supervision—these sessions focused only on reinforcing the concepts taught in TARGET (for example, techniques to assist the facilitators in teaching the FREEDOM steps). Purveyor-certified TARGET coaches are provided with their own coaching with the purveyor, which ensures that the direction provided in individual coaching is in line with the model.

Following Level 1 training, TARGET therapists work toward two levels of facilitator status. A therapist's progress toward these levels is based on the purveyor's Quality Assurance review of videotaped sessions and the therapist's satisfactory participation in individual and group coaching sessions. The first level is the designation of proficiency in the TARGET model. To achieve Proficient status, a therapist must submit a minimum of 16 videotaped sessions for review, obtain a score of at least 75% on the proficiency standards, and attend at least 80% of coaching sessions. After a Proficient status is achieved, the therapist can work toward Certified status. The standards for certification are more stringent than those outlined for proficiency, focusing specifically on sessions in which the therapist teaches the FREEDOM steps. Based on a review of eight sessions, a therapist must obtain a score of at least 75% and attend at least 80% of coaching sessions to achieve Certified status. For example, a therapist who meets the coaching requirements and submits 8 sessions, scoring at least 75% on 6 of the 8 sessions, will achieve Certified status. TARGET therapists are required to maintain certification status on an annual basis by submitting a sufficient number of videotaped sessions to obtain a score of at least 75% on certification standards.

4. Policies and Procedures

The need for policy changes is system specific and may or may not be necessary.

5. Data Systems

There is no standard data collection system, so a site implementing TARGET will need to determine what data must be collected and how it will be captured. Data that the site might want to capture include:

- » Client demographic information
- » Results of outreach efforts
- » Results of the eligibility screening
- » Referral and enrollment information
- » TARGET session information

6. Program Expert

Advanced Trauma Solutions, Inc. the developer and purveyor of TARGET provides ongoing technical support and consultation, critical to TARGET implementation, service delivery and certification.

7. Financial and Material Considerations

To be certified to deliver TARGET to families, the purveyor requires clinicians to attend training and participate in coaching and videotape reviews as described in the Fidelity section. Fees for training and coaching sessions were fixed and somewhat predictable. However, because the length of time it took facilitators to become certified varied, the fees associated with uploading and storing video recordings and for the review of session content became unpredictable and variable. Once facilitators achieved certification, the number of required reviews and coaching sessions was reduced, thus reducing costs.

The TARGET purveyor requires the purchase of a training manual and set of tools used to engage clients during TARGET sessions. Tools included posters, wristbands, and brochures for each participant.

CHAPTER 3

CORE COMPONENTS

The various elements making up interventions vary widely but some core components are critical to the identity and aim of each intervention. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), “core components are the most essential and indispensable components of an intervention, practice or program.”

This chapter addresses the following topics:

I. INTERVENTION CORE COMPONENTS

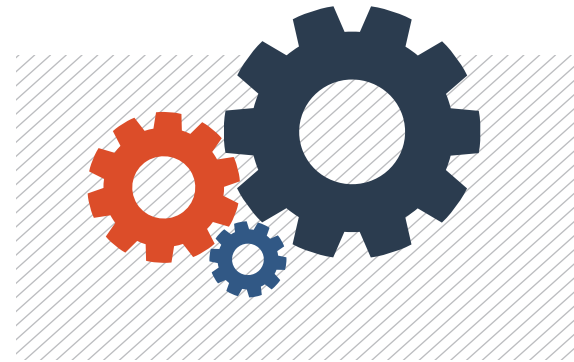
This section includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) a description of how the Illinois Team implemented the process, activity, or task; (d) lessons the Illinois Team learned during implementation.



INTERVENTION CORE COMPONENTS

TARGET is comprised of four core components:

1. Learning to manage affect dysregulation
2. Understanding the body's stress response systems
3. Using the FREEDOM Steps
4. Family participation in TARGET



CORE COMPONENTS 1 TO 3: LEARNING TO MANAGE AFFECT REGULATION; UNDERSTANDING THE BODY'S STRESS RESPONSE SYSTEMS; AND USING THE FREEDOM STEPS

TARGET teaches youth how to recognize and understand their stress triggers so they can regulate overwhelming feelings (or prevent feelings from becoming overwhelming), enabling them to make and achieve their goals. Learning to manage affect is a skill that helps participating youth not only understand their reactions to stress but also regulate their emotions and behaviors.

TARGET uses non-technical language to explain the difference between normal stress and extreme stress (i.e., trauma). Extreme stress causes alarm reactions in the brain that activate the body's fight/flight reaction, which short-circuits normal thinking processes. TARGET shows how people of all ages who have experienced extreme stress can use seven skills or steps to gain freedom from their reactions to that extreme stress. TARGET

¹ Retrieved from: www.advancedtrauma.com/Services.html

facilitators teach these skills (known as the FREEDOM steps) as a method for recognizing and processing unfinished emotional business that arises in current life experiences. Each of the seven letters in the FREEDOM acronym represents a unique step that “turns down the brain’s alarm”¹: **F**ocus, **R**ecognize triggers, **E**motion self-check, **E**valuate thoughts, **D**efine goals, **O**ptions, and **M**ake a contribution.

TARGET can be delivered in a group setting or in an individual session. It is a manualized intervention that includes semi-scripted session notes and corresponding materials such as worksheets and other handouts that are used as part of the session process. Sessions are delivered in sequential order. The TARGET purveyor provides the materials used in sessions, which also include posters, flash cards, wrist bands, and other tools that help facilitators teach TARGET concepts.

Given the nature of the TARGET program—that is, teaching skills for processing and managing trauma-related reactions to stressful situations—youth with the following characteristics are **unlikely** to benefit from the intervention:

- » An IQ lower than 70
- » Significant symptoms or functional impairment
- » Severe autism
- » Untreated substance abuse
- » Significant developmental disabilities

When determining how to create a supportive environment in which youth and families can learn, understand, and use the skills taught in TARGET, start with the following tasks:

- » Determine whether TARGET will be offered as individual or group sessions.
- » Consider the setting (in-home vs. office setting) most conducive to working with the youth and the family.
- » Consider the program implications of offering families scheduling flexibility.
- » Determine if adaptations are needed to support “goodness-of-fit” with your intended population.
- » Create a mechanism to screen youth for characteristics that might indicate TARGET would not be effective.
- » Ensure that program staff have the materials needed to conduct TARGET sessions as intended.

Rather than offering TARGET in a group setting, the Illinois Team determined, based on stakeholder feedback, that offering TARGET individually in the family’s home was likely to be the most desirable option for families. Providing TARGET in individual settings also fits well with the existing delivery approach of the Illinois private agencies whose staff provide in-home adoption support and preservation services as well as service as the TARGET facilitators. Although the family’s home was the program “default” setting, during the outreach process, families were told they could opt to have sessions in an office setting.

Because TARGET was not specifically created for families who had achieved permanence, the Illinois Team created a supplemental document to the TARGET Manual that included information on adoption and guardianship as well as how to deliver TARGET with adoption competency. This supplement to the manual addresses the impact of complex trauma on children and families, key elements about the experiences of adopting from other countries or as a private domestic adoption, and the importance of recognizing the lifelong nature of the adoption/guardianship journey.

TARGET teaches a set of skills and helps youth and families practice these skills with the ultimate goal of helping the youth transfer what they learn in the session to everyday situations in their home and community. During the eligibility screening process, a series of questions are asked of the parents or guardians to determine the youth's ability to learn a new concept and then apply that concept to solving a problem. In some cases, TARGET was initiated but the youth did not seem to be grasping the concepts in a way that was transferable; in these cases, the TARGET facilitators worked with their coaches to discuss possible adaptations to the material that might help the youth learn and apply the concepts.



LESSONS LEARNED

- » Consider adaptations to the manualized intervention based on unique family needs. Balancing the structure of a manualized intervention with the flexibility needed when working with youth and families is challenging. In Illinois, individual and group consultation with the TARGET purveyor was important for TARGET staff, who gave thorough case presentations and then used the discussion with the purveyor to develop plans for the unique needs of specific youth and families.
- » Maintain flexibility when deciding the best location to offer the TARGET intervention. While some families might like the convenience of in-home sessions, others might prefer sessions to be conducted outside the home. Families might have concerns about their child's reaction to a stranger coming to the home, or the home setting might have distractions (e.g., loud or unsupportive family members, rambunctious pets) that impede participation.

CORE COMPONENT 4: FAMILY PARTICIPATION IN TARGET

TARGET supports a family-centered approach to therapy. The developer of TARGET, Dr. Julian Ford, has indicated that parent participation in TARGET is a significant factor in successful outcomes. According to the TARGET Family Manual, the goal of the intervention “is to enable family members to process the emotional, somatic (physical body), and cognitive information that was not fully processed at the time of trauma exposure rather than intensifying intrusive re-experiencing by suggesting that the focus should be on the objective traumatic events.”²

WHEN DETERMINING HOW TO ENCOURAGE FAMILY PARTICIPATION IN THE INTERVENTION, START WITH THE FOLLOWING TASKS:

- » Consider which engagement strategies are most likely to be effective in getting youth and families to agree to participate.
- » Develop program materials in a way that highlights the benefits of family participation.
- » Provide guidance to TARGET program staff to help them use a variety of ways to describe the intervention when speaking with parents, using their judgment to determine what might be most meaningful for the parent/guardian to know (based on their conversation) and to create interest in the program.
- » When providing services in the family’s home, be sure to account for travel time and its impact on staff time. Traffic issues and rural areas that create long commute times reduce the time that can be spent on direct services.
- » Think realistically about family availability and staff capacity in terms of scheduling. A family’s availability is likely to be reduced by existing schedules of school, work, or other family commitments. The Illinois Team found Saturday appointments were often needed to help with scheduling. These various issues limited the number of sessions that could be conducted by one facilitator in a week, especially given evening and weekend times were outside of regular business hours.
- » Consider the impact of agency policy on work hours. Some of the agencies implementing TARGET were not able to allow staff to schedule weekend sessions due to gaps in liability insurance as well as the lack of supervisors on weekends. These restrictions further reduced options for families unable to schedule sessions during weekdays. Parents and guardians were encouraged to participate in TARGET. Learning the TARGET skills helps parents regulate their own emotional responses and increase their ability to effectively respond to their child’s emotions and behaviors.

² Advanced Trauma Solutions, 2015, p. 18

While TARGET facilitators tried to set the expectation that TARGET is a family intervention, meaning that both the child and parent/caregiver should participate, if a parent/guardian decided not to participate, their decision was respected. Facilitators continued to encourage parent/guardian participation throughout TARGET delivery. Some reasons parents/guardians chose not to participate included: belief that their children would be more willing to engage with the facilitator if the parent/guardian was not present; not having the time to participate; or other barriers (such as health care issues or other family responsibilities) that would not permit them to participate.

Coaching sessions for TARGET facilitators were provided by the purveyor. The focus of the sessions was primarily family engagement. The purveyor provided additional support for working with families with parents who were difficult to engage or who did not participate in TARGET sessions in positive or effective ways.



LESSONS LEARNED

- » The active engagement process needs to be tailored for each family. Be open and flexible in redefining what is acceptable for active engagement. Instead of closing cases when families could not participate in one session, TARGET facilitators were encouraged to accommodate scheduling variances whenever possible, and to keep a family's status open as long as was needed for them to complete TARGET. This flexibility enabled families to continue with TARGET when they might otherwise have been dropped from the program.
- » Consider having open and clear discussions with families to address parents' and guardians' concerns about the time commitment. TARGET staff can adapt delivery of the intervention to make it feel manageable and suited to the family's needs. Initially, the Illinois project struggled to get families to participate in a 12-session program if they were not currently experiencing problems and juggling other commitments such as school, work, and extracurricular obligations. Outreach Coordinators and facilitators shifted to describing TARGET as a 12-session program with two phases that were shorter in duration, and therefore, did not feel as daunting. The TARGET facilitators also emphasized that the skills would be relevant to the particular family's needs by asking families about their individual goals and then making sure the lessons addressed specific needs.

CHAPTER 4

CHOOSING THE RIGHT INTERVENTION

It is critical to determine if the intervention is a good fit for your site so that limited resources are not used to support a program that does not meet the needs of the children and families in your system.

This chapter addresses the following topics:

I. IDENTIFY THE PROBLEM AND THE TARGET POPULATION

II. DEVELOP A THEORY OF CHANGE

III. RESEARCH AND SELECTION OF AN INTERVENTION

Each section includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) a description of how the Illinois Team implemented the process, activity, or task; (d) lessons the Illinois Team learned during implementation.

1.

IDENTIFY THE PROBLEM AND THE TARGET POPULATION

To determine if an intervention is the right intervention for your site, make sure the intervention addresses the root cause of the problem and meets the needs of your identified population. The QIC-AG Population Template (Appendix A) is a helpful tool for (a) clearly defining the population that will be the target of the intervention and (b) for gaining a clear understanding of the problem that the intervention must address. By using system data and other available information sources, the Population Template can help identify the underlying causes of the needs of the target population.

Notably, the QIC-AG Population Template can help a project team accomplish the following foundation tasks:

- » **Identify the population most affected by the problem**
- » **Understand the needs of the target population**
- » **Refine the eligibility criteria for intervention participation**
- » **Develop a theory of change**
- » **Provide a geographic focus for implementation and evaluation of an evaluable intervention**

The next step in determining if the intervention is right for your site is to determine the system strengths and needs. This step can be accomplished by completing a critical assessment. The Illinois Team used the QIC-AG Continuum Assessment Template (Appendix B) to guide their macro- and service-level assessment of system functioning and services availability.

When completed, the Continuum Assessment enables a site to:

- » **Identify existing services offered at each interval of the continuum**
- » **Identify gaps and strengths along the continuum of service provision**
- » **Identify areas within the system in need of strengthening**



Ultimately, completion of the Continuum Assessment and the Population Template are critical steps in determining if an intervention such as TARGET is a worthwhile intervention for your site and population of interest.

The final piece of the system assessment is to obtain the feedback of consumers of post-permanency services and providers who serve that population. This assessment can be carried out using a structured stakeholder interview guided by the Stakeholder Focus Group Questions (Appendix C).

The Population Template was completed using Illinois Department of Children and Family Services (DCFS) data on post-adoption services, adoption subsidy and guardianship assistance, and relevant administrative data. Although there was no consistent data collection mechanism for information on the numbers of private and intercountry adoptive families served, the agencies serving this population were interviewed and their responses provided insight into this population's needs. In addition, data on families seeking assistance from DCFS and other agencies was obtained and reviewed. Last, data on children obtaining permanence and those experiencing post-permanency discontinuity were analyzed by region to determine areas with highest need.

The Illinois Team worked collaboratively to gather and review key documents to help understand the full array of post-permanency services and supports currently available to families in Illinois. In addition, to complete the continuum assessment, Team members interviewed several key leaders representing both the public and private service delivery systems. Although time-intensive, this process revealed valuable insights that helped to create a solid understanding of the strengths and challenges within the Illinois system, ultimately leading the Team to determine a preventative approach would best fit the needs of the target population.



LESSONS LEARNED

- » Consider conducting interviews with key representatives within the service system. Their perspectives are an invaluable part of the continuum assessment process. In many cases, the Illinois Team was able to interview individuals with significant historical knowledge that provided not only rich information and a better understanding of how the system had evolved to its current state but also strengthened the Team's ability to determine what kinds of enhancements might be best suited to the current context and population needs.

II.

DEVELOP A THEORY OF CHANGE

The theory of change provides a road map that addresses how and why change will happen in a practice, program, or organizational system to promote the attainment of a desired result. Essentially, the theory explains why the change being proposed should work by explaining how the steps being taken are expected to lead to the desired results. A well-crafted theory of change serves many purposes. Most important, the theory of change serves as a guide for identifying the intervention that will be implemented.

The theory of change should be based on research. To avoid theories based on assumptions, it is important to consider available theories and existing research evidence. Examples of existing research evidence include peer-reviewed articles and other less rigorously reviewed child-welfare products/publications. The research evidence should support the pathway to change proposed in the theory of change.

Developing a theory of change can be a time-consuming practice, but given that the theory of change guides the selection of the intervention, it is crucially important to invest the time needed. If chosen correctly, the intervention, in Illinois' case TARGET, should facilitate the change identified in the theory of change.

ILLINOIS THEORY OF CHANGE

Adoptive parents and guardians need to be connected with supports and services that help them meet the emerging and future needs of the children in their care. If parents and guardians are offered services when their child's needs do not exceed the caregivers' capacity, then parents/guardians will be better able to anticipate issues that might arise and will have a basic understanding of the resources and services that are available to them. If parents and guardians are connected to services and supports early, they will be more likely to use these services and supports at the earliest signs of difficulty. If parents and guardians have the capacity to meet the emerging needs of the children in their care, then discontinuity will decrease, keeping children in the home and avoiding costly therapeutic placements or situations where a youth's parent refuses to allow him/her to return home upon discharge from a psychiatric hospital or residential treatment facility.

A site can use the Illinois theory of change to support the rationale for implementing TARGET, but each site must ensure the theory of change applies to what has been learned about their target population and system gaps.



LESSONS LEARNED

- » Identifying the root cause of a problem is key to implementing an effective intervention. By “peeling the onion,” the Illinois Team determined that families often did not have access to the support they need *at the time* they needed it. This led the Team to think about the importance of early outreach, which became the basis for the program’s theory of change.



RESEARCH AND INTERVENTION SELECTION

Once a site selects one or more interventions to address the identified need, tools can be used to explore the viability of implementing the intervention. One such tool is the Hexagon Tool, which was developed by the National Implementation Research Network.³ Using the Hexagon Tool to explore and ask questions in broad areas will help determine if TARGET is the right intervention to implement in your site.

Although an intervention might sound exciting and innovative, the program might not be practical to implement. The Hexagon Tool helps a site consider the practicality of implementing a specific intervention.

- » **NEED:** What are the community and consumer perceptions of need? Are data available to support that the need exists?
- » **FIT:** Does the intervention fit with current initiatives? Is the intervention consistent with the site's practice model?
- » **RESOURCES AND SUPPORTS:** Are training and coaching available? Are technology and data needs supported? Are there supports for an infrastructure?
- » **OUTCOMES:** Is there evidence to support the outcomes that can be reasonably expected if the intervention is implemented as designed. Are the outcomes worth it?
- » **READINESS FOR REPLICATION:** Is a qualified purveyor or technical assistance available? Is a manual available? Are there mature sites to observe?
- » **CAPACITY:** Does staff meet minimum requirements? Can the intervention be implemented and sustained structurally and financially over time?

In Illinois, the intervention selection process was guided by a dedicated team, called the Project Management Team (PMT). The PMT was an active and engaged group of key leaders and decision makers that met several times during the intervention selection process. In addition, the PMT was charged with completing the Hexagon Tool. As part of the information gathering process, several PMT members participated in interviews with the TARGET purveyor, which allowed them to thoroughly address the components in the Hexagon Tool. Diversity within the PMT fostered a range of perspectives that enhanced the process of completing the Hexagon Tool.

The Hexagon Tool completed by the Illinois Team is located in Appendix D.

³ <https://implementation.fpg.unc.edu/resources/lesson-1-hexagon-tool>



LESSONS LEARNED

- » Do not rush through the Hexagon Tool. Thoughtfully considering each category is important to getting the most from this process. Thinking through each of the elements can save a site from trying to implement an intervention that cannot or will not be supported by the system or agency. For example, when assessing site capacity, it might become clear that the agency does not have staff with the qualifications needed to implement a particular intervention or that a site has a hiring freeze that will prevent hiring the additional staff needed for the intervention. Completing the Hexagon Tool will help prevent a site from expending energy on an intervention that the system is not equipped to administer.

CHAPTER 5

PLANNING TO IMPLEMENT

Successful implementation, defined as implementation with fidelity and integrity, takes planning. If done well, planning has multiple benefits, including the promotion of a well-developed, logical approach to implementation and the description of strategies to address ongoing implementation issues.

Planning activities provide the process for thinking through each of the intervention's critical components, enabling planners to anticipate possible barriers and develop steps to address these barriers. Moreover, the planning process also helps to develop a common understanding of how the identified program goal will be achieved. In addition, a carefully considered plan can serve as a communication tool with leadership to promote buy-in and sustain support.

Planning should be captured in an Initial Design and Implementation Plan (IDIP) (Appendix E). The IDIP document guides the implementation of the evaluable intervention, supports the use of an intervention to address an identified problem, and outlines the steps to be taken to ensure the intervention is delivered as the intervention's developers intended. Having a single, comprehensive document can help organize and guide the work as the project moves forward. In addition, the IDIP helps bridge knowledge gaps if turnover occurs in key positions.

The members of the Implementation Team were highly involved in the development of the IDIP. Each section of the IDIP was assigned to a team member who was the lead person for gathering the information needed and assisting with the creation of content

for the IDIP. The Implementation Team's reviews of the IDIP often generated discussion that either confirmed the feasibility of implementation supports or revealed potential pitfalls to be considered. In addition, the Implementation Team consulted with DCFS staff who had been involved in a prior project that implemented TARGET. These individuals shared advice and guidance about the lessons they learned in their implementation of TARGET, providing invaluable insights to the process.

This chapter addresses the following topics:

I. RESEARCH CONSIDERATIONS

II. GETTING YOUR SYSTEM READY: IMPLEMENTATION SUPPORTS

III. WHO WILL DO THE WORK: TEAMING AND COMMUNICATION

Each section includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) how the Illinois Team implemented the process, activity, or task; and (d) lessons the Illinois Team learned during implementation.

I.

RESEARCH
CONSIDERATIONS

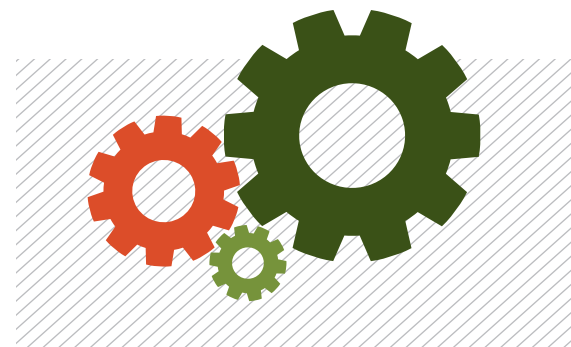
It is always important to evaluate the impact of the intervention to ensure the intervention is effective and achieving the delineated goals. Given the critical role of evaluation, it is important to implement the intervention in collaboration with partners with research skills such as an in-house evaluator or university partner. Evaluation starts with a well-formed research question that is directly relevant to the problem at hand and phrased in a way that leads to precise answers.⁴ Testa and Poertner have recommended the PICO framework, which requires careful articulation of four key components :⁵



- P** a well-defined target population;
- I** the intervention to be evaluated;
- C** the comparison group; and
- O** the outcomes expected to be achieved.

This section addresses the following topics:

1. **Developing the research question**
2. **Creating a logic model**
3. **Case flow/project enrollment**
4. **Data collection**



⁴ Richardson, W., Wilson, M., Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, 123, A12.

⁵ Testa, M. F. (2010). Evaluation of child welfare interventions. In M. F. Testa & J. Poertner (Eds.), *Fostering accountability: Using evidence to guide and improve child welfare policy* (pp. 195–230). New York, NY: Oxford University Press

1. DEVELOPING THE RESEARCH QUESTION

The importance of having a clearly defined research question cannot be overstated. The research question will be answered by the evaluation of the intervention. Following the PICO framework, a well-formed research question has four components that must be delineated:

P

TARGET POPULATION: Using the Population Template (Appendix A) as a starting point, additional data from a data system should be used to clearly define the population that will receive the intervention. Developing this component can include incorporating the following types of data from the target population:

- » Characteristics, demographics, or past experiences (e.g., age, race, ethnicity, placement history, family structure)
- » Eligibility and exclusionary criteria
- » Geographic service areas
- » Needs (e.g., parents or guardians who lack the capacity to address trauma-related issues, or lack of parental skills and ability to manage behavior)
- » Estimates of the total number of children or families who will be served

I

INTERVENTION: An intervention is an intentional change strategy offered to the target population.⁶ An intervention has core components designed to affect a desired outcome.

C

COMPARISON GROUP: Randomized controlled trials (RCTs) are considered the “gold standard” of research because this true experimental design enables researchers to determine if the observed outcomes are the result of the intervention. An RCT design includes a treatment group that receives the intervention and a comparison group that receives “services-as-usual.” RCTs use random assignment of participants to either the treatment /intervention group or the control group. Comparison groups are also used in research using quasi-experimental designs. The most common quasi-experimental design uses the pre-test/post-test comparison group design.

O

OUTCOMES: A result or consequence of the intervention. Outcomes are specific to the intervention and linked to the theory of change.

⁶ Fraser, M. W., Richman, J. M., Galinsky, M. J., & Day, S. H. (2009). *Intervention research: Developing social programs*. New York, NY: Oxford University Press.

The elements of the PICO framework are identified below in the Illinois project's research question:

Will youth between the ages of 12 and 14 in Cook County or in specific counties within the Central Region with a finalized adoption of guardianship (P) who receive Trauma Affect Regulation: Guide for Education and Therapy (I) experience reductions in post-permanency discontinuity improved well-being and improved behavioral health (O) as compared with similar youth who receive services-as-usual (C)?

P

TARGET POPULATION: The target population in Illinois was families with youth who were either in their teenage years or about to begin adolescence. The youth must have had an active adoption/guardianship subsidy and be living with their adoptive parent or guardian in Cook County or in selected counties within the Central Region. The intervention was also offered to youth older than 10 years who had been adopted either internationally or domestically. Please note that the age range of the target population was expanded from the original PICO question to include youth between the ages of 10 and 17 to help increase enrollment.

I

INTERVENTION: Trauma Affect Regulation: Guide for Education and Therapy (TARGET)

C

COMPARISON GROUP: Comparison Group: Once eligibility was established, a random assignment strategy was used to assign children to either intervention or comparison groups. Families randomly assigned to the comparison group were eligible for services-as-usual, which varied slightly between Cook County and the selected Central Region counties. In Cook County, adoptive and guardianship families could access post-permanency services through various avenues, including 1) the DCFS Post Adoption Unit; 2) the Adoption Support and Preservation agencies assigned to serve families in Cook County; and 3) first responders, such as the Screening, Assessment and Support Services (SASS) and psychiatric hospitals. In the Central Region, families could access post-permanency services through similar channels. However, in the Central Region, there was usually one (as opposed to several) Adoption Support and Preservation agencies assigned to service families in a particular county.

O

OUTCOMES: The Illinois project's short-term outcomes are:

- » Reduced child behavioral issues
- » Reduced school-based problem behaviors
- » Increased level of caregiver commitment
- » Reduced caregiver strain

2. LOGIC MODEL

A logic model illustrates the conceptual linkages between core components and intervention activities, and expected outputs and short and long-term outcomes. The logic model should clearly explain how specific activities or services are expected to produce or influence their associated outcomes. The Illinois logic model is located in Appendix F.



LESSONS LEARNED

- » It is important to recognize that logic models can evolve over time as the details of the intervention become more clearly delineated.

3. CASE FLOW/PROJECT ENROLLMENT

As previously discussed, if an intervention uses an RCT design, then the project team/site team will need to determine a method for assigning participants to the intervention group and the comparison group (i.e., services-as-usual). This will include the development of a case flow that clearly depicts the criteria for assignment to the intervention group or the group receiving services-as-usual.

The Illinois Team used different methods for enrollment and randomization in each of the two geographic areas of the state where the intervention was implemented. The outreach procedures in Cook County involved mailing a letter from DCFS that alerted potential participants that they were selected to participate in a research study, and that someone would call them with additional information, or that they could call the outreach worker to find out more information. After describing the study to potential participants, the outreach worker asked families to consent to being part of the study. Parents and guardians who agreed to participate in the study were randomly assigned to one group, either the intervention or comparison group. Random assignment was conducted by the outreach worker through the use of a random assignment calculator. The online random assignment calculator is designed to facilitate randomization of youth into treatment as usual or special services. The outreach worker explained to the family that they have no control over the outcome of the randomization. In the Central Region, the project used a random consent design for assignment to the intervention or comparison group. In this design, participants were randomized into either the interven-

tion or comparison group by the evaluation team in advance of any outreach. Subsequently, only parents or guardians assigned to the intervention group received outreach.

Initial letters were sent to families in both geographic areas, with slight modifications to the letters in each site based on the randomization design used. Letters were sent from DCFS introducing the study and alerting the family that an Outreach Coordinator would be attempting to contact them. Outreach Coordinators began contacting families 2 weeks after the introductory letter was mailed.

In both Cook County and the Central Region, Outreach Coordinators attempted to reach families by calling up to four times over a 2-week period (calling at different times, including evenings, and using all numbers listed for the family). If these attempts were not successful, a second letter was mailed to the family with a self-addressed, stamped postcard that provided options for families 1) to indicate they did not want to be contacted again, or 2) to provide the best time and number to be contacted. If the family did not respond within 2 weeks of the date the follow-up letter and postcard, the Outreach Coordinator made one more attempt to contact the family. If all of these attempts failed to establish contact with a family, the Outreach Coordinator closed the case.

In the Central Region, during the initial contact the Outreach Coordinator explained the intervention and conducted a second level of eligibility screening specific to the youth exclusion criteria (see Overview of Intervention section). If the youth was not eligible based on exclusion criteria, the Outreach Coordinator explained that the youth and family remained eligible for services as usual and referred the family to the DCFS Post Adoption Unit for further information and assistance in obtaining services. For families in Cook County, the Outreach Coordinator contacted all families in the sample, explained the study, and if the parent or guardian agreed to participate in the study, the Outreach Coordinator would then randomly assign the family to the comparison or intervention group (using an on-line random assignment calculator). Families assigned to the comparison group were eligible for services as usual, while families assigned to the intervention group were eligible for the TARGET program (as well as services as usual). If a youth assigned to the intervention group was determined ineligible for TARGET based on the secondary eligibility screening, the Outreach Coordinator would explain to the family that they remained eligible for services as usual and would refer the family to the DCFS Post Adoption Unit for further information and assistance in obtaining services.



LESSONS LEARNED

- » Sites should consider carefully wording their recruitment messages. It is important that written materials be carefully crafted to increase the acceptability of the TARGET program among families. The Illinois Team highlighted TARGET as a preventative no-cost opportunity for families, limited mention of the DCFS, and emphasized the participation incentives for the family and youth.
- » TARGET staff need a broad set of skills in order to respond to each family's unique needs. Staff conducting outreach must have a variety of competencies, including strong communication, clinical, and organizational skills. These skills are necessary to connect with families, screen for program eligibility, and to collaborate with TARGET facilitators and supervisors regarding scheduling and other administrative issues.
- » Using compelling, family-friendly language is an important part of recruiting families into a prevention program. Administrators must think strategically about how to describe a prevention program. Using language that resonates with the family's perception of their need is crucial, especially when families might feel everything is fine. Because families being contacted for TARGET had not expressed an explicit need for service, Outreach Coordinators refrained from using "intense" language such as *trauma* and *therapy* when doing outreach.
- » Flexible staff schedules are needed to meet families when they are free. Staff need to be available to conduct outreach calls in the evenings and on weekends. Based on feedback from the Outreach Coordinators, families are more easily reached in the morning or in the evening. Although not used in the Illinois outreach, in addition to phone calls and postal mail, project teams should consider using other methods of outreach to families such as text messages and e-mail.
- » It is important to limit the time lapse between a family agreeing to participate in the program and their first contact with the TARGET facilitator/therapist. To help ensure that families were connected to their TARGET facilitator, Outreach Coordinators made follow-up calls to families 10 days after facilitator assignments were made to confirm they had been contacted.

4. DATA COLLECTION

The Health and Human Services, Office of Research Integrity defines *data collection* as “the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions, test hypotheses, and evaluate outcomes.”

The Illinois Evaluation Team reviewed several types of data to assist with determining the achievement of short-term outcomes. First, the team members examined information on the receipt of TARGET services such as dates of service and which sessions parents and/or children had attended. Second, service records were linked with DCFS records so that evaluators could review information about the child’s history, including dates and types of placements while in foster care. Last, a survey was sent via postal mail about 6 months after TARGET services were completed. The survey contained questions that were mapped to short-term outcomes to help evaluators understand the impact of TARGET on youth and family outcomes.

The delivery of TARGET included two client satisfaction surveys—one for parents/ guardians and the other for youth participating in TARGET. These surveys were completed at two time points during the program: 1) after the completion of Session 4 of the training, and 2) at the conclusion of TARGET services. At each time point, the facilitators provided a copy of the survey to the parents or guardians and the participating youth, along with a self-addressed, stamped envelopes (facilitators could also collect completed surveys). Even if a parent or guardian was not participating fully in sessions, they were still given an opportunity to complete a survey. Surveys were processed by the TARGET purveyor, who generated quarterly reports summarizing the survey results.

All project procedures were designed to guarantee the confidentiality of participants and family information. For example, Outreach Coordinators used contact details from LexisNexis, a service designed to help find current contact information for people. This contact information was considered confidential and was used only for the purpose of locating the family to inform them of the opportunity to participate in the project. The names of families participating in the project were not available to anyone other than Outreach Coordinators and TARGET facilitators. Study IDs were assigned to each family and these IDs were used in the reports that were generated to monitor project activities. All e-mails about families involved in the project were transmitted through the secure DCFS e-mail system.

Outreach Coordinators and TARGET facilitators were also expected to adhere to their agencies’ policies and procedures for handling confidential client information. In cases when Outreach Coordinators needed to leave a message with someone in the household or leave a message on an answering machine or voice mail system, they were instructed never to leave a message that referenced anything about adoption, but to simply state their name and contact information.

II.

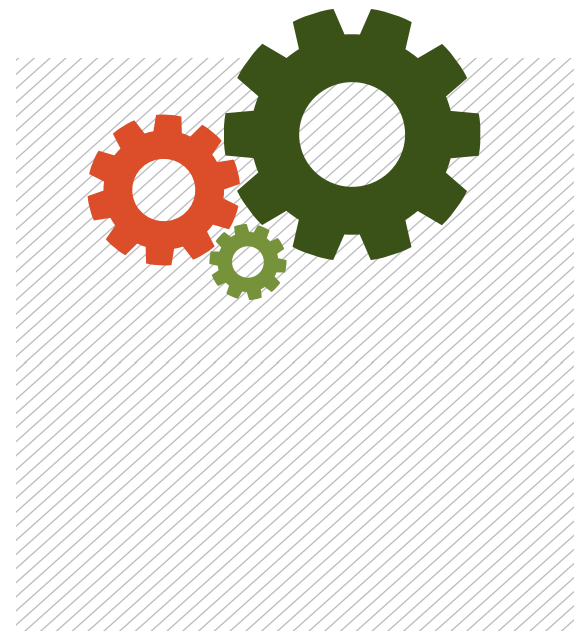
GETTING YOUR SYSTEM READY: IMPLEMENTATION SUPPORTS

Once an intervention is selected, it is important to know how the system will be readied to support service delivery. The term *implementation supports* refers to the infrastructure developed to facilitate the successful implementation of an intervention, which also helps to ensure the stability of the intervention over time. Without implementation supports, the system will not have the capacity to support the delivery of the intervention to the target population. Because implementation supports facilitate intervention delivery, assessing these supports is crucially important and should be carried out during the initial implementation stage to allow modifications before full implementation.

In addition to identifying the system's capacity to support service delivery, the project team will need to identify the work that needs to be done to develop additional supports. Further, it is critically important that the project team not only identifies potential barriers to implementing the intervention but also determines strategies for addressing such barriers.

This section addresses the following topics:

1. **Staffing**
2. **Training, coaching, and supervision**
3. **Fidelity**
4. **Policies and procedures**
5. **Data systems**
6. **Program expert**
7. **Financial and material considerations**
8. **Leadership**
9. **System partners and community linkages**



1. STAFFING

Staffing is the process of recruiting, selecting, and hiring qualified people for the support positions.

WHEN CONSIDERING STAFFING, START WITH THE FOLLOWING TASKS:

- » Examine the effectiveness of the recruitment and selection process. For example, were the selection criteria correct? Did the recruitment process get the “right” staff to apply; did the interviews yield the information needed to make staffing decisions?
- » Determine the skills, knowledge, and abilities needed by implementation staff.
- » Determine the workload-to-staff ratio.
- » Determine the number of staff (by position) needed to support full implementation.
- » Determine if any internal capacity or barriers exist to obtaining qualified staff.
- » Consider the likelihood of staff retention and the implications on filling staff vacancies in terms of training, scheduling, and so forth.

TARGET can be taught to and delivered by persons from a wide variety of cultural and educational backgrounds and professions including, but not limited to, mental or behavioral health, counseling, medicine, nursing, education, social work, marriage and family therapy, addiction recovery, personal coaching, and human resources professionals. While the purveyor prefers to train professionals with a master’s degree, if an agency wishes to use the model with bachelor-level professionals, the purveyor will work with the agency to make appropriate adaptations to the instructional and coaching tasks associated with implementation to ensure the right level of support is provided to staff.⁷

Staff in the Illinois project were selected from the existing complement of Adoption Support and Preservation Agencies and private providers. Therapists who provided TARGET were identified from a pool of existing staff at the ASAP agencies. A variety of considerations were part of the decision to house staff in these agencies, including availability of existing contractual capacity, stability of staff, and reputation and trust level within the adoption and guardianship community. Initially, 11 staff members were trained deliver TARGET. Although attrition was expected, the Illinois Team experienced a significant amount of turnover in a short period. However, because referrals to TARGET were slower than anticipated, this initial turnover did not have a negative impact on service delivery. As intake increased, the Team added additional staff to deliver the intervention.

⁷https://www.nctsn.org/sites/default/files/interventions/target_training_guidelines.pdf



LESSONS LEARNED

- » Consider how much time staff will need to be prepared to teach the core components, including training, coaching, and preparation activities. Keep in mind that additional time for preparation is often needed when learning and using new skills.
- » Talk with staff about their comfort level teaching the TARGET skills as designed. One therapist who participated in the initial TARGET training indicated that it would not be possible for her to modify her approach with her clients to ensure that she would implement TARGET as designed. To ensure the fidelity of the intervention, this facilitator opted not to continue with the project.

2. TRAINING, COACHING, AND SUPERVISION

Training is the process of providing the information and instruction an individual will need to successfully execute a specific function within a program.

Coaching is a structured process in which a practitioner with expertise in a specific intervention works closely with someone who is learning the intervention to enhance his or her skills, with the goal of delivering the intervention with fidelity.

Supervision is the process of reviewing the work of another individual to determine the person's extent of alignment with established performance standards.

WHEN CONSIDERING THE TRAINING, COACHING, AND SUPERVISION NEEDS OF YOUR PROJECT, START WITH THE FOLLOWING TASKS:

- » Determine the availability of trainers, a training curriculum, supervision, and coaching from the intervention purveyor or other entity.
- » Assess the content of training materials to determine if they are adequate to address the knowledge and skills needed to provide the intervention.
- » If a training curriculum is not available, determine who will develop one.
- » Assess the cost for training.
- » Determine if ongoing training will be needed to reinforce or boost the initial training.
- » Establish the qualifications for trainers.
- » Establish the frequency of supervision to ensure staff are meeting expectations.
- » Select a coaching model that helps staff explore their strengths and weaknesses.

Initial training for TARGET therapists/facilitators is referred to as Level 1 training and consists of 4 days of training (i.e., 3 full days of training on TARGET content and a fourth day of training on the fidelity and coaching requirements for therapists). Each training cohort is limited to no more than 20 facilitators. Level 1 training teaches therapists how to deliver TARGET in an individual service delivery model, referred to as the TARGET Individual/Family Manual. The first 3 days of the training provide an overview of the following topics: impact

of traumatic stress on the brain; social and emotional development, and ability to regulate affect; the neurobiology of stress and coping; and use of the manual to provide TARGET. Day 4 of the training provides therapists with an overview of the fidelity monitoring and on-going coaching requirements for TARGET facilitators, including the steps to achieving certification status. Supervisors and program directors from the agencies where TARGET therapists were located were offered a half-day orientation in TARGET. Supervisors were also invited to attend Day 4 of the Level 1 training to familiarize them with the TARGET fidelity monitoring and coaching requirements (resolved, when possible).

Immediately following the Level 1 training, therapists began individual and group coaching provided by a purveyor-certified TARGET coach. The coaching sessions were used to reinforce content learned in training and served as a mechanism to help facilitators prepare for their initial sessions with families assigned to the intervention group. Once therapists began meeting with their assigned families, the coaching sessions were used to discuss specific case situations and the application of TARGET in each case. This high level of involvement and follow up was intended to ensure the core components of the intervention were established and maintained over time.

All TARGET facilitators received regular clinical supervision within their existing agency structure. In situations in which families presented with needs beyond the scope of TARGET, the project used a special process to facilitate a referral to the DCFS Post Adoption Unit for additional assistance. Because TARGET sessions are recorded as part of the fidelity process, the fidelity coach could also note clinical concerns that were beyond the scope of TARGET. A report is triggered when a clinical concern is raised during a TARGET session that does not also show evidence of resolution. These alerts are sent to the therapist/facilitator and their supervisor and vetted using established agency protocols.



LESSONS LEARNED

- » Minimize the time lag between the therapists' completion of Level 1 training and their start of sessions with families. In the Illinois project, too much elapsed time made it challenging for therapists just learning the TARGET model to retain what they had learned in their initial training; this delay resulted in a need for even more time to prepare for the delivery of TARGET sessions.
- » Allow time for training preparation. To deliver TARGET skills training effectively, facilitators need time to integrate the information learned in their training and to become comfortable with the content. Facilitators in Illinois underestimated the amount of time they needed after the TARGET training to learn the material and to feel comfortable with the model. As facilitators gained experience with the model, the amount of preparation time decreased.

- » Planning around staff training for an intervention is a careful balance of financial and programmatic needs. To minimize costs, the Illinois Team had planned to offer only one TARGET facilitator training. However, similar to the instability of the child welfare workforce in general, the Illinois Team experienced turnover among staff trained in TARGET, making a second TARGET facilitator training necessary less than one year into implementation. In hindsight, it might have been better to train fewer numbers of staff initially, build their caseloads to capacity, and then offer a second facilitator training as the demand increased. On the other hand, if fewer staff are trained initially, staff turnover could lead to capacity levels too low to provide the program consistently and effectively.

3. FIDELITY

Fidelity can be defined as the extent to which the delivery or performance of an intervention is in accordance with the protocol or program design as originally developed.

WHEN DETERMINING HOW BEST TO ENSURE FIDELITY, START WITH THE FOLLOWING TASKS:

- » Obtain fidelity measures from the intervention purveyor, if available. Adapt the fidelity measures, if necessary. If fidelity measures are not available, determine who will be responsible for developing fidelity measures for your intervention.
- » Examine the usefulness of the fidelity measures. Do the fidelity measures support answering the question, “Is the intervention being delivered as the developers intended?”
- » Determine if fidelity measures yield discrete data adequate to support modifying implementation supports such as training, coaching, and supervision.

TARGET uses a well-developed and well-defined fidelity system complimented by individual and group coaching. The specific elements of this system include:

- » Use of videotaping with validated fidelity monitoring
- » One individual coaching session per month, per therapist
- » Two group coaching sessions per month

To assure the TARGET model is being delivered as intended by the developers, all TARGET sessions are recorded (with the camera focused on the facilitator only to protect the identity of participants). Facilitators submit recordings of every session conducted and receive feedback on a sample of these sessions from their fidelity coach. Through this process, facilitators can work toward proficiency and certification statuses (described below). Facilitators explain the purpose of the recording but families have the option to not have sessions recorded.

Sessions with the assigned fidelity coach begin prior to the first clients receiving the intervention. This forum is used to support facilitator preparation for first clients and to ask any intervention-specific questions. When sessions with clients begin, coaching sessions are focused on development of the necessary skills to successfully implement TARGET with active clients. The coaching sessions provided by TARGET coaches were not intended to replace clinical supervision—these sessions focused only on reinforcing the concepts taught in TARGET (for example, techniques to assist the facilitators in teaching the FREEDOM steps). Purveyor-certified TARGET coaches are provided with their own coaching with the purveyor, which ensures that the direction provided in individual coaching is in line with the model.

Following Level 1 training, TARGET therapists work toward two levels of facilitator status. A therapist's progress toward these levels is based on the purveyor's Quality Assurance review of videotaped sessions and the therapist's satisfactory participation in individual and group coaching sessions. The first level is the designation of proficiency in the TARGET model. To achieve Proficient status, a therapist must submit a minimum of 16 videotaped sessions for review, obtain a score of at least 75% on the proficiency standards, and attend at least 80% of coaching sessions. After a Proficient status is achieved, the therapist can work toward Certified status. The standards for certification are more stringent than those outlined for proficiency, focusing specifically on sessions in which the therapist teaches the FREEDOM steps. Based on a review of eight sessions, a therapist must obtain a score of at least 75% and attend at least 80% of coaching sessions to achieve Certified status. For example, a therapist who meets the coaching requirements and submits 8 sessions, scoring at least 75% on 6 of the 8 sessions, will achieve Certified status. TARGET therapists are required to maintain certification status on an annual basis by submitting a sufficient number of videotaped sessions to obtain a score of at least 75% on certification standards.



LESSONS LEARNED

- » Have a clear understanding of the cost implications of the fidelity process. The Illinois Team found that variables such as caseload size, acuity of presenting issues, and the number of recorded sessions reviewed by the TARGET purveyor affected the intervention's cost in ways that had not been anticipated.
- » Involve Information Technology staff early in the process when an intervention includes significant use of technology. Limits to agency bandwidth and slow Internet speeds resulted in session uploads to the purveyor's Quality Assurance portal taking several hours, a situation that could have been mitigated with technology support early in the project.

4. POLICIES AND PROCEDURES

Policies and *procedures* are formalized directives guiding the delivery of an intervention or program, and give detailed explanations of program activities. Policies are the principles that guide the decision-making process.

WHEN CONSIDERING POLICIES AND PROCEDURES, START WITH THE FOLLOWING TASKS:

- » Examine the completeness and effectiveness of the policies or procedures to ensure they support the new work and clearly articulate the steps of the new processes.
- » Consider whether policies are accessible to those who need them.
- » Confirm whether policies and procedures have been sufficiently articulated and documented to allow someone else to run the program in the absence of current staff or leadership.
- » Confirm that policies and procedures reflect what has been learned during usability testing.

The Illinois Team developed two documents to guide the implementation of TARGET. A *Frequently Asked Questions* document was developed and updated as needed to support the project team, Outreach Coordinators, and TARGET facilitators. The document contained procedural information on general outreach processes, nuances related to TARGET delivery, technical aspects such as use of the REDCap online platform, and instructions for uploading recorded sessions to the purveyor portal.

An Outreach Coordinator Manual was also developed for the project that included a description of the protocol for calling families, the script to be used during outreach calls, the case referral process, and engagement strategies. As the project evolved, this manual was updated several times to reflect process changes. In addition to these two documents, a set of flyers, template letters, and other materials were developed and approved for use during outreach and service delivery.



LESSONS LEARNED

- » A project will benefit from establishing a process to ensure all project staff have the most current information regarding delivery of the intervention. Early in the project, the Illinois Team was faced with learning an overwhelming amount of information regarding implementation. To avoid confusion, the Team created a cloud-based shared folder that enabled all project staff to access the content by simply using a shared link. This folder housed all current outreach documents (e.g., FAQ, Outreach Coordinator Manual, flyers, and template letters) for easy access by project staff. No identifying information was stored in this location.

5. DATA SYSTEMS

A *data system* is the network that will identify, collect, organize, store, analyze, and transfer the data.

WHEN DEVELOPING A DATA SYSTEM, START WITH THE FOLLOWING TASKS:

- » Ensure the effectiveness of the hardware and software that collects and manages information related to implementation.
- » Determine staff capacity to effectively use the database.
- » Confirm that technology resources are available to support the technology needs of the project.
- » Identify and test processes for the secure transmission of data.
- » Determine if a data sharing agreement is necessary. Obtaining a data sharing agreement can take considerable time: if such an agreement is required, begin the process early in the project.
- » Create a data dictionary to communicate how specific data are entered.
- » Determine if the system can capture the data needed to determine fidelity, outputs, and needs assessments of participants.
- » Determine if the reports generated from the data system inform the process and outcomes in a standardized manner.
- » Determine whether data are reliable, collected on a standardized schedule, easily accessible, and reviewed by implementation support teams.
- » Confirm that the data system is backed-up regularly

The Illinois Team developed its data collection system using REDCap, a secure Web-based system that provided secure access for DCFS and private agency staff to enter information. REDCap data is secure and backed up on a regular basis. Development work included the identification of data elements to be included in the REDCap data system as well as designing the data-entry system for ease of input and simplified reporting and data extraction. The data system captured program outputs (specified in the logic model), including:

- » Client demographic information
- » Results of outreach efforts
- » Results of the eligibility screening
- » Referral and enrollment information
- » TARGET session information

Training on the REDCap system was provided via webinar in two sessions; the sessions were recorded for use as a training tool for new staff or as a refresher for existing project staff.



LESSONS LEARNED

- » It is important to closely monitor data systems to ensure they are working as intended. The Illinois Team frequently sought feedback from Outreach Coordinators and TARGET facilitators to assess the ease of use of the REDCap system. REDCap reports were monitored weekly and adjustments to the system were made as needed.

6. PROGRAM EXPERT

A *program expert* is a person with extensive knowledge, skills, and ability based on experience, occupation, or research in a specific program or practice. Typically, a program expert is the individual or entity that developed the intervention.

WHEN CONSIDERING INVOLVEMENT OF A PROGRAM EXPERT, START WITH THE FOLLOWING TASKS:

- » Examine the effectiveness and usefulness of the program expert in supporting the implementation of the intervention. For example, determine whether the program expert is able to provide your project with materials that facilitate implementation as intended such as manuals, fidelity measures, or a train-the-trainer curriculum.
- » Assess the program expert's availability for coaching.
- » Determine if the program expert supports the development of internal supervision.
- » Determine if the program expert supports adaptations to the intervention or changes to service delivery systems required by the intervention.
- » If available, interview the purveyor.

Although DCFS had previously used TARGET and had an existing relationship with the intervention's purveyor (Advanced Trauma Solutions, Inc.) the Illinois Team interviewed the TARGET developer as part of their intervention selection process to ensure fit for the QIC-AG project. Once TARGET was selected, quarterly calls were conducted with the Illinois project leadership and purveyor representatives to review progress and to address any barriers to the rollout of the TARGET model. The purveyor provided the Illinois Team with ongoing technical support and consultation. The adoption and guardianship overlay adaptation to supplement the TARGET Family Manual and handouts used in sessions was supported and approved by the purveyor.

Through the previous implementation of TARGET, DCFS was able to build internal expertise on the intervention. Key leadership staff involved in the previous implementation provided invaluable support to the Illinois Team around decision making and implementation issues.



LESSONS LEARNED

- » Expect to need ongoing contact with an intervention purveyor during the implementation process. Frequent communication with the purveyor can help ensure smooth implementation. TARGET is complex, both in terms of learning to deliver the intervention and processes related to the fidelity monitoring. Frequent conversations with the purveyor provided essential information that helped the Illinois Team consider the implications of changes to implementation along the way.

7. FINANCIAL AND MATERIAL CONSIDERATIONS

Financial and material considerations are the costs and materials needed to develop and deliver the intervention.

WHEN EXPLORING FINANCIAL AND MATERIAL CONSIDERATIONS, START WITH THE FOLLOWING TASKS:

- » Determine the costs associated with the implementation of the intervention, and then determine if resources are available to implement the intervention with fidelity.
- » Plan for and include associated costs such as purveyor fees, training or coaching fees, facility and technology fees, and the cost of implementation staff.
- » Determine if opportunities exist to leverage the support or funding of existing programs.

To be certified to deliver TARGET to families, the purveyor requires clinicians to attend training and participate in coaching and videotape reviews (described in the Fidelity section). Fees for training and coaching sessions were fixed and somewhat predictable. However, because the length of time it took facilitators to become certified varied, the fees associated with uploading and storing video recordings and for the review of session content became unpredictable and variable. Once facilitators achieved certification, the number of required reviews and coaching sessions was reduced, thus reducing costs.

The Illinois Team mitigated some of the costs associated with coaching by using purveyor-certified coaches who were part of the DCFS staffing structure. While this was a cost savings to the project, annual fees paid to the purveyor to maintain DCFS TARGET coaches (paid out of a separate program budget) essentially offset that cost savings.

The TARGET purveyor required the Illinois Team to purchase a training manual and set of tools used to engage clients during TARGET sessions. Tools included posters, wristbands, and brochures for each participant. Additional quantities of the tools used in client sessions were also purchased so that they were readily available. Laptops and recording equipment (cameras and tripods) were purchased for use in the fidelity monitoring system.



LESSONS LEARNED

- » Interventions can be difficult to maintain if they require extensive upfront, preparatory training and sustained involvement of the program's purveyor. In the Illinois implementation, the time for facilitators to reach TARGET Certified status was highly variable, making it challenging to plan the financial resources that would be needed over time.
- » Think carefully about the implications of reducing material costs by having staff share equipment. Because the vast majority of TARGET sessions are recorded, having staff share cameras would complicate and limit staff capacity to schedule sessions when there are competing needs for the use of the equipment. The Illinois Team eliminated this potential barrier by purchasing a camera for each facilitator.

8. LEADERSHIP

Leadership refers to those in a position of influence within an agency, organization, or system.

WHEN CONSIDERING PROJECT LEADERSHIP, START WITH THE FOLLOWING TASKS:

- » Assess the status of state, county, and local leadership buy-in to the project.
- » Identify leadership members who could be potential project champions.
- » Determine areas where further engagement with leadership is needed.

Illinois DCFS had experience with implementing TARGET as part of a previous project. Upper-level leadership as well as direct service leadership saw TARGET as a beneficial intervention and DCFS had decided to continue TARGET as an intervention for the foster care population. DCFS had invested substantial resources in getting staff certified in TARGET so that those staff could train, coach, and provide fidelity monitoring for other staff within the DCFS system. Thus, the existing knowledge and exposure to TARGET within DCFS laid a strong foundation for buy in when the Illinois Team chose TARGET as the intervention for the QIC-AG population. The proposed TARGET initiative had early, positive support of key groups. First, the Project Management Team supported the selection of TARGET. Second, the Adoption Support and Preservation agencies that would be impacted by the program expressed a great deal of positive interest in participating in the TARGET initiative. Third, key stakeholders were supportive of the TARGET intervention and were confident it would be well received by adoptive and guardianship families.



LESSONS LEARNED

- » Actively seek leadership buy-in to protect against decisions that could have a significant impact on implementation. In Illinois, midway through implementation, DCFS made the decision to phase out their internal TARGET training and fidelity monitoring capacity. Because the Illinois project had a strong partnership with DCFS, the DCFS leadership considered the implications of this decision on the project and modified their phase-down timelines in a way that allowed the Illinois Team sufficient time to plan as well as have continued access to the resources needed to keep implementation on track.

9. SYSTEM PARTNERS AND COMMUNITY LINKAGES

Systems partners and community linkages are those entities within the service network that provide services or supports to the target population. Some examples of system partners are other social service agencies, advocacy groups, mental health providers, and the education system.

WHEN CONSIDERING SYSTEMS PARTNERS AND COMMUNITY LINKAGES, START WITH THE FOLLOWING TASKS:

- » Identify partners or collaborators on board with your project.
- » Identify those not on board and determine what efforts are needed and most likely to engage these entities.
- » If community resources are required for providing the intervention, identify the availability and quality of linkages to community resources.
- » Consider a public-private partnership. This partnership can provide a variety of perspectives, increase the diversity of the project, and provide an opportunity to leverage system resources.

The selection of the TARGET intervention had widespread support among system partners. The agencies employing the outreach coordinators and TARGET facilitators were instrumental in TARGET implementation. A private agency assisted with recruiting families who had adopted children through intercountry and private domestic adoptions. The Illinois Team collaborated with the DCFS Post Adoption Unit, clinical, and training and professional development staff, all supportive of the project.



LESSONS LEARNED

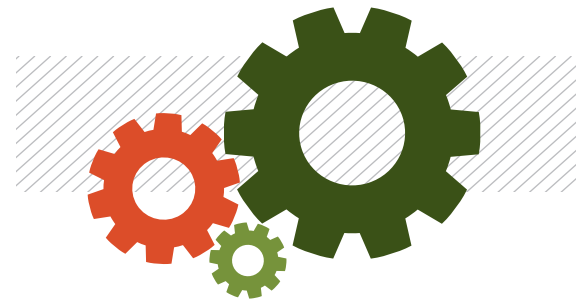
- » It is important to build collaborations and maintain connections throughout a project with multiple system partners. By keeping system partners engaged, the Illinois Team was able to tap into additional resources when implementation needs changed, without losing time getting partners up to speed.



WHO WILL DO THE WORK: TEAMING AND COMMUNICATION

Determining who will be responsible to complete the work is essential to moving the project forward. The teaming structure should include decision makers, stakeholders, and implementers. A plan is needed to communicate project progress internally and externally. This section covers the following topics:

1. **Teaming Structure**
2. **Communication Strategies**



1. TEAMING STRUCTURE

An effective teaming structure ensures a site has the capacity and decision-making authority to get the work done. Sites need to think about a teaming structure that supports the work as well as the roles and responsibilities of members of the teams. Although structures will change over the life of a project, consider starting with the following structural components:

- a. Project Management Team (PMT).** Forming a PMT can help not only to ensure leadership capacity for the duration of the project but also to ensure the sustainability of the intervention and Illinois leadership capacity. Members of a PMT are higher-level staff with decision-making authority in their respective departments.
- b. Stakeholder Advisory Team (SAT).** A SAT is essential to providing the project with the perspective of the consumers of the service and community providers engaged in serving that population. The Illinois SAT identified the unmet needs of children and families in the community. This SAT included representatives from agencies that serve the post-permanency population, other social service and adoption agencies, mental health and educational providers, and adoptive, guardianship and kinship families.
- c. Implementation Team (IT).** An IT guides the overall project and attends to the key functions of the initiative. The IT has a two-fold purpose. First, the IT organizes and prioritizes the work that needs to be done, establishes tasks and timelines, analyzes data, and troubleshoots problems. Second, the IT provides leadership and guidance to support the staff implementing the intervention. Including decision-makers as members of the IT is important because the IT is charged with overseeing the implementation and will have to resolve challenges that arise.

Members of the Project Management Team (PMT) were senior child welfare leaders who were expected to represent the views of the target population and provide expertise and advice in relation to the constituency they represented. The PMT met quarterly at a minimum, and was convened more frequently as needed to work on various goals and deliverables throughout the project.

The Stakeholder Advisory Team (SAT) was composed of foster and adoptive parents as well as stakeholders from private and public agencies. A liaison between the SAT and PMT was identified and put in place to provide continuity between the two teams. Eventually, the Illinois Team agreed to move the stakeholder group to the Illinois Adoption Advisory Council (IAAC) because many SAT members were IAAC members. This change enabled more parents to participate. Additional stakeholders who were not able to participate in the IAAC were engaged through other existing opportunities and through outreach by the Site Implementation Manager (SIM). The SAT meeting was highly productive in generating ideas related to the recruitment and engagement of families.

The Implementation Team was active throughout the project, meeting twice a month until late into the initial implementation phase. The Implementation Team provided structure to the project operation and included membership from all of the agencies that employed Outreach Coordinators and TARGET facilitators as well as DCFS Post Adoption Unit staff and leadership.



LESSONS LEARNED

- » Team building and partnership can lead to project sustainability during leadership turnover. Well-developed and active project teams can protect against the potential disruption brought about by leadership changes. Over the course of the Illinois project, many changes took place in DCFS leadership, but these changes did not affect the project because it had continuity in guidance from its strong Project Management, Stakeholder Advisory, and Implementation Teams.
- » The composition of team membership might change over time. As the Illinois project progressed, some members of the Project Management, Stakeholder Advisory, and Implementation Teams joined more than one team and new team members were added. A review of team membership led to a re-alignment of some members serving on different teams that could better utilize the members' expertise.

2. COMMUNICATION STRATEGIES

Communication strategies can range from face-to-face exchanges to electronic reports. Using a variety of communication strategies is key to keeping team members and stakeholders informed about the project status.

WHEN CONSIDERING COMMUNICATION STRATEGIES, START WITH THE FOLLOWING TASKS:

- » Determine the methods you will use to communicate information about the intervention and to whom the information will be communicated (e.g., broad internal or external communication).
- » Think through the when and how information will be disseminated.
- » Put protocols in place that specify how information is communicated across networks.

The formal team structure and governance framework for the Illinois project included active communication linkage across committees, workgroups, and teams. These linkages were supported through shared membership across committees and other groups. For example, the Stakeholder Advisory Committee liaison, who was an adoptive parent, was also a co-chair of the Illinois Statewide Adoption Advisory Council. The project's first SIM was a DCFS employee with the Division of Operations; the second SIM had been previously employed by DCFS, and had extensive knowledge of and existing relationships with the adoption stakeholder community in Illinois. A communication plan was developed as part of the project's IDIP (Initial Design and Implementation Plan). Several brief overview documents (1–2 pages) were created to provide a consistent mechanism for sharing information with key partners. Whenever possible, the SIM attended various work groups and committees from various DCFS departments to share information and updates about the project.



LESSONS LEARNED

- » Open communication is critically important to project success. Effectively informing system partners encourages cooperation and engagement.

CHAPTER 6

ASSESSING READINESS: USABILITY TESTING

Once the implementation planning is done, it is important to make sure the intervention is working as intended and the implementation supports are in place and effective.

The chapter addresses the following topic:

I. USABILITY TESTING

This chapter includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) a description of how the Illinois Team implemented the process, activity, or task; and (d) lessons the Illinois Team learned during implementation.

I. USABILITY TESTING

According to the Children's Bureau's 2016 publication, *Providing Technical Assistance to Build Implementation Capacity in Child Welfare*:

Usability testing is the process of establishing the innovation within the organization and learning whether procedures, processes, or innovation components need to be adapted for implementation to move forward. The purpose of usability testing is to help further operationalize the essential functions of the innovation, implementation supports (training, coaching, recruitment, selection, and fidelity assessment), and data collection. (p. 69)

Thus, usability testing is the initial implementation phase of the intervention when the first participants receive the intervention. This phase is a critical time to ensure implementation supports are effectively facilitating the delivery of the intervention and that the intervention is being delivered as intended.

Creating a structured process to evaluate findings from usability testing is the key to a successful full implementation. Findings from a critical evaluation will identify what worked, what did not, and what requires modification. Ongoing evaluation can be carried out by developing a matrix or grid that is reviewed regularly and allows for the usability findings to be documented for each intervention component.

It is important that usability reports include or describe the following:

- » Usability questions for each core component
- » Measures or metrics for each usability question
- » Summary of what the team learned from the metrics
- » What worked as intended and what did not work as intended
- » What needs to be done to address gaps or problems
- » What changes are needed or what changes have been made

By applying the findings from usability testing, modifications can be made to the project processes and procedures. Once all components are evaluated and modifications are made, the intervention is ready for full implementation.

The Illinois Team modified processes that did not perform as intended in the usability test. An example of a substantive change based on usability findings was the expansion of the target population from 12–14 year olds to 12–16 year olds in both Cook County and the Central Region counties. In addition, usability testing revealed the need for a change in the evaluation design in Cook County from the Zelen method of randomization (i.e., randomization precedes outreach) to a traditional randomized controlled trial design (i.e., participants are recruited and then randomized). To accommodate this change, the outreach protocol in Cook County had to be completely changed. Although the uptake in the Central Region counties was not as high as the Illinois Team hoped, the decision was made to not change the evaluation plan due to service delivery issues unique to this region.

The Usability Testing Plan and Tracking Tool (Appendix G) was used to complete usability testing. The tool provides a structure to delineate the questions to be answered and the metrics that will be used to answer the questions. The tool also allows for tracking the changes made a result of the usability testing.



LESSONS LEARNED

- » Consider usability testing to allow for adjustments before full implementation. It is important to critically assess the processes and procedures of each service component with a limited cohort. This approach enabled the Illinois Team to make a number of modifications prior to full implementation that improved the effectiveness of the intervention.

CHAPTER 7

TRACKING PROGRESS

Establishing and documenting time frames and responsible parties ensures the project stays on track and progresses as planned. A work plan has maximum benefit when reviewed regularly and incorporates procedures for documenting progress and keeping track of unanticipated delays.

The chapter addresses the following topic:

I. TRACKING PROGRESS THROUGH WORK PLANS

This chapter includes the following elements: (a) a general description of the process, activity, or task; (b) implementation considerations or suggestions; (c) a description of how the Illinois Team implemented the process, activity, or task; (d) lessons the Illinois Team learned during implementation.

I.

TRACKING PROGRESS THROUGH WORK PLANS

A work plan is a tool that can be used to track the progress of the activities that have to be completed at each implementation stage.

A work plan should include the following components:

- » **Activity**
- » **Responsible manager or team**
- » **Target date**
- » **Completion date**

The Illinois Team used the work plan to maintain focus on the necessary tasks and established timeframes during each phase of the intervention. The Team frequently referred to the work plan to identify upcoming activities and to evaluate progress on project goals.



LESSONS LEARNED

- » Consider using a structured work plan to keep a project team organized and focused. At a minimum, the Illinois team reviewed the work plan each quarter; however, during periods of heavier workloads, the work plan was used to create the agenda for weekly team meetings.

APPENDICES

- A. QIC-AG Population Template
- B. QIC-AG Continuum Assessment
- C. Stakeholder Focus Group Questions
- D. Hexagon Tool: Trauma Affect Regulation: Guide for Education and Therapy
- E. Initial Design and Implementation Plan
- F. QIC-AG Logic Model: Illinois
- G. Usability Testing Plan and Tracking Tool

APPENDIX A

QIC-AG POPULATION TEMPLATE

A

QIC-AG POPULATION TEMPLATE: TARGET GROUP 2

The population template is designed to help sites clearly define a population that will be the target of the evaluable intervention associated with the QIC-AG. Through this process each site will gain a clear understanding of the problem that needs to be addressed, the population that is most impacted by the problem, and ultimately, to initiate thinking about how the problem can best be addressed. Understanding the problem and the population can be accomplished by using data and other available information and anecdotes which allow you to consider the underlying causes of the needs of the identified population.

The population template will be used to: 1) understand the continuum of services; 2) understand the needs of the target population; 3) develop a theory of change and 4) provide a geographic focus for implementation and evaluation of an evaluable intervention.

Completion of the population template will be completed by the site with assistance from the evaluation team with support from the consultants. Each site is asked to complete as much of the template as is possible given the availability of quantitative data, qualitative data, and anecdotes. No new data should be collected to complete the template. In the event that no information is available to answer a question, please make a note of this and if possible, move on to the next question.

BACKGROUND: WHAT IS THE PROBLEM?

PRIMARY PROBLEM DEFINITION

The primary problem to be addressed by the QIC-AG with Target Group 2 is post-permanency discontinuity. Post-permanence discontinuity occurs when a child experiences one of the following:

- » Re-enters state custody (e.g. a traditional foster care placement, residential or hospitalization) for behavioral, psychological or other issues
- » Re-enters state custody (e.g. a traditional foster care placement, residential or hospitalization) due to the death or incapacitation of their adoptive parent or legal guardian
- » Enters or resides in an out of home placement without re-entering state custody (e.g. residential or hospitalization, living with a relative) and remains in the legal custody of the adoptive parent or legal guardian
- » Termination of an adoption or guardianship subsidy for reason other than those listed above.

BACKGROUND

The QIC-AG will build on an existing evidence base that recognizes that the problems facing families after legal permanence often stem from the complex behavioral and mental health needs of traumatized children and youth. Adoptive parents and legal guardians (caregivers) are often ill-prepared or ill-equipped to address these needs. Furthermore, the supports and services that are provided are often too late (when families have a weakened sense of commitment or are in crisis, rather than as a preventative measure), or inadequately address the needs of these families. The development of appropriate culturally responsive supports and services is needed to address the unique and challenging behavioral, mental health, and medical issues that may threaten stability and long-term permanency commitments of these families. Finally, interventions which support families from pre-permanence through post-permanence are necessary to successfully achieve safety, well-being, and lasting permanence.

Child welfare interventions that target families who have adopted or assumed legal guardianship of children previously in foster care who are having difficulties maintaining the adoptive or guardianship placement are often provided too late, and therefore, do not serve the best interests of children, youth and families. Even though most adoptive parents and permanent guardians are able to manage on their own, when the need arises, it is in everyone's best interest to receive evidence-supported, post-permanency services and supports (PPSS) at the earliest signs of trouble rather than at the later stages of weakened family commitment. Ideally preparation for the potential for post-permanency instability should begin prior to adoption or guardianship

finalization though evidence-supported, permanency planning services (PPS) that prepare and equip families with the capacity to weather unexpected difficulties and to seek services and supports if the need arises.

The best way to ensure that families will seek-out needed PPS and PPSS is to prepare them in advance for such contingencies and to check-in periodically after finalization to identify any unmet needs of the children, youth and families. It may also be necessary to assess the strength of the permanency commitments, which while firm at finalization, can weaken as unexpected difficulties arise and child problem behaviors strain the family's capacity to meet those challenges.

1. SOURCE OF PROBLEM DATA

BACKGROUND

Child Welfare Adoptions and Guardianships

The QIC-AG wants to develop the ability to track children from pre-permanence through post-permanence. In order to do this, a system for linking children who have exited foster care through adoption or guardianship to their foster care records needs to be developed so that we can use these histories to identify potential risk and protective factors. For children who were previously adopted through the child welfare system, the linking of pre- and post-adoption IDs is complicated. One difficulty is that names and social security numbers associated with these youth often change after adoption and child welfare systems deliberately don't link pre and post adoption identities. As part of this initiative, we will work with sites to develop and use a linking file that allows pre- and post-adoption IDs to link. The same issue does not exist for guardianship cases as their IDs do not change.

An additional issue is that states may not have physical addresses and current contact information for these families. Many states have moved from mailing subsidy checks to direct deposits of subsidies. Often there is not a mechanism for keeping current contact information on this population after finalization. In addition, many states have stopped sending annual recertification letters to families receiving adoption or guardianship subsidies so states may not have updated contact information for the families.

Furthermore, the tracking of children after adoption or guardianship finalization is complicated by the fact that these children and their families are no longer under the care, protection and monitoring of the child welfare system. As such, changes in placements, difficulties the children and youth are experiencing, are not often tracked by the child welfare system. Children and youth can become homeless, enter residential treatment facilities, be placed in the care of relatives, or move out of the home for a variety of reasons (e.g., rehom-ing) and these actions may not be tracked through the child welfare data systems. Sometimes they may be known to child welfare staff, and other times they may not be known to the staff.

Child welfare adoption and guardianship national data. National data are available from 1984 through 2013. In 1984 there were 102,000 children in IV-E substitute care and 11,600 in receiving IV-E adoption subsidies; children in adoptive homes made up 10% of the subsidy population. By 2000, there were 287,000 children in IV-E subsidized substitute care and 228,300 children in IV-E adoptive homes; adoptions made up 44% of the IV-E population. The most recent data show 159,000 children in IV-E subsidized substitute care and 431,500 in IV-E subsidized adoptive placements and adoptions make up the majority (73%) of the IV-E population.

Source: Committee on Ways and Means of the U.S. House of Representatives. (2014). 2014 Green book: Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. Retrieved from <http://greenbook.waysandmeans.house.gov>.

International and Private Domestic Adoptions

We know very little about these children and their families. Many states that provide post-permanency services allow families who have adopted by any means to access services. However, in some states non-child welfare families may not be eligible for post permanency services or may be eligible but required to pay for the services.

International and private domestic adoption national data. Between 1999 and 2013 there were 249,694 international adoptions. Majority of these adoptions were with children two or younger. Primary places for adoption were China and Russia.

In 2013 alone, there were 7,092 international adoptions. Most of the adoptions were with children two or younger but there was an increase in the number of older children being adopted (5 – 12 years).

Source: <http://travel.state.gov/content/adoptionsabroad/en/about-us/statistics.html>

CHILDREN RECEIVING AN ADOPTION SUBSIDY FFY13							
IV-E REIMBURSABLE							
NOT IV-E REIMBURSABLE							
CHILDREN RECEIVING A GUARDIANSHIP SUBSIDY FFY13							
GAP REIMBURSABLE							
GAP REIMBURSABLE							
NOT GAP REIMBURSABLE							
CHILDREN ADOPTED INTERNATIONALLY IN 1999-2013							

SITE SPECIFIC INFORMATION REQUEST

In responding to the questions below, please include the source of data or information. When you have data, use it; otherwise do your best to tell the story.

A. How many children in your site are currently receiving an adoption subsidy? Please provide state and county-level data.

B. How many children in your site are currently receiving a guardianship subsidy? Please provide state and county-level data.

C. How many children in your site have been adopted internationally in the past year? Please provide state and county-level data.

D. How many children in your site have been adopted privately in the past year? Please provide state and county-level data.

2. WHO IS AT RISK OF EXPERIENCING THE PROBLEM?

BACKGROUND

While there is consistency in the finding that the vast majority of adoptive families do not formally disrupt or dissolve, researchers have cautioned the field not to overlook the needs of these families, noting that the child-parent relationship may break down in other ways, and that many families struggle after adoption from foster care (Festinger, 2002; Smith & Howard, 1991). Some factors that may impact discontinuity:

- » Behavioral problems
- » Caregiver commitment
- » Biological relationship between the child and caregiver
- » Marital status of caregiver
- » Siblings
- » Age of child at time of permanence
- » Formal supportive services
- » Number of moves in foster care

Sources: Barth & Berry, 1988; Barth, Berry, Yoshikami & Carson, 1988; Festinger, 2002; Houston & Kramer, 2008; Koh & Testa, 2011; Rosenthal, Schmidt & Commer, 1988; Smith & Howard, 1991; Smith, Howard & Monroe, 2000; Zosky, Howard, Smith, Howard & Shelvin, 2005

SITE SPECIFIC INFORMATION REQUEST

Please include the source of data or information. When you have data, use it; otherwise do your best to tell the story.

CHILDREN ADOPTED THROUGH THE CHILD WELFARE SYSTEM

In this section, we are looking for information on the needs of children, some of these needs will be general in nature and others may be crisis-orientated. We realize that the two groups may overlap (some families may have both general and crisis needs). We also recognize that in some sites these data may be kept at a call level (how many calls did you receive in the past year) and others may be kept at a family or child level. We ask at the child level, but encourage you to provide it at any level.

Responses to questions A, B, and C below will help to answer question D.

A. Over the past year, how many children or families (post adoption finalization) came to the attention of your site because they had general needs (e.g., questions about where to go for services, monetary subsidy issues, referrals)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents' inability to effectively address behavioral issues).
- » Who were the people asking for services (e.g., grandparents, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
- » Describe the three most prevalent reasons families are identifying as to why they are having difficulties (e.g., lack of social support, lack of sufficient services, unrealistic expectations, inadequate parental preparation/training, inadequate or insufficient information on the child and his or her history).

B. Over the past year, how many children or families (post adoption finalization) came to the attention of your site because they had crisis needs (e.g., sexually aggressive behavior, fire-starting, immediate removal from

home, suicidal ideation)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B?).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues).
- » Who were the people asking (e.g., grandparents, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).

C. Is there a specific group of families that your site has proactively reached out to (e.g., is there a specific age group, developmental stage, or problem at the time of adoption) in the past year?

- » How are these families identified?
- » How many families are targeted?
- » Is there a geographic focus of your outreach?
- » Why has this group been identified?

D. Of all the issues discussed above, what are the most pressing issues? Which characteristics put children most at risk for post-adoption discontinuity? What is the cause of these needs? Why do you think families or children are experiencing these issues?

CHILDREN EXITING FROM THE CHILD WELFARE SYSTEM THROUGH GUARDIANSHIP

In this section, we are looking for information on the needs of children, some of these needs will be general in nature and others may be crisis-orientated. We realize that the two groups may overlap (some families may have both general and crisis needs). We also recognize that in some sites these data may be kept at a call level (how many calls did you receive in the past year) and others may be kept at a family or child level. We ask at the child level, but encourage you to provide it at any level.

Responses to questions A, B, and C below will help to answer question D.

A. Over the past year, how many children or families (post guardianship finalization) came to the attention of your site because they had general needs (e.g., questions about where to go for services, monetary subsidy issues, referrals)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues)
- » Who were the people asking (e.g., grandparents, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
- » Describe the three most prevalent reasons families are identifying as to why they are having difficulties (e.g., lack of social support, lack of sufficient services, unrealistic expectations, inadequate parental preparation/training, inadequate or insufficient information on the child and his or her history).

B. Over the past year, how many children or families (post guardianship finalization) came to the attention of your site because they had crisis needs (e.g., sexually aggressive behavior, fire-starting, immediate removal from home, suicidal ideation)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B?).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues).

- » Who were the people asking (e.g., grandparents, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).

C. Is there a specific group of families that your site has proactively reached out to (e.g., is there a specific age group, developmental stage, or problem at the time of adoption) in the past year?

- » How are these families identified?
- » How many families are targeted?
- » Is there a geographic focus of your outreach?
- » Why has this group been identified?

D. Of all the issues discussed above, what are the most pressing issues? Which characteristics put children most at risk for post-adoption discontinuity? What is the cause of these needs? Why do you think families or children are experiencing these issues?

INTERNATIONAL ADOPTIONS

In this section, we are looking for information on the needs of children, some of these needs will be general in nature and others may be crisis-orientated. We realize that the two groups may overlap (some families may have both general and crisis needs). We also recognize that in some sites these data may be kept at a call level (how many calls did you receive in the past year) and others may be kept at a family or child level. We ask at the child level, but encourage you to provide it at any level.

Responses to questions A, B, and C below will help to answer question D.

A. Over the past year, how many children or families (post international adoption finalization) came to the attention of your site because they had general needs (e.g., questions about where to go for services, referrals)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues)
- » Who were the people asking (e.g., children from specific countries, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
- » Describe the three most prevalent reasons families are identifying as to why they are having difficulties (e.g., lack of social support, lack of sufficient services, unrealistic expectations, inadequate parental preparation/training, inadequate or insufficient information on the child and his or her history).

B. Over the past year, how many children or families (post international adoption finalization) came to the attention of your site because they had crisis needs (e.g., sexually aggressive behavior, fire-starting, immediate removal from home, suicidal ideation)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B?).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues).

- » Who were the people asking (e.g., children from specific countries, parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).

C. Is there a specific group of families that your site has proactively reached out to (e.g., is there a specific age group, developmental stage, or problem at the time of adoption) in the past year?

- » How are these families identified?
- » How many families are targeted?
- » Is there a geographic focus of your outreach?
- » Why has this group been identified?

D. Of all the issues discussed above, what are the most pressing issues? Which characteristics put children most at risk for post-adoption discontinuity? What is the cause of these needs? Why do you think families or children are experiencing these issues?

PRIVATE DOMESTIC ADOPTIONS

In this section, we are looking for information on the needs of children, some of these needs will be general in nature and others may be crisis-orientated. We realize that the two groups may overlap (some families may have both general and crisis needs). We also recognize that in some sites these data may be kept at a call level (how many calls did you receive in the past year) and others may be kept at a family or child level. We ask at the child level, but encourage you to provide it at any level.

Responses to questions A, B, and C below will help to answer question D.

A. Over the past year, how many children or families (post private domestic adoption finalization) came to the attention of your site because they had general needs (e.g., questions about where to go for services, referrals)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues)
- » Who were the people asking (e.g., parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).
- » Describe the three most prevalent reasons families are identifying as to why they are having difficulties (e.g., lack of social support, lack of sufficient services, unrealistic expectations, inadequate parental preparation/training, inadequate or insufficient information on the child and his or her history).

B. Over the past year, how many children or families (post private domestic adoption finalization) came to the attention of your site because they had crisis needs (e.g., sexually aggressive behavior, fire-starting, immediate removal from home, suicidal ideation)? Please describe any differences in need by region (e.g., in county A are the needs are different than in county B?).

- » What were the needs the children or families expressed? Here we are looking for the circumstances and conditions families expressed that can be remedied (e.g., difficulty with emotional or behavioral regulation in children; parents inability to effectively address behavioral issues)

- » Who were the people asking (e.g., parents of teens, rural families, homeless youth)?
- » Describe the three most prevalent characteristics of the children in need of assistance (e.g., substance abuse, internalizing and externalizing behavioral issues, school problems).
- » Describe the three most prevalent characteristics of the family in need of assistance (e.g., parent competency, housing instability, substance abuse).

C. Is there a specific group of families that your site has proactively reached out to (e.g., is there a specific age group, developmental stage, or problem at the time of adoption) in the past year?

- » How are these families identified?
- » How many families are targeted?
- » Is there a geographic focus of your outreach?
- » Why has this group been identified?

D. Of all the issues discussed above, what are the most pressing issues? Which characteristics put children most at risk for post-adoption discontinuity? What is the cause of these needs? Why do you think families or children are experiencing these issues?

APPENDIX B

QIC-AG CONTINUUM ASSESSMENT FOR PARTNER SITES

B

QIC-AG CONTINUUM ASSESSMENT FOR PARTNER SITES

OVERVIEW

The QIC-AG Continuum Assessment builds off of the initial assessments that have already been completed with the sites for target population 1 and 2. Target population 1 and 2 are defined as follows:

- » **Target Group 1:** Children with challenging mental health, emotional or behavioral issues who are waiting for an adoptive or guardianship placement as well as children in an identified adoptive or guardianship home for whom the placement has not resulted in finalization for a significant period of time.
- » **Target Group 2:** Children and families who have already finalized the adoption or guardianship. This group includes children who have obtained permanency through private guardianship and domestic private or international adoptions.

The continuum assessment is composed of two separate but inter-connected elements. The first element gathers macro level organizational information on the site. This information is organized by capacity domains that fall under process, outcomes and cost. Listed below are the capacity domains broken out by the categories.

PROCESS

- » Infrastructure (includes questions related to legal and policy)
- » Functioning (includes questions related to structure, communication and assessment)
- » Operations (includes questions related to inter and intra agency relationships, monitoring/management , programs/interventions and availability/access)

OUTCOMES

- » Knowledge (includes questions related to training)
- » Ability (includes questions related to provider capacity)
- » Attitudes (includes questions related to culture of the system)
- » Critical reflection and evaluation (includes questions related to needs identification and impact)

COST

- » Resources (includes questions related to finances)

The second element gathers specific information about the programs/interventions that are offered at each of the intervals on the QIC-AG continuum framework:

- » Stage setting
- » Preparation
- » Focused
- » Universal
- » Selective
- » Indicated
- » Intensive
- » Maintenance

The completed continuum assessment will: 1) clarify the existing services offered at each interval of the continuum; 2) assist in identifying gaps and strengths along the site's continuum; 3) inform the identification of evaluable interval assignment; and 4) identify areas for capacity building. Ultimately, the continuum along with the population template will lay the foundation for the work that will be done with the sites over the course of the initiative. A similar assessment will be completed at the conclusion of the project with each site to assess changes that have been made to both the macro level system and the continuum of services since the start of the QIC-AG. This information will be critical to the evaluation of the QIC-AG.

ELEMENT #1

MACRO LEVEL ORGANIZATIONAL INFORMATION

PROCESS

INFRASTRUCTURE

Legal and Legislative: Legislation is in place that supports the provision of services to target group 1 and 2.

- » What legal mandates/legislation/statutes positively or negatively impact target group 1 and/or 2? Please describe including date they were instituted.
- » Are there any active lawsuits and the impact on target group 1 and 2? If yes, please describe including start and estimated end date.
- » Is there any pending legislation that may impact target group 1 and 2? If yes, please describe.

Policy: The agency has written policies and procedures that promote and support service delivery to target group 1 and 2.

- » What are the policies and procedures that impact service delivery to target group 1 and 2 (i.e.: subsidy eligibility)?
- » Are there gaps in these policies and procedures that hinder the work with target group 1 and 2? What has been done to address these noted gaps? When did the efforts occur?

FUNCTIONING

Structure: The agency has methods in place to identify needs of target group 1 and 2 and this information is used to develop and structure services for the Target Group 1 and 2.

- » What are the site's current plan for the identification, development and refinement of services for adoptive and guardianship families? How is this plan used to inform your practice model?
- » Are post adoption/guardianship family's needs and issues represented in the site's current strategic plan? (If so, how? What process was used to get this information) (If their needs are not included, what is the willingness to include this information?)
- » What is the current structure to coordinate and support pre- and post-adoption/guardianship service providers?

- » Is there an existing committee or governance structure that coordinates work related to services for target group 1 and 2?
- » How does the site currently determine needs, develop strategies, and prioritize projects and initiatives related to target group 1 and 2? How does the site assess program effectiveness? What and how are stakeholders involved with this process?

Communication: The agency has developed strategies to ensure information is consistently obtained about target group 1 and 2 and that this information is shared among key services providers and stakeholders relevant to the population.

- » What are the current outreach and engagement plans that target adoptive/ guardianship families?
- » How is information shared across departments, systems, private and voluntary sectors related to the needs of adoptive and guardianship families?
- » Are there current statewide information systems/processes that collect information on target group 1 and 2 and provide this information to service providers (i.e. performance dashboard, monthly QA reports, survey results, policy transmittals)?

Assessment: The agency has established methods to gather information on the needs of individual children and families in target group 1 and 2 and uses this information to inform the development and delivery of services.

- » How is the site conducting comprehensive screening and functional assessments of children to ensure appropriate service intervention?
- » What standardized assessment tools are used to identify risks, protective factors and treatment needs of children and families in target group 1 and 2?
- » What is the linkage between assessments, interventions and outcomes? In other words, how is data from assessments used to target interventions and to determine the extent to which selected interventions contributed to the outcomes?

OPERATIONS

Interagency and Intra-Agency Relationships: The agency has developed cross system, interdepartmental and community partnerships that maximize resources for target group 1 and 2.

- » Are there any relationships with private provider networks/associations involved with target group 1 and 2? If yes, please describe their role and relationship with the child welfare agency.

- » Does your site have a state/local foster/adoptive/guardianship parent association? If yes, describe their role and relationship with the child welfare agency. How do they provide input regarding the needs of Target Group 1? Target Group 2?
- » Are the coordinated referrals and hand-offs between pre and post adoption and guardianship services/workers? If yes, please describe.
- » Are there formal linkages between cross system service providers (i.e. mental health and child welfare committee meetings, human service coordinating bodies) that coordinate services for target group 1 and 2? If yes, please describe their role and relationship with the child welfare agency.

Availability/Access: The agency has developed methods and strategies to consistently inform adoptive parents and guardians of the availability and process for accessing services for target group 1 and 2.

Pre Adoption/Guardianship (target group 1):

- » How are families informed of services that will be available to them after finalization of adoption/guardianship?
- » Are there any services/vendors that start providing services prior to finalization and continue to provide services post finalization?

Post Adoption/Guardianship

- » How and when are adoptive and guardianship families made aware of the services that are available to them?
- » Are there families that you are aware of that do not know how to access services? How do you become aware of these families and what do you do to assist them?
- » Is there a centralized process for families to access services? If yes explain. If not explain the process for accessing services.
- » Is there currently a warm or hotline for pre- and post-adoptive/guardianship families to contact? If yes, what are the hours?
- » Is there currently an up to date online database that families can access to get information on pre- and post -adoption and guardianship services? Who keeps this up to date? If there is not an online database, what other methods are families using to get information on pre- and post-adoption and guardianship services?
- » Do you routinely track the reason families call for services? What barriers do adoptive and guardianship families most often report in accessing services?

Monitoring and Management: The agency has developed methods and strategies to gather detailed information on programs and services provided to target group 1 and 2 and uses this information to refine their processes.

- » How does your site monitor programs/interventions that serve the target groups?
- » How is this information used to increase staff effectiveness (improved knowledge, skills, attitudes/perspectives, behaviors) or improve program components?
- » What challenges do you face in monitoring these programs/interventions?
- » Are there standard implementation/outcome expectations for vendors that provide services to target group 1 and 2? If yes, what are the expectations and how are they monitored?
- » Does your site have a current client satisfaction process for foster parents and/or adoptive parents/guardians?

Programs/Interventions: The agency has developed culturally sensitive methods and strategies to identify the services and interventions that will respond to the needs of target group 1 and 2.

- » What assessments are done routinely to identify the needs of target group 1 and 2?
- » How are assessments and diagnoses currently used to identify the program or interventions that appropriately matches the identified need?
- » What is the process to roll out a new intervention in the state/county/tribe?
- » How does the site identify and assess the appropriateness of a new intervention before implementation? (i.e. Evidence Based Intervention (EBI) Integration Committee, a specific department/unit) Who are the key staff involved in these decisions? Can you describe any success or failures in trying to implement EBI in the past?

OUTCOMES

KNOWLEDGE

Training: The agency has a training and education process that includes components to prepare staff and families to respond to the needs of target group 1 and 2 in a culturally sensitive/relevant manner.

- » What trainings are offered to providers that serve target group 1 and 2 (i.e.: related to assessment, intervention, and evaluation)?
- » What regular trainings are offered to foster, adoptive and guardianship families? Are any offered to youth?
- » Are there current expectations and standards related to the level of adoption competency for staff that work with target group 1 or 2? If yes, describe.
- » Is there a training structure that will be included in the planning and support of the QIC-AG initiative?
- » What trainings are offered to integrate trauma informed practice into the service environment?

ABILITY

Capacity of Providers: The agency has processes in place to identify and monitor the capacity of providers working with target group 1 and 2.

- » How does the site currently assess the capacity of providers to respond to the needs identified for target group 1 and 2?
- » Are there sufficient providers with adoption/guardianship competency to respond to the needs of target group 1 and 2?
- » How does the system measure the ability of providers to effectively serve target group 1 and 2?

ATTITUDES

Culture: The agency has an understanding of its current culture and uses this information to guide the plans for positive change.

- » How often has the site implemented new interventions in the past year? past five years?

- » What is the history of the site in terms of implementation and expectation of utilizing new practices for target group 1 and 2?
- » How motivated are line staff, middle managers and directors to implement new practices for target group 1 and 2?
- » Does the agency administration perceive there to be a need to change the continuum of services for target group 1 and 2? Do line level staff?
- » What is the current workload and time pressures for staff providing services to target group 1 and 2?
- » Does the agency value the philosophy of trauma informed services? How has trauma informed practice been integrated into the practice philosophy?
- » How does the site feel about the significance of developing an evidence base to support child welfare practice? Does the agency culture support/value the use of evidenced supported intervention?

CRITICAL REFLECTION AND EVALUATION

Needs Identification: The agency has developed strategies that routinely assess needs and preferences of target group 1 and 2.

- » Are there currently any standardized processes at a macro level to determine what needs and additional supports may be necessary for target group 1 and 2?
- » How are adoptive and guardianship families involved in the identification of services/interventions?

Impact: The agency has a process in place to collect outcome data on services/interventions offered to target group 1 and 2.

- » Is there a research/data division that does or can provide information about the outcomes of services that focus on target group 1 and 2? If yes, how frequently are the outcome data collected and what information is currently being collected on the continuum services?
- » Is there an outside vendor(s) that your system works with to collect outcomes on interventions for target group 1 or 2?
- » What data is currently available establishing the effectiveness of interventions designed for target population 1 and 2?

COST

RESOURCES

Finances: The agency has resources to develop and implement services to meet the needs of target group 1 and 2.

- » What is the site’s ability to financially support the development and implementation of services to meet the needs of target group 1 and 2?
- » What is your site’s current budget for target group 2?
- » Is the availability of services for target group 1 and 2 driven more by resources or need? Explain.
- » Are there any barriers to identifying and hiring sufficient staff with the necessary characteristics and attitudes to serve as implementers?
- » Is the site currently under or expecting any budgetary reductions that could impact their ability to allocate resources and staff time to this initiative?

ELEMENT #2: PROGRAMS/INTERVENTIONS OFFERED AT EACH INTERVAL ON THE QIC-AG CONTINUUM FRAMEWORK

DIRECTIONS

Conduct a thorough assessment of all services/interventions offered by the site that work with the QIC-AG target populations. For each service/intervention identified, answer all of the questions below. We are interested in collecting information for each of the intervals along the QIC-AG continuum: Stage Setting, Preparation, Focused, Universal, Selective Indicated, Intensive, and Maintenance. Services/interventions listed below should be directly related to target group 1 and/or 2. Please note that we are asking for specific services rather than programs. For example ASAP may be the program that provides post adoption services in TN. However, ASAP provides many services. Each of these services should be listed below and not lumped under one entry called ASAP. Please also note that we are looking for services/interventions that are offered anywhere in the site (i.e. designated state, county that is working with QIC-AG).

Following the interval specific questions, there are some broad questions about the site's overall continuum.

Questions to be asked for each service/intervention in the interval:

- » Type of service (Information and referrals, educational programs or materials, support programs (groups, mentors, buddy families, etc.), in-home counseling, out-of-home counseling, respite, residential/day treatment, mediation, assessment, specialized recruitment and development, educational advocacy, other)
- » Name of service/intervention
- » Length of time service/intervention has been in use
- » What is the primary goal of the service/intervention?
- » Who are the current providers?
- » Practitioner characteristics (Number of staff, minimum educational standards, training requirements, case ratio, clinical supervision, types of practitioner such as social worker, physician, parent, current workload and time pressures of staff who are providing current service)

- » **Regions/locations served:**
 - › Eligibility criteria for service/intervention

- » **Characteristics of service/intervention**
 - › Evidence supported/promising practice (name, if applicable)
 - › Risk factors/protective factors addressed by service/intervention
 - › Intended client
 - › Service delivery (frequency, duration, source of referrals)
 - › How did the site originally identify the need for the program?
 - › What assessment tools are used (functional, resiliency, mental health) and are these used to determine eligibility for the service/intervention

- » **Outcomes**
 - › Is output and/or outcome data collected?
 - › How is data collected?
 - › Number of clients served in last fiscal year?
 - › What was impact on families served in last fiscal year?
 - › Is there a standard set of outcome measures for this program/intervention?

Questions to be asked for each the interval:

- › What services/interventions are missing in this interval to meet the needs of target group 1 or 2?
- › What are the major barriers in this interval to providing services to target group 1 or 2?
- › Are there major barriers target group 1 or 2 encounter accessing services in this interval?
- › What are the major strengths in this interval to providing services for target group 1 or 2?

APPENDIX C

QUESTIONS FOR CAREGIVER STAKEHOLDER INTERVIEWS

C

QUESTIONS FOR CAREGIVER STAKEHOLDER INTERVIEWS

As participants enter have them put their first name on the table tents and give them a copy of the consent form to read and sign. Answer any questions that may arise about the consent form. Have participants also fill out the sign in sheet.

INTRODUCTION

HELLO, I'M _____ FROM _____. I REPRESENT THE QIC-AG WHICH IS A NATIONAL PROJECT FUNDED BY THE CHILDREN'S BUREAU TO IMPROVE SERVICES OFFERED IN (NAME STATE) TO FAMILIES THAT HAVE ADOPTED AND ASSUMED GUARDIANSHIP OF A CHILD OR ARE PLANNING TO ADOPT OR TAKE GUARDIANSHIP OF A CHILD. WE WANT TO KNOW HOW YOU FEEL ABOUT THE SERVICES THAT ARE AVAILABLE TO HELP YOU SUPPORT THE CHILD IN YOUR HOME WHO YOU HAVE/OR PLAN TO ADOPT OR ASSUME GUARDIANSHIP. THIS INFORMATION WILL HELP (NAME STATE) IMPROVE THE SERVICES AVAILABLE TO FAMILIES WHO ARE WORKING TOWARD PERMANENCE OR WHO HAVE PERMANENCE THROUGH ADOPTION AND GUARDIANSHIP.

YOUR PARTICIPATION IN THIS MEETING IS VOLUNTARY, AND YOU MAY CHOOSE NOT TO ANSWER ANY OF THE QUESTIONS ASKED. THE INFORMATION WE LEARN FROM YOU WILL BE COMBINED TOGETHER WITH THE RESPONSES FROM OTHERS SO THAT NO ONE OUTSIDE OF THE ROOM WILL BE ABLE TO IDENTIFY WHO SAID WHAT. YOUR COMMENTS WILL BE USED TO HELP US GAIN AN OVERALL UNDERSTANDING OF THE SYSTEM.

AS MENTIONED ON THE CONSENT FORM, WE WILL NOT USE ANY OF YOUR PERSONAL INFORMATION. HOWEVER, WE WILL BE TAKING NOTES DURING THE MEETING.

THE MEETING IS SCHEDULED TO RUN ABOUT 2 HOURS. DO YOU HAVE ANY QUESTIONS FOR ME BEFORE WE START?

TO START, WE WOULD LIKE TO GET A SENSE OF WHO WE HAVE IN THE ROOM WITH US TODAY. EVERYONE SHOULD HAVE A PIECE OF PAPER TITLED DEMOGRAPHICS OF THE GROUP. DO NOT PUT YOUR NAME ON THE PIECE OF PAPER. WE WILL READ EACH QUESTION OUT LOUD AS WELL AS THE ANSWER CHOICES. PLEASE PUT AN "X" NEXT TO THE ANSWER THAT BEST DESCRIBES YOU.

The rest of the questions will help us better understand the services that are offered in (name state) to children and families that have finalized adoptions or guardianships as well as children and families moving toward adoption and guardianship. This understanding will help the project determine where to focus efforts to improve services.

OPERATIONS

1. What services did you receive before the adoption or guardianship was finalized that helped you be the most prepared to adopt/assume guardianship?
2. What services/information would you have liked to have received prior to making a decision to adopt/assume guardianship?
3. Before your adoption/guardianship was finalized, were you told about services that you could get for your child after finalization?
4. If you needed services for your adopted/guardianship child today, who would you call to get help?
5. What services have you received after finalization that have been the most beneficial to your child or your family?
6. Since you adopted or assumed guardianship what services have you or your child needed that were difficult to get? Why were the services difficult to get?
7. Are you aware of a foster/adoptive/guardianship parent peer group (association or support group) that you can join? If yes, what is the name(s) of the group(s)?
8. What services have you needed that you have been unable to get?

KNOWLEDGE

1. Have you attended any training to help you in your role as adoptive parent/guardian? If yes, what trainings did you find most helpful?
2. Are you aware of training in your state/county/tribe that is offered to adoptive parents/guardians?
3. Are you aware of training in your state/county/tribe for youth who have been adopted/moved to guardianship?
4. Has your child attended training regarding adoption/guardianship? If yes, what trainings did your child find most helpful?

FUNCTIONING

1. How do you learn about services that you and your family can use?
2. Is there a place (number, person, etc.) that adoptive and guardianship parents can contact to voice their opinions or suggestions about the child welfare system?

ATTITUDES

1. Overall how would you rate the following statement: The child welfare agency helps families make well thought out decisions about permanency for children who are not able to return home to either adoption or guardianship? *Strongly agree, agree, neutral, disagree, strongly disagree*
2. Overall how would you rate the following statement: The child welfare agency is there to help children and families that need help after adoption or guardianship has been finalized? *Strongly agree, agree, neutral, disagree, strongly disagree*

THAT IS ALL OF THE QUESTIONS THAT I HAVE FOR THE GROUP. WE TRULY APPRECIATE YOUR WILLINGNESS TO SHARE YOUR THOUGHTS.

APPENDIX D

HEXAGON TOOL: TARGET

D

HEXAGON FOR TARGET

Trauma Affect Regulation: Guide for Education and Therapy (TARGET) is a strength based approach to education and therapy for individuals who have experienced trauma. TARGET was originally implemented with an adult population but has been adapted for adolescents.

SUMMARY

TARGET is an evidence-based practice (EBP) designed for children and adolescents who have experienced complex trauma. While there are many EBPs available to treat complex trauma, TARGET is unique in that it is designed to build affect regulation skills and links this closely to the stress response system in the brain. The stress response system in the brain is the primary mechanism for survival and can often “hijack the brain” so a child may react as if every stressful experience is life-threatening even when it is a normal stress experience. It does not require kids to engage in discussions about their traumatic experiences and all the bad things that have happened to them, but helps them to recognize they can control their emotions and behaviors. This intervention is time-limited, strength-based and empowering, helping children and their families recognize and understand what is happening to them when their stress response system is triggered by trauma reminders and make choices that are in line with their core beliefs and values.

The TARGET treatment is developed for clients with complex trauma exposure that show problems in the identification, expression and modulation of affect that often leads to behavioral and emotional problems and difficulties with functioning in a variety of settings including school, home and community. TARGET is a psychoeducational 12-20 session model that provides education about the impact of stress and trauma on cognition, behaviors, and emotions and teaches clients how to identify their own stress triggers so that they can better regulate their emotional and behavioral reactions as well as make and achieve positive goals for themselves and their families. TARGET can be provided to youth, caregivers, biological parents, and other adults who may serve as permanency resources for youth.

NEEDS

Root causes of discrepancy between the capacity of the adoptive parents and guardians and the needs of the child (as described in TOC):

- » It is difficult to understand when problematic behavior is a result of underlying trauma, a reaction to parental beliefs and practices, or part of normal child development.
- » Expectations (by the family or the system) that the adoptive parents and guardians should be able to address the needs of the child on their own, including navigating complex and cumbersome service delivery systems.
- » Child's needs trigger something in the parent's past and/or impact the overall family system.
- » Adoptive parents and guardians need to be connected with supports and services that help them meet the emerging and future needs of their children.
- » Services offered should build on the adoptive parent and guardian's resiliency factors that can strengthen permanency commitments.

TARGET will:

- » Provide youth with a set of skills they can employ when a trigger that could cause emotional or behavioral issues for a youth is identified. As youth maintain control over their reactions, they will experience a reduction in emotional or behavioral issues, resulting in increased capacity to form and maintain healthy relationships.
- » Improve youth ability to manage affect & behavior even in stressful situations.
- » Provide parents with training and support in the foundation and skills necessary to assist youth when a trigger occurs, working with the youth to employ the skills that will ultimately result in improved self-regulation for the youth.
- » Help parents develop appropriate responses to youth and provide opportunities for relationship-building between parents and youth
- » Improve parent functioning and support sustained permanency of the child, and well-being of the child and family.
- » Through participation in TARGET, they will also gain knowledge and be able to support their children as they develop their own set of emotional regulation skills through TARGET.
- » FREEDOM steps seem not to be overly-intrusive, does not "take over" family life

FIT

Good fit:

- » The Permanency Innovations Initiative (PII) federal grant enabled Illinois to begin using TARGET treatment with children involved with the child welfare system. Currently, there are TARGET therapists available throughout the state with capacity based on population density; we will sustain those

current therapists through the IPS program and add more over time to enable the capacity to provide the intervention statewide.

- » Builds on DCFS' Family-Centered, Strength-Based, Trauma-Informed (FTS) model used in pre-permanency practice. TARGET is family-centered; it targets training at the family so that they understand and can support and reinforce the FREEDOM steps. TARGET also builds upon the youth's strengths, incorporating these into the intervention.
- » Strong psycho-educational element

Questionable fit:

- » TARGET does not treat trauma; it helps with emotional regulation that can support trauma treatment. This could be a benefit for youth who do not need trauma treatment, but have trauma experiences, however additional treatment may be indicated for youth who are experiencing trauma. TARGET can be supportive of these efforts as they will be better able to manage their emotions. (We will need linkage to another treatment—could be achieved via Pres programs)
- » Can we use TARGET for youth younger than 10? Some indications that purveyors may be strict about age range.
- » Can we access the TARGET trained therapists (sustainability)

RESOURCE AVAILABILITY (NEED MORE INFO TO SCORE)

- » We may be able to re-purpose some resources already in place
- » \$2300 equipment costs—what were the costs in PII?
- » Many elements in place that we can build on (manuals, teaching tools, etc)
- » *What are the funding requirements? Is funding available to implement and sustain the program or practice as intended? What are the staffing and training needs? What are the data and IT needs?*

EVIDENCE

- » There is evidence to support the use of TARGET with juveniles in detention facilities (Ford & Hawke, in press); and with delinquent girls who were diagnosed with full or partial PTSD (Ford, Steinberg, Hawke, Levine, & Zhang, 2012). While TARGET will need to be adapted and effectiveness with a child welfare population has not been tested, it has had success in improving emotional and behavioral self-regulation among youth, one of the key proximal outcomes of the Illinois PII study.

- » An RCT study [Girls in Recovery from Life Stresses (GIRLS) Study] with 59 delinquent girls aged 13 to 17 years old who were diagnosed with full or partial PTSD compared TARGET to enhanced treatment as usual (ETAU) (Ford, Steinberg, Hawke, Levine, & Zhang, 2012). This study appears to be the most relevant test of the effectiveness of TARGET with a population similar to Illinois PII's target population as this study was conducted with girls in outpatient settings. Time-limited TARGET was associated with reduced severity of PTSD and associated symptoms and beliefs, and increased optimism or self-efficacy. TARGET was associated with almost twice as much reduction in PTSD symptom severity, and clinically significant change in PTSD as compared to ETAU. On the other primary outcome, affect regulation, TARGET was associated with a small effect size improvement, whereas ETAU showed no evidence of change. TARGET also was associated with medium effect size reductions in anxiety and posttraumatic cognitions, whereas ETAU achieved only small effect size changes. However, ETAU was superior to TARGET on gains in optimism or self-efficacy and reduced anger.

Fidelity. Fidelity monitoring is a strength of this model. The purveyors of TARGET have developed and tested fidelity instruments that they have used in other locales. These include review criteria for reviewing taped sessions and ongoing consultation with providers until fidelity to the model has been reached. This method to reach optimal fidelity to the model can be used with individual or group sessions and with adults or youth.

INTERVENTION READINESS FOR REPLICATION

- » Currently, there are TARGET therapists available throughout the state with capacity based on population density; we will sustain those current therapists through the IPS program and add more over time to enable the capacity to provide the intervention statewide.
- » TARGET has developed manuals, training materials and other teaching tools that are used to engage clients and in assisting with both group and individual treatment modalities. Materials are available for adult and adolescent treatment in both individual and group modalities. The SAMHSA registry of evidence based programs and practices reports that the materials are “well organized, clearly written and comprehensive”; the training, coaching and quality assurance received the highest scores possible.
- » Discussions with TARGET users found that the purveyors are very available, knowledgeable, supportive and aggressive in their efforts to ensure fidelity.

CAPACITY TO IMPLEMENT

- » Therapists will be the main implementation drivers for TARGET in Illinois. Therapists will work individually and in group sessions with youth, biological and foster parents. In addition, case workers and managers will be trained in TARGET and will support the youth, biological and foster parents in the TARGET process. TARGET does not require a Masters’ level credential. (Would want to be sure Bachelor’s level has good level experience)
- » Buy-in and trust is likely (staff and parents alike)
- » Being sustained after PII

TARGET	HIGH	MEDIUM	LOW
NEEDS		3	
FIT	4		
RESOURCE AVAILABILITY	DID NOT SCORE		
EVIDENCE	4		
READINESS FOR REPLICATION	5		
CAPACITY TO IMPLEMENT	4		
TOTAL SCORE			20

APPENDIX E

QIC-AG INITIAL DESIGN AND IMPLEMENTATION PLAN (IDIP)

E

QIC-AG INITIAL DESIGN AND IMPLEMENTATION PLAN (IDIP)

INTRODUCTION

The Initial Design and Implementation Plan (IDIP) is a document that serves as a tool for the QIC-AG site to thoughtfully and strategically plan for successful implementation of the initiative and to ensure that the initiative has intervention validity and implementation integrity. The result of the implementation plan should be a document that guides the implementation of the evaluable intervention, supports the use of an intervention to address an identified problem, and outlines the steps that need to be taken to ensure that the intervention is delivered to clients in the way that it was intended. To accomplish this, the Initial Design and Implementation Plan (IDIP) will describe the following:

1. Project Overview
2. Key Components of your Research Question
3. What will be implemented
4. How the system will be modified or readied to support the intervention
5. Who is going to do the work

If done well, an IDIP has many benefits, including the promotion of a well-developed, logical approach to implementation and the description of strategies to address on-going implementation issues. Planning activities provide the process for thinking through the intervention's critical components, allowing for anticipation of possible barriers and the steps to address them and developing a common understanding of how the identified program goal will be achieved. In addition, the plan can serve as a communication tool with leadership to promote buy-in and sustain support.

Please note: All components of the plan do not require the development of new materials or content. In some sections of the plan you will simply need to pull together and/or expand upon existing materials, documentation or products to complete that element of the plan. Having just one comprehensive document will help guide the work as the project moves forward.

I. PROJECT OVERVIEW

A. PROBLEM

Using the information gathered during the “Identify and Explore” stage, briefly state the problem and the QIC-AG interval your intervention will address.

B. THEORY OF CHANGE

Insert the QIC-AG approved site specific theory of change.

II. KEY COMPONENTS OF YOUR RESEARCH QUESTION

A well-built research question is one that is directly relevant to the problem at hand and is phrased in a way that leads to precise answers (Wilson, Nishikawa & Hayward, 1995). Testa and Poertner (2010) recommend the PICO framework, which requires careful articulation of four key components: P – a well-defined target population; I – the intervention to be evaluated; C – the comparison group; and O – the outcomes expected to be achieved. Please note: Intervention (I) will be discussed in Section III. To complete this section, expand upon the QIC-AG approved PICO question.

A. TARGET POPULATION

Using your population template as a starting point, supplemented with additional data from the evaluation team (as available) or through your site’s data system, clearly define the target population for the evaluable intervention. This may include data on the following:

- » Eligibility and exclusionary criteria
- » Geographic service areas
- » Characteristics, demographics, or past experiences (e.g., age, race, ethnicity, or placement history, family structure)
- » Needs (e.g., parents or guardians who lack the capacity to address trauma-related issues, or lack of parental skills and abilities to manage behavior)
- » Estimates of the total number of children that will be served by the QIC-AG each year

B. COMPARISON GROUP

Describe the criteria for selecting your comparison group, and any anticipated concerns or processes that need to be developed for the comparison group. Please describe services as usual as they will be provided to the comparison group.

C. OUTCOMES

Short-term outcomes: Short-term outcomes will be specific to your selected intervention. Describe the short-term outcomes you expect to achieve with this initiative. In your description, please discuss how your short-term outcomes are linked to your theory of change. Also explain how these outcomes are different or similar to outcomes previously examined with the intervention.

Long-term outcomes: Please note that each site will be examining the same long term outcomes regardless of the selected intervention. The long-term outcomes are as follows:

- » Increased post permanency stability
- » Improved child and family well being
- » Improved behavioral health for children and youth

D. LOGIC MODEL

Present a logic model that illustrates the conceptual linkages between core components and your selected intervention, expected outputs, and short-term and long-term outcomes. The logic model should clearly explain how specific activities or services are expected to produce or influence their associated outcomes. Please include the visual representation of the logic model as an appendix.

E. CASE FLOW/PROJECT ENROLLMENT

Describe how participants will be identified, selected or recruited to participate in the initiative. Please include when and how randomization will occur and when and how consent will be obtained. Also please describe any anticipated issues that may prevent the processes from occurring as planned.

F. DATA COLLECTION

Describe the process for collecting information related to implementation (outputs, core components and fidelity measures). Indicate any concerns regarding the processes that need to be developed. In addition, describe the process for collecting data to support short- and long-term outcome measures. Indicate any concerns regarding the processes that need to be developed.

III. DESCRIBING THE WHAT: INTERVENTION

Using your completed Hexagon Tool as a starting point, describe the intervention that was chosen for the QIC-AG evaluable intervention including the following:

A. PHILOSOPHY, VALUES, AND PRINCIPALS

The philosophy, values and principals of the intervention and how the intervention's fit with current initiatives and values of the site (examples: families are experts about their children, children with disabilities have the right to be integrated into classrooms, culture sensitivity is critical to child welfare service delivery).

B. CORE COMPONENTS

- » The core components of the intervention (if core components do not exist, then note that the development of core components is needed). Core components are features of the intervention that must be present to achieve the intended impact (examples: use of modeling, practice, and feedback to acquire parenting skills, acquisition of social skills, and recreation and community activities with high functioning peers). If there are optional intervention components specified, please describe.
- » The research and theory that demonstrates that the core components support the theory of change. Core components should be grounded in research or theory that supports the theory of change.
- » The operationalized definition of each core component. Core components must be operationalized to ensure that they are teachable, learnable and doable and facilitate consistency across practice.
- » For the operationalized core components please describe any difficulties in execution that may arise.

C. MATERIALS

Any materials that are available to support implementation such as manuals, training videos, assessment instruments, etc.

D. FIDELITY

Any fidelity measures that have been created for the intervention. Please note if the fidelity measures have been positively correlated with better outcomes and if yes, what specific outcomes have been impacted.

E. ADAPTATION

A description of any adaptation or development work that will need to be done to ensure that the intervention meets the needs of the target population and any concerns that exist regarding this work. If adaptation

work is necessary please make sure to include this activity in the intervention specific work plan described in Section IV. B.

F. DEVELOPMENTAL PHASE OF THE INTERVENTION

Using the “Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare” developed by the Child Welfare Research and Evaluation Framework Workgroup (AKA the “flower”), determine within which phase the intervention falls.

IV. DESCRIBING THE HOW: IMPLEMENTATION SUPPORT

Once an intervention is selected it is important to know how the system will be readied to support service delivery. In this section describe the system’s exiting capacity to support service delivery, as well as work that needs to be done to develop supports that are not currently available. Please include discussion about any anticipated concerns and strategies for addressing them. Please note that any work that needs to be done to support the development of the implementation supports should be reflected in the intervention specific work plan (See Section IV. B.). Use information documented in your completed Hexagon Tool and Purveyor Interview Tool as starting point for this section.

A. IMPLEMENTATION SUPPORTS

- » **Staff:** Qualification of staff and other criteria needed to select, recruit, and retain staff as well as the number of staff needed. Any barriers to obtaining appropriate staff.
- » **Training:** Training curriculum and supervision or coaching plan, and the length of the training.
- » **Fidelity:** Measures and protocols to assess practitioner’s implementation of essential functions and core components.
- » **Policies and procedures:** Policies and procedures to support the new work; adaptations that are required and barriers to accomplishing this work.
- » **Data systems:**
 - » Required hardware and software or modifications needed to collect and manage information related to implementation (core components and fidelity measures). Anticipated barriers to accomplishing any modifications or acquisitions.
 - » Required hardware and software or modifications needed to collect and manage information related to short- and long-term outcome measures. Anticipated barriers to accomplishing any modifications or acquisitions.

- » **Leadership:** Current status of state, county, and local leadership buy-in and where further engagement may be needed.
- » **Community linkages:** Availability and quality of linkages to community resources if necessary to provide the intervention.
- » **Systems partners:** Availability of partners or collaborators, including those who are on board and those who are not yet on board (e.g., mental health, education, courts, substance abuse providers, other providers), and what is needed to engage these partners.
- » **Program experts:** Experts who have been engaged, or need to be engaged in the use of the intervention.

B. INTERVENTION SPECIFIC WORK PLAN

The intervention specific work plan will be incorporated into the site specific work plan. It is necessary to create a plan that delineates the developmental activities that need to occur before the first clients can be served. These tasks will support the modification or adaption of the selected evaluable intervention as well as the development of implementation supports. The work plan should support the site work plan submitted to QIC-AG leadership, but will likely be more detailed with respect to tasks and will focus only on the evaluable intervention. The following detail should be captured:

- » Activity
- » Responsible team
- » Start date
- » End date

V. DESCRIBING THE WHO: TEAMING AND GOVERNANCE STRUCTURE

Once you have determined the intervention and the necessary systems modifications, it is important to understand who will actually be responsible for the work that needs to be done. This section will capture the existing teaming structure and any additions/modifications that have been developed to ensure that the work can be completed. Please attach completed team charters as appendices.

A. TEAMING STRUCTURE

Review the existing teaming structure and charters for the PMT and Stakeholder Advisory Teams as well as any other teams that have already been developed. Make necessary modification to support implementation, including expanding the teaming structure. For example, develop an implementation team if not already in place.

B. TEAM CHARTERS

Develop team charters for newly defined team(s). A team charter describes the work a team will do, how the work will be done, and who on the team is responsible for the various work areas. The team charter should support the Intervention Specific Work Plan.

C. COMMUNICATION STRATEGIES

Detail the processes, procedures, and strategies for maintaining efficient and effective communication among leadership, staff, and partners who are:

- » Paid by the cooperative agreement
- » Members of a team as defined by the teaming structure

Critical to the successful implementation and utilization of the intervention (have an active role).

APPENDIX F

QIC-AG LOGIC MODEL: ILLINOIS



APPENDIX G

USABILITY TESTING PLAN AND TRACKING TOOL

