TENNESSEE

QIC•AG

TENNESSEE IMPLEMENTATION MANUAL

NEUROSEQUENTIAL MODEL OF THERAPEUTICS

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 contain 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 Neurosequential Model of Therapeutics (NMT) was implemented by a team of child welfare professionals from the Tennessee Department of Children's Services, Harmony Family Center, and the QIC-AG site consultants and evaluators, collectively referred to as the Tennessee Team. Tennessee selected the Neurosequential Model of Therapeutics (NMT) because the NMT approach met the need for a therapeutic assessment tool that could match the unique needs and strengths of a child with a therapeutic modality or intervention.

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 NMT was developed by Dr. Bruce D. Perry at The ChildTrauma Academy. The NMT is a developmentally informed and trauma-sensitive approach to working with at-risk children and their families. The NMT integrates principles from the neurosciences, developmental psychology, and a range of other disciplines to create a comprehensive understanding of a child, their family, and their broader community. Although the NMT is not a specific therapeutic technique or intervention, the model provides a way to organize a child's developmental history and current functioning to inform the clinical decision-making and treatment planning process. The NMT assessment helps the clinical team better understand the nature and timing of adversity and resilience-related factors during the child's development. This approach helps the parent, teacher, and clinician better understand the child's current functional strengths and needs.[1]

Additional information on NMT is available from The Child Trauma Academy.

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[1] Dinwoodie. A. (2019, April 4). Profiles in permanency: Improving stress response for adoptive parents. Retrieved from the Chronicle for Social Change Website at https://chronicleofsocialchange.org/featured/profiles-in-permanency-improving-stress-response-for-adoptive-parents/34296

II. INTERVENTION 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." The NMT Metrics are rooted in three core elements:

1.   **Assessment: Where the child has been**

2.   **Functional review: Where the child is now**

3.   **Recommended interventions: Where the child can grow**

CORE COMPONENT 1 AND 2:
ASSESSMENT AND FUNCTIONAL REVIEW

"The NMT assessment process is guided by a set of web-based tools also known as the NMT Metrics that help clinicians organize a child's history and assess current functioning. Such assessment is especially relevant to children who have *experienced* early trauma. The information gathered in the Metrics is used to identify various areas in the brain that may have functional or developmental impairments and ultimately helps guide the selection of the most appropriate, developmentally sensitive interventions for a child."[2]

[2] Dinwoodie. A. (2019, para. 8). Profiles in permanency: Improving stress response for adoptive parents. Retrieved from the Chronicle for Social Change Website at https://chronicleofsocialchange.org/featured/profiles-in-permanency-improving-stress-response-for-adoptive-parents/34296

CORE COMPONENT 3:
RECOMMENDED INTERVENTIONS

The NMT incorporates key principles of neurodevelopment into a capacity-building component for the NMT-guided clinical team. Clinicians, educators, caregivers, and if appropriate, clients, learn about the sequential development of the brain—from bottom-up and inside-out. This includes how the timing of stress, abuse, and neglect, as well as the intensity, duration and pattern (e.g., chaotic, unpredictable vs. predictable), affect the developing brain. This basic background in brain organization and neurodevelopment helps provide the rationale for the sequential therapeutic approach.

The brain develops from the bottom-up, that is from brain stem to cortex, processes sensory input from the bottom-up, and is most likely to "heal" from the bottom-up — especially if adversity in the client's development impaired typical brain organization and functioning. With this in mind, the NMT is rooted in the belief that therapeutic interventions should focus on repairing the brain from the bottom-up and provide a structured process to help guide the selection of interventions and track the effectiveness of those interventions. Treatment planning involves selection of the types of interventions (e.g., somatosensory dominant vs. cognitive dominant approaches), as well as the intervention "dosage" (i.e., intensity and duration) and pattern (e.g., daily, weekly).[3]

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[3] Dinwoodie. A. (2019). Profiles in permanency: Improving stress response for adoptive parents. Retrieved from the Chronicle for Social Change Website at https://chronicleofsocialchange.org/featured/profiles-in-permanency-improving-stress-response-for-adoptive-parents/34296

III. 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 NMT.

1. Staffing

The NMT assessment process is complex and requires professionals to complete a lengthy and rigorous training before they are approved to use the approach.

2. Training, Coaching, and Supervision

The ChildTrauma Academy (CTA) developed a set of training materials, supervised training experiences, and clinical practice tools to help clinicians develop their capacity to use the NMT with children and youth. The NMT training focuses on principles of neurobiology, traumatology, attachment theory, and other relevant areas to understand how maltreatment and trauma impact a child's development. The training includes the presentation of cases by clinicians and an introduction to the web-based NMT metrics.

There are several phases of NMT training. Phase 1 of NMT certification enables trained staff to utilize NMT with clients and requires approximately 14-20 hours of training time each month for 12 to 14 months. Although it will not be described here, Phase Two training affords an NMT provider the opportunity to train other staff. Monthly, staff were provided with an NMT learning plan that included the materials to be reviewed as a part of that month's module.

Fidelity

At any stage of the NMT Training Certification or Maintenance, staff are required to complete scheduled fidelity exercises, which are conducted once every 6 months.

3.   Policies and Procedures

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

4.   Data Systems

The NMT metrics are completed using a web-based portal supported by the ChildTrauma Academy.

5.   Program Expert

Staff from ChildTrauma Academy are available to provide expert technical assistance throughout the life of the project. NMT is supported by the ChildTrauma Academy (CTA), and the CTA team is accessible throughout implementation of the NMT approach, providing guidance when implementation issues arise. Certified Flagship Programs provide another resource for support during implementation.

6.   Financial and Material Considerations:

The financial costs of implementing NMT include the initial training costs and the ongoing costs for maintenance of counselors' certification. In addition, there is a charge to access the CTA portal where the NMT Metrics are completed. Contact the purveyor for cost information to ensure that your budget allows for initial implementation and on-going support.

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 topic:

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 Tennessee Team implemented the process, activity, or task; (d) lessons the Tennessee Team learned during implementation.

I. INTERVENTION CORE COMPONENTS
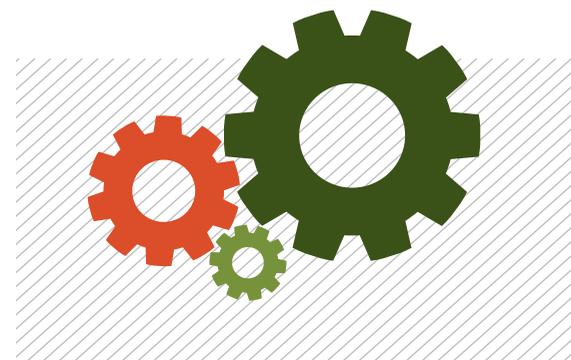
The NMT Metrics are rooted in three core elements:

1. **Assessment: Where the child has been**

2. **Functional review: Where the child is now**

3. **Recommended interventions: Where the child can grow**

CORE COMPONENTS 1 AND 2:
ASSESSMENT AND FUNCTIONAL REVIEW

The NMT has been described as follows:

> The NMT assessment process is guided by a set of web-based tools also known as the NMT Metrics that help clinicians organize a child's history and assess current functioning. Such assessment is especially relevant to children who have experienced early trauma. The information gathered in the Metrics is used to identify various areas in the brain that may have functional or developmental impairments and ultimately helps guide the selection of the most appropriate, developmentally sensitive interventions for a child.[4]

[4] Dinwoodie. A. (2019, para. 8). Profiles in permanency: Improving stress response for adoptive parents. Retrieved from the Chronicle for Social Change Website at https://chronicleofsocialchange.org/featured/profiles-in-permanency-improving-stress-response-for-adoptive-parents/34296

When considering how to obtain the information needed for the NMT assessment and functional review process, start with the following tasks:

» Review the type of information needed to complete the NMT Metrics and determine to what extent current assessment tools collect this information.

» Consider if historical information is accessible to staff completing the Metrics such as birth records, records of early childhood, birth family history and involvement, incidents of medical/psychological trauma, and documents regarding educational needs.

» Determine how existing assessment tools and processes could be enhanced to collect the information needed for the NMT Metrics.

» Consider creating standardized processes and tools to guide the data collection and documentation of information used to complete the NMT Metrics.

WHEN DETERMINING HOW TO SELECT FACILITATORS, START WITH THE FOLLOWING TASKS:

» Determine a process for facilitator selection that includes an assessment of the candidate's knowledge and skills.

» Consider the total assigned responsibilities for staff who will facilitate Pathway 2 sessions to ensure that facilitators will have the time needed to prepare for and deliver sessions.

Harmony Family Center expanded their existing comprehensive assessment to include information needed to complete the NMT Metrics. In addition to the comprehensive assessment, families are asked complete various assessment tools, including the Parent Feelings Form, the Behavior Problem Index, and the Belonging and Emotional Security Tool. Prior to finalization of adoption, families adopting through the Tennessee Child Welfare System should receive a Presentation Summary provided by their caseworker; this summary provides critical information regarding the child's history. The Family Counselor attempts to access this document and any other pertinent documents for inclusion in the child's ASAP case record. Parental interviews also aid in a more thorough understanding of the child's history and functioning — both past and present. All of this information is used by the Family Counselor to complete the NMT Metrics. The Metrics can be completed again after implementing the treatment plan to determine if there have been changes in the child's functional strengths and needs.

LESSONS LEARNED

» Consider creating a structured interview guide that combines all of the necessary questions to complete the NMT Metrics into one single document. Completing the NMT Metrics requires staff to collect and synthesize a significant amount of developmental history and current functioning information. If not documented consistently, the information gathered, particularly from caregiver interviews, might be lost or be inaccessible. This structured interview guide can ensure staff obtain all the information necessary to complete the NMT Metrics, reducing the need for follow-up calls to obtain additional information or clarification from the caregiver.

CORE COMPONENT 3:
RECOMMENDED INTERVENTIONS

The NMT is rooted in the belief that therapeutic interventions should focus on repairing the brain from the bottom-up and provide a structured process to help guide the selection of interventions and track the effectiveness of those interventions. Treatment planning involves selection of the types of interventions (e.g., somatosensory dominant vs. cognitive dominant approaches), as well as the intervention "dosage" (i.e., intensity and duration) and pattern (e.g., daily, weekly).[5]

WHEN DETERMINING HOW RECOMMENDED INTERVENTIONS RESULTING FROM THE NMT METRICS WILL BE INCORPORATED INTO SERVICE DELIVERY, START WITH THE FOLLOWING TASKS:

» **Create a process that ensures the NMT recommendations are incorporated into the treatment plan.**

» **Consider what resources are available to your agency to support the implementation of recommendations in the treatment plan that are derived from the Metrics.**

» **Consider how to monitor adherence to the recommendations over time.**

» **Develop a process to complete subsequent Metrics before case closure to determine progress over time.**

Based on the results of the NMT Metrics, individual clinicians determine which interventions will be incorporated into the individualized service plan. The service plan documents the intervention type, the frequency for providing the intervention, and the length of time over which the intervention should be delivered. While initially the Tennessee Team did not complete a second set of Metrics, completion of a subsequent set of Metrics was added into the process at case closure.

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[5] Dinwoodie. A. (2019). Profiles in permanency: Improving stress response for adoptive parents. Retrieved from the Chronicle for Social Change Website at https://chronicleofsocialchange.org/featured/profiles-in-permanency-improving-stress-response-for-adoptive-parents/34296

LESSONS LEARNED

» Consider educating staff about the benefits of the NMT, specifically educational and experiential activities that differ from traditional talk therapy. Staff using the NMT framework might need to shift their thinking toward understanding how interventions such as equine therapy and yoga, are a legitimate part of healing complex trauma. Because the NMT is rooted in the belief that therapeutic interventions should focus on repairing the brain from the bottom up, the initial treatment focus may be on sensory integration and self-regulation practices (e.g., drumming a drum, jumping on a trampoline). While these activities are essential, they can be misperceived by staff (or families) as not having as much sophistication or impact as cognitive-based interventions. This false perception can leave staff using the NMT approach feeling as though their work is not valuable or useful.

» Educating families about the NMT approach is critical to their participation. To ensure families will implement recommended interventions, the family needs to understand and buy-in to the science behind the NMT. The Harmony team developed a narrated PowerPoint presentation that provided an introduction to the impact of developmental trauma, the NMT Metrics, and the ways in which the Metrics inform the assessment and development of recommendations for the family. Family Counselors use the tool during their initial visits with the family.

» The NMT approach does not recommend specific interventions. The information gathered in the Metrics creates a visual representation of the functioning of the child's brain which is then used to help professionals select developmentally appropriate education, enrichment and therapeutic activities. It is important to recognize and accept clinical subjectivity in determining which specific therapeutic activities are offered to children and families, as well as the dosage of selected therapeutic activities.

» Having staff trained in a variety of treatment modalities supports the delivery of services that meet the youth's needs at various phases of brain development.

» Purchasing material supports is a good investment when using the NMT approach. Having the right materials at the ready can support the level of a family's adherence to recommendations. For example, Harmony has a sensory room available in their office, and their staff have access to a variety of portable sensorimotor tools. In addition, Harmony provided "sensory bags" to families.

» Remember that change takes time. It is important to consider the length of service delivery when examining the impact of the recommendations derived from the Metrics. Currently, the typical length of ASAP services in Tennessee is about 9 months, with some families engaging in additional services over longer periods. The NMT purveyor noted functional changes in the child are more likely to be detected after one year of service.

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 Tennessee Team implemented the process, activity, or task; (d) lessons the Tennessee Team learned during implementation.

I. 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 Tennessee 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 the Neurosequential Model of Therapeutics (NMT) 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).

In Tennessee, both the state system and the private agency providing services to the post-permanence population have robust data systems. Reports generated from these data systems helped the Tennessee Team understand their target population well.

To understand their population, the Tennessee Team first identified the children receiving adoption subsidy in Tennessee. The Team reviewed the findings of a 2014 survey of Tennessee adoptive families, which found that while the majority of families were committed to their child and confident they could meet their child's needs, 8% reported they had thought of ending the adoption. Forty-four percent reported that meeting their child's emotional or behavioral needs was more demanding than they had expected. With this data in mind, the Tennessee Team narrowed their population of children who had been adopted and who were referred (or self-refer) to Adoption Support and Preservation (ASAP) services in seven regions of the state: Shelby, East, Northeast, Tennessee Valley, Knox, Smoky Mountain, and Upper Cumberland. NMT services were offered to families who had adopted from the public child welfare system as well as families who had adopted through an intercountry or private domestic process. Through usability testing, the Team learned that it was essential for the parents and the child to be willing to engage in services. Therefore, families who refused to sign a Client's Rights and Responsibilities document were not eligible to participate in services.

The Tennessee Team's completion of the Continuum Assessment confirmed the presence of a robust service system. In addition, the assessment process provided a mechanism to review the implementation of other initiatives occurring simultaneously within the system, which allowed the Tennessee Team to explore the implications around the system's capacity to implement another initiative. Recognizing that Tennessee already had a strong service array in place that could be offered to families, discussions eventually led to thinking more about how the services already in place could be used more effectively.

LESSONS LEARNED

» Data systems that capture comprehensive data elements make it easier to understand the needs of your population. In Tennessee, data was utilized from the Statewide Automated Child Welfare Information System (SACWIS) and many other sources to inform system 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 Tennessee's case the Neurosequential Model of Therapeutics (NMT), should facilitate the change identified in the theory of change.

TENNESSEE THEORY OF CHANGE

There are children who have exited foster care through adoption or guardianship and are in crisis and at risk for discontinuity. In times of crisis, if Tennessee uses a family-centered trauma-informed bio-psychosocial assessment process to identify the needs of the child and family, then the most appropriate interventions will be identified. If Tennessee is able to identify the most appropriate interventions then they will be able to target the specific needs of the parents, guardians, and children. If the needs of the parents, guardians and children are addressed then there will be an improvement in the parents, guardians and children's ability to understand and manage crisis episodes and or lessen crises in the future. If crisis within the family is reduced then families will experience increased stability and be at a reduced risk of discontinuity.

A site can use the Tennessee theory of change to support the rationale for implementing the Neurosequential Model of Therapeutics, 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 selecting an effective intervention. By "peeling the onion," the Tennessee Team determined that a comprehensive assessment process was needed to identify what treatment approach or approaches would be the most beneficial to the family based on the child's history, current functioning, and areas of needed growth and development.

III. 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.[6] Using the Hexagon Tool to explore and ask questions in broad areas will help determine if the Neurosequential Model of Therapeutics 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?

As noted earlier, a robust post-permanency service system already exists in Tennessee, and despite the Tennessee Team's excitement and commitment related to implementing a new intervention, the Team had some concern about the extent to which system resources could handle the implementation of another initiative. When completing the Hexagon Tool, the Tennessee Team explored how existing regional and statewide initiatives aligned with the NMT, and determined the NMT was a good fit that would not overtax the available system resources. When considering readiness and capacity, the Tennessee Team was able to problem solve with the purveyor to expedite the training process to meet identified project deadlines.

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

[6] https://implementation.fpg.unc.edu/resources/hexagon-exploration-tool

✦ LESSONS LEARNED

» Do not rush through the Hexagon Tool. It is important to thoughtfully consider each category. Thinking through these 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 the intervention or that a site has a hiring freeze that prevents 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.

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.

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 Tennessee Team implemented the process, activity, or task; and (d) lessons the Tennessee 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.[7] Testa and Poertner have recommended the PICO framework, which requires careful articulation of four key components:[8]
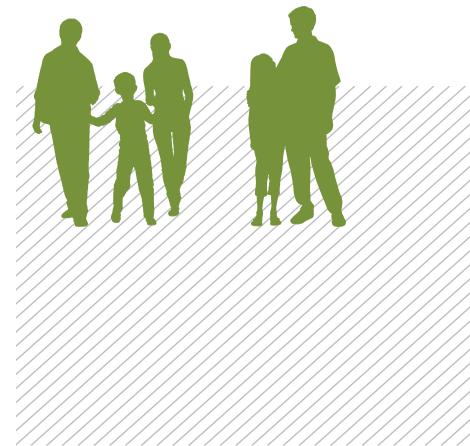
P   a well-defined target population;

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**

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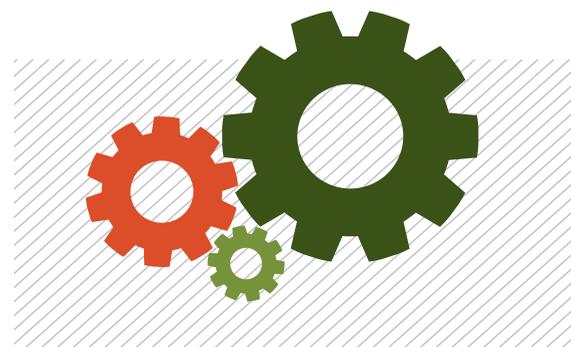
[7] Richardson, W., Wilson, M., Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, 123, A12.

[8] 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.[9] 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.

[9] 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 Tennessee project's research question:

Will children and youth who have been adopted and have been referred to the Adoption Support and Preservation Program (P) who receive the Neurosequential Model of Therapeutics (I) experience increased placement stability, improved child and family well-being, and improved child and youth behavioral health outcomes (O) as compared to children who are referred to the Adoption Support and Preservation Program in comparison counties who receive services-as-usual (C).

P **TARGET POPULATION:** The Tennessee site's target population included families with children who had been adopted and referred (or self-referred) to the Adoption Support and Preservation program's (ASAP) post-adoption services in the East, Northeast, Tennessee Valley, Knox, Smoky Mountain, and Upper Cumberland regions of the state. Initially, the Shelby region was also included in the intervention areas; however, the Shelby region was later excluded from the intervention when adequate staffing could not be secured in the region.

The intervention group did not include families without a finalized adoption, guardianship cases, or adoptive families who were seeking case management rather than in-home services. A key factor in providing services to families is the willingness of the parents and the child to engage in services. Therefore, families who refused to sign the client's rights and responsibilities document were not eligible to participate in services.

I **INTERVENTION:** Neurosequential Model of Therapeutics (NMT)

C **COMPARISON GROUP:** The comparison group was comprised of adopted children receiving services-as-usual, including assessment and referrals, who resided in a region of Tennessee where the NMT was not being offered. Specifically, during the data analysis stage, the Evaluation Team used propensity score matching to select children from the comparison regions who matched key characteristics of children in the NMT intervention group. The comparison group consisted of the following Tennessee Department of Children's Services regions: Northwest, Southwest, Mid Cumberland, South Central, and Davidson. ASAP services-as-usual were provided for post adoption crisis and non-crisis cases in the comparison or non-intervention regions.

O **OUTCOMES:** The Tennessee project's short-term outcomes are:

- » **Reduction in post-permanency discontinuity**
- » **Improved child and family well-being**
- » **Improved child and youth behavioral health**

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 Tennessee 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.

For all ASAP cases in Tennessee, the referral process is initiated when a Request for Services form is completed either by the adoptive parent or by a service provider on the behalf of the child/family. The ASAP Clinical Manager enters the information from this form into the ASAP online database, which uses an algorithm to designate a status of crisis or non-crisis. The Clinical Manager contacts the family within 24 hours of the initial request for services and makes a final determination of crisis or non-crisis status based upon parental report, severity of need, and risk of discontinuity. The case is then assigned to a Family Counselor who contacts the family within 24 hours to identify a date/time for the initial home visit. In the event that a family declines ASAP in-home services, the case is closed; if the Clinical Manager is unable to reach the family by telephone, a 10-day letter of intent to close the case is mailed to the family.

Clients who receive in-home services through the ASAP program receive a comprehensive initial assessment, an individualized treatment plan, case coordination and referrals to appropriate community resources as needed. After the initial consent paperwork is completed, the parent(s) are asked to fill out various assessment tools. If crisis stabilization is needed before proceeding, the routine tasks of completing the assessment tools and the initial assessment process are delayed until the second session. Completing the initial assessment is the focus of the first in-home sessions (typically, one to three sessions), generally occurring within 30 days of the first assessment session. An individualized, comprehensive treatment plan is developed and implemented within 30–45 days of the first in-home session. In-home services are typically provided on a weekly to bi-weekly basis for a period of 6 to 9 months (or an average of 20 -24 sessions). The length and frequency of services is customized to meet the unique needs of the client and family being served. Assessment tools completed during the initial assessment included the Belonging and Emotional Security Tool (BEST), Behavior Problem Index (BPI) and the Parent Feelings Form (PFF).

At the conclusion of services, the child and family are asked to complete post-tests (i.e., BPI, PFF, BEST). In the experimental regions, the Neurosequential Model of Therapeutics was added to the assessment and treatment planning process as described above.

Tennessee uses a universal outreach approach to inform new adoptive parents about ASAP services (via the ASAP brochure and in the Adoption Assistance agreement). During implementation of the NMT. DCS staff reached out to existing adoptive families receiving adoption assistance to ensure families were informed about their eligibility for ASAP services; these families were contacted via e-mail (2,300 families) and postal mail (2,700 families). DCS staff also expanded the ASAP contract to include mandatory adoption preparation training for families prior to the finalization of an adoption or the finalization of a guardianship agreement. Many families are transitioning directly from pre- to post-adoption services after finalization of their adoption.

LESSONS LEARNED

» Consider the impact of using proactive outreach methods to reach families for post-adoption services. Throughout the NMT project implementation, the ASAP program began experiencing an influx of referrals at higher than typical levels. This referral pattern was a result of a change in practice from a reactive approach to providing support to a proactive approach of making sure adoptive and guardianship families were aware of available services. Over time, additional staff were added to support increased service utilization.

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 initial assessment process, in place prior to the QIC-AG, provided the foundation for the Tennessee Team's data collection. The existing comprehensive assessment was modified to include questions related to commitment and parenting. In addition, adapted versions of the Belonging and Emotional Security Tool (BEST), Behavior Problem Index (BPI) and the Parent Feelings Form (PFF) were completed during the initial assessment. Based on the caregivers' preference, these measures were either mailed or e-mailed to the caregivers for completion along with other required paperwork included in the intake packet. The same measures were administered to the caregivers at the conclusion of ASAP service provision. Client satisfaction surveys were completed at three time points: discharge, 6-months post discharge, and 12-months post discharge. Short-term outcomes were tracked through qualitative data collection, specifically questions staff asked during the assessment process.

All data were de-identified before being submitted to the evaluator for analysis. The ASAP Consent to Care form, which caregivers signed at the initial intake session, covered all consent to treatment issues related to the NMT. However, it was later determined that consent was not needed because no identifying information was shared with the evaluator.

LESSONS LEARNED

» Do not assume that completing assessment tools will be too burdensome. Although the Tennessee Team had some concerns about the impact of completing the assessment tools on caregivers and staff, the completion rates for the PFF, BPI and BEST were satisfactory. During the initial implementation that involved 39 families who completed the assessment forms, only one family indicated dissatisfaction with the process.

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**
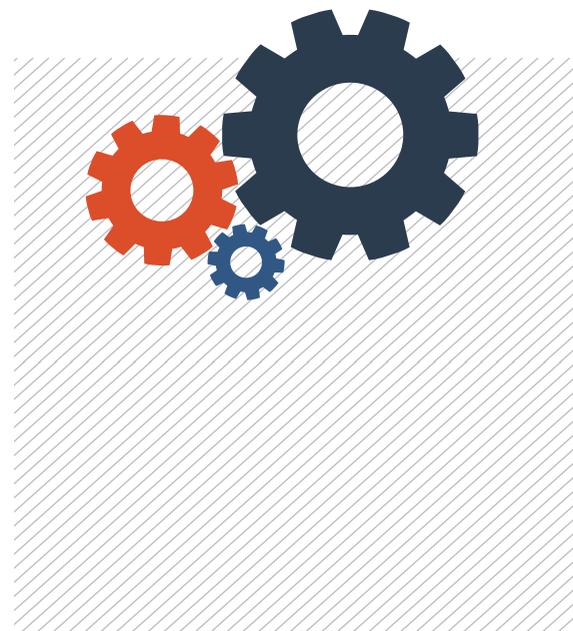
1. STAFFING

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 agency's experience with staff turnover and retention before making the investment in staff time and cost.

The NMT assessment process is complex and requires professionals to complete a lengthy and rigorous training before they are approved to use the approach. Tennessee's Implementation Team considered the range of skills and abilities as well as the aptitude for learning that a family counselor would need to successfully implement the NMT. The Implementation Team concluded they could use existing Harmony Center staff to administer the NMT because the Harmony staff held advanced degrees, had clinical training, and had demonstrated their capacity through their current responsibilities with Harmony. Ultimately, the NMT was set up to succeed because it was equipped with well-qualified staff. When new staff needed to be hired, Harmony looked for people with a passion for working with children affected by trauma, who were flexible thinkers, and who had intellectual curiosity. Harmony conducted a two-phase interview process to gauge the quality of the potential staff person. Although no written protocol exists, over time the team informally added questions to the interview process to better understand the person's ability to be flexible, to work creatively, and to determine their knowledge of sensory-motor interventions.

✦ LESSONS LEARNED

» Using existing staff in a new intervention might seem like an easy solution, but only if the staff are the right fit for the intervention.

» Consider strategies that can protect the investment made in training staff. Given the investment in staff time and dollars needed to complete the NMT training, staff who participated in training were required to sign a non-compete contract.

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.

» Consider the time and resource investment that will be needed, including the extent to which your system can accommodate having fewer staff available to see clients during the training and capacity building phase.

» 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.

The ChildTrauma Academy (CTA) developed a set of training materials, supervised training experiences, and clinical practice tools to help clinicians develop their capacity to use the NMT with children and youth. The NMT training focuses on principles of neurobiology, traumatology, attachment theory, and other relevant

areas to understand how maltreatment and trauma impact a child's development. The training includes the presentation of cases by clinicians and an introduction to the web-based NMT metrics.

NMT training began with a 2-day "boot camp" delivered by Dr. Bruce Perry. The boot camp was designed to expose staff to an overview of NMT, key NMT principles, and online resources to ensure trainees were comfortable with the self-directed learning opportunities that characterize Phase 1 of the NMT training curriculum.

Phase 1 of the NMT certification requires approximately 14–20 hours of time each month for 12-14 months. Each month staff were provided with an NMT learning plan that included the materials to be reviewed as a part of that month's module. During the QIC-AG implementation of NMT, Tennessee made 14 months the standard length of training. The longer time frame gave the counselors an opportunity to take breaks from formal study, allowing the material to "sink in" while they integrated the practices into their work. The reflection time proved to be so beneficial that the NMT purveyor adopted the 14-month time frame for future training.

Coaching occurred in two forms as part of the NMT training process. At the end of each month, the learning period culminated with an internal Harmony staff person leading a group phone call and a subsequent mentor phone call with members of the learning group and Dr. Bruce Perry. These calls are intense and require significant preparation time. To help the counselors/trainees prepare, the Tennessee Team created an internal learning/study group that met monthly to reinforce the concepts and content covered during the previous weeks. Led by the Harmony training director, the sessions created a forum in which trainees could share comments, raise questions, and voice concerns about the NMT curriculum. In addition, the counselors/ trainees could reach out at any point via phone or e-mail to the training director and their direct supervisor to ask questions or voice concerns about the training. The Harmony counselors reported this combination of study group and open communication was a helpful and worthwhile part of the learning process that enabled them to discuss concepts and areas in which they need additional support or direction.

LESSONS LEARNED

» A dedicated staff person to guide, support, and administer training and coaching activities makes the substantial training requirements more manageable. Although the ChildTrauma Academy provides comprehensive training materials and guidance, the implementing agency has to organize and manage a considerable amount of complex material. One example was the "micro-agenda" that the Harmony training director developed for each month. In one or two pages, each month's micro-agenda laid out all the work to be done and links to the online materials. The Harmony training director also made the curriculum materials easily accessible in printed form and, whenever possible, available for download. These considerations created greater flexibility for counselors/trainees, allowing them to more easily study the content when and where they had time.

» Provide an incentive for staff to participate in the workload associated with the learning process. For example, the work involved in completing assignments, participating in learning group meetings, and attending mentor calls with the NMT purveyor were all activities required above and beyond a Family Counselor's regular job duties. Staff were permitted to bill for their time on these activities as an incentive to offset the impact of the overage of hours and time required to complete NMT certification requirements.

» Counselors need time to gain the experience to become adept and gain fluency in delivering an intervention. Tennessee added more layers of support (reduced work hours, flexible work hours, allowing additional time to complete training) for the Family Counselors while they underwent the training to ensure that trainees successfully completed certification. Certification ensured counselors were prepared to hold true to the NMT approach.

» Reduced caseloads can help to mitigate the intense work related to learning and integrating complex interventions into the service delivery process. The Tennessee Team discussed the necessity of reducing the NMT family counselor's caseload size through the end of Phase 1 of the NMT training. The Team ultimately decided to limit NMT counselors' caseloads to 12-14 cases, instead of the full 14-17 caseload they carry when not engaged in training.

» Supervision needs may change when implementing new interventions. The Tennessee Team determined that more supervision was needed for staff who were newly trained to provide NMT. While the staff were well trained, it takes a long time to solidly integrate the new concepts into practice. Supervision is critical to ensuring that this integration happens. As a result, Harmony had to re-think its structure and staffing related to supervision.

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.

Fidelity measurement for the NMT involves monitoring clinician competency on a bi-annual basis. To ensure interrater reliability, all NMT-certified clinicians as well as those in the process of certification are required to score cases using the NMT online clinical practice tools. Measuring fidelity for adherence to the service plan and the engagement of the therapeutic web is less well defined. The Tennessee Team developed a systematic way to monitor adherence to recommendations, creating a calculation to rate adherence as *low*, *medium* or *high*. Ratings were based on clinical efficacy, not on the family's ability to take the action.

LESSONS LEARNED

» Understanding all components of fidelity is important. The Tennessee Team was initially focused on fidelity exercises related to the use of the NMT Metrics, and did not initially examine fidelity at the client/family level. As implementation progressed, the Tennessee Team realized that additional protocols were needed to ensure fidelity to recommended interventions.

> » A monitoring process is necessary to ensure recommended interventions are implemented, achieved, and the subsequent NMT Metrics completed. Initially, recommended interventions were not tracked and post services Metrics were not completed. Subsequently, a standard format and process was developed for staff to enter notes related to NMT Metrics recommendations and dosages into the CTA Dashboard (a Web-based platform hosted by the ChildTrauma Academy that collects Metrics information generates reports used to develop recommendations). Protocols were put into place to ensure that subsequent Metrics were completed at case closure.

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 Tennessee Team followed Harmony's existing internal process for the creation and/or modification of policies and procedures for the use of the NMT or other assessments related to the QIC-AG project. The Tennessee Team made changes to the initial assessment procedures and intake processes (changes to the time frames for

completion of the initial assessment and treatment plans). Changes in policy that were solely related to NMT were pursued when it became clear that the Tennessee Team would be sustaining the intervention. Examples of NMT-specific policy changes included implementation of protocols around incorporating recommendations from the Metrics into the treatment plan and monitoring adherence to these recommendations.

LESSONS LEARNED

» It is important to have written procedures that define and operationalize how staff should translate the NMT recommendations into the child and family's service plan. This document will help ensure that the therapeutic activities based on the child's specific developmental stage and physiological needs are recommended as supported by the Metrics. While the intention of using the NMT approach is that the process leads to the identification of a set of recommendations that can be incorporated into the service or treatment plan, Harmony did not have a formal protocol in place to guide this process. As a result, it was difficult to determine how the recommendations were operationalized in the service plan as well as to determine the level of utilization by families.

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.

» 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 Tennessee Team used the ASAP database as well as the ChildTrauma Academy Web portal to capture the Metrics data and produce recommendations for treatment plans. Using the existing ASAP system with modifications, rather than building a new data system from scratch, meant that staff were familiar with the platform and many of the elements. Staff were given access to the ChildTrauma Academy database early in the training process so that they could begin to become familiar with the CTA database and platform.

LESSONS LEARNED

» When modifying an existing database, it is important to consider both the workload and cost associated with such changes. Once the Tennessee Team had made decisions regarding the modifications to the comprehensive assessment, the data team worked with a contractor to make the corresponding changes to the ASAP database. This step was a challenge from both a workload and cost perspective.

» Careful consideration is needed when developing or modifying a database so that the collection of data meets program goals while not becoming overwhelming to users. The process of determining the content/components of the initial assessment uncovered a dichotomy between the data needed for evaluation and outcome monitoring and the data needed for service delivery. The Tennessee Team worked toward a balance that would serve both of these needs.

» Familiarizing staff with data systems as early as possible and providing staff with support around the functions of the data systems being used is a step that cannot be overlooked. Despite being familiar with many elements of the ASAP data system, it still took some time to get everyone "up to speed" on the modifications to the platform. The Tennessee Team found it was important to emphasize why capturing the additional elements in the data system was important for clients, the success of the NMT, and for the NMT evaluation.

» Allow sufficient time to develop and test data collection systems. The Tennessee Team found that it took longer than anticipated for all aspects of the database to become functional. The Team identified system bugs and other fixes needed, and communicated these issues to the database developers so that they had the information necessary to expediently fix the problem. After original changes were made to the data collection platform, there were ongoing discussions with the system users to ensure utility.

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.

As the purveyor of the NMT, Dr. Bruce Perry was aware of and supportive of Tennessee's desire to pursue the NMT training and certification process for clinicians within the ASAP program. Dr. Perry was available to provide expert technical assistance to the Tennessee Team throughout the life of the project. NMT is supported by the ChildTrauma Academy (CTA), and the CTA team was accessible to the Tennessee Team throughout implementation of the NMT approach. CTA provided guidance when implementation issues arose. The Tennessee Team also made connections with NMT-Certified Flagship Programs, which provided another resource for support during implementation.

LESSONS LEARNED

» Working with a flexible and accessible purveyor can strengthen the implementation of an intervention. Dr. Perry and CTA were willing to work with the Tennessee Team to expedite the

training process by offering a shorter, more intense training session to kick off Phase I training (referred to as "boot camp") to meet identified project deadlines. Purveyor flexibility regarding the established time frame for certification was helpful; the NMT certification process was formally modified to incorporate 2 months of reflection, throughout the training process, to allow the NMT trainees an opportunity to apply concepts they were learning before tackling new material in the NMT curriculum.

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.

The financial costs of implementing NMT include the initial training costs and the ongoing costs for maintenance of counselors' certification. In addition, there is a charge each time a clinician completes the NMT Metrics, which are accessed in a web-based system called the CTA Portal. In addition to the expenses related to the NMT, Harmony incurred other expenses for supports that they decided would strengthen staff implementation of the NMT approach, such as Eye Movement Desensitization Reprocessing (EMDR), equilateral equine training, and yoga certification. ASAP staff were provided access to a variety of portable sensorimotor tools (i.e., body socks, resistance bands, yoga balls, weighted blankets) that could be easily transported and used with clients during in-home sessions. Harmony also provided "sensory bags" for children which included a water timer, fidget cube, stress ball, Bendeez stick (a flexible, rubber-coat bendable sensory tool), and marble mesh fidget.

LESSONS LEARNED

» It is important to consider the costs associated with implementation and ongoing use of the NMT to ensure the viability of sustaining the program over time.

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.

Tennessee DCS has long understood the need for services to post-adoption and guardianship families. This commitment to service access created the context needed for successful implementation of the NMT. Tennessee DCS and Harmony have a long-standing partnership and successful track record of jointly supporting service delivery to the target population through special projects, contracts, and general collaboration. The NMT implementation was boosted by the considerable resources the Harmony Family Center brought to the project, including fiscal, legal, technical, and human resources. Tennessee DCS administrators and Harmony leadership demonstrated a strong commitment to understanding how the system can improve upon what was already a respectable track record of supporting post-adoptive children and families. Tennessee DCS administrators and Harmony leadership participated in quarterly project management meetings, informed discussions about ongoing needs, and contributed ideas to increase capacity and market the program more broadly.

LESSONS LEARNED

» The implementation of a complex intervention requires leadership that can cultivate relationships with stakeholders and manage the strain of systems change. The collaboration between the Tennessee DCS and Harmony Family Center provided the leadership and support needed to ensure the success of the project by providing the necessary fiscal, database, human resources, legal, and technical resources.

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 Tennessee Team made purposeful efforts to cultivate relationships with community providers and to foster relationships between providers and families. Staff of the ASAP program served on several boards and committees in their respective communities, and regularly presented NMT trauma-informed workshops at local and statewide conferences. The Tennessee Team also developed trauma-informed materials and resources to help build partnerships with teachers, doctors, occupational therapists, speech therapists, and other professionals who serve children.

LESSONS LEARNED

» Internal collaboration and outside partnerships can increase impact. Services to address child-specific needs often straddle medical, education, and human services systems. To better serve these families using the NMT model, the Tennessee Team leveraged existing relationships among child welfare providers and community entities so that the NMT could reach more families. The Tennessee Team's ongoing involvement in community events and dissemination of information about ASAP services helped bolster the therapeutic web and institutionalize new practices and new ways of approaching work with families.

# III. WHO WILL DO THE WORK: TEAMING AND COMMUNCATION

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**
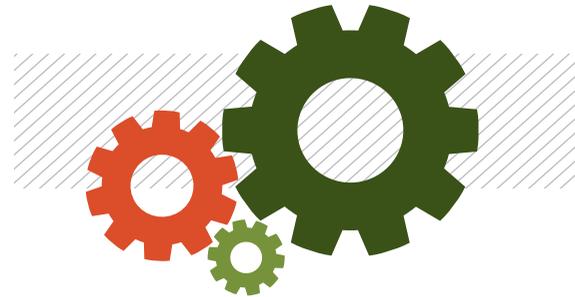
1. TEAMING STRUCTURE

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 Tennessee 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 Tennessee 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.

The Project Management Team (PMT) guided installation and implementation of the NMT approach in Tennessee. In Tennessee, the PMT consisted of a variety of professionals from Harmony and Tennessee DCS. An Executive Management Team provided approval authority for PMT decisions impacting the child welfare system. A key leader was identified as the PMT liaison to the Executive Management Team. Decisions affecting external stakeholders were vetted to the Stakeholder Advisory Team (SAT). The SAT consisted of foster and adoptive parents, community stakeholders, and representatives from private providers of adoption services. The SAT provided helpful feedback on the project's theory of change and identification of the problem statement. Over time, the PMT and SAT meetings were combined, and attendance dwindled. The Implementation Team (IT) consisted primarily of staff from Harmony who oversaw the day-to-day elements of installation and implementation. These teams communicated regularly.

LESSONS LEARNED

» Project teams with clear expectations and direction have the potential to leverage resources to support the intervention both initially and as the intervention evolves over time. The Tennessee project teams did not add new members as the work progressed, and SAT members became less engaged over time.

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 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.

A communication plan was added to the site work plan to identify the various levels of communication within the project to include what is being communicated, to whom, the target of the communication and achieved goal date, and the mode of communication (e.g., white papers, team meetings, newsletter).

LESSONS LEARNED

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

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 Tennessee Team implemented the process, activity, or task; and (d) lessons the Tennessee 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.

When the Tennessee Team began using the NMT for all eligible cases in the intervention regions of the project, ASAP implemented the use of the new initial assessment process (i.e., comprehensive assessment, pre-

assessment measures, and presentation summaries) on a statewide basis. During the usability testing, the Tennessee Team monitored timeframes around the completion of the comprehensive assessment and additional measures as well as the time that it took to complete the NMT Metrics and treatment plan. Usability testing also allowed the Tennessee Team to assess whether families would complete the packet of assessment tools, which included the Parent Feelings Form, the Behavior Problem Index, and the Belonging and Emotional Security Tool.

The Tennessee 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 determination that the time frame of 30 days for the completion of the initial assessment and the NMT Metrics was not long enough. Given the amount of information that must be gathered and integrated (including the presentation summary) the staff felt they needed more time. After some discussion, it was determined that the NMT Metrics (along with the treatment plan) could be completed within 45 days after case opening.

The Usability Testing Plan and Tracking Tool 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 the tracking of changes made a result of the usability testing (Appendix G).

LESSONS LEARNED

» It was important to critically assess the processes and procedures of each component of the NMT approach with a limited cohort at first, to ensure that the processes worked. This allowed the Team to make a number of modifications prior to full implementation that improved the effectiveness of the intervention.

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 Tennessee Team implemented the process, activity, or task; (d) lessons the Tennessee 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 Tennessee Team used the work plan to maintain focus on the necessary tasks and established time frames 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

- » A work plan keeps a project team organized and focused. At a minimum, the Tennessee Team reviewed the work plan each quarter; however, during periods with 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: The Neurosequential Model of Therapeutics (NMT)

E. Initial Design and Implementation Plan

F. Tennessee Logic Model

G. Usability Testing Plan and Tracking Tool

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., rehoming) 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?

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/statues 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 or 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?

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 OF 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 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.

HEXAGON TOOL: THE NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT)

D HEXAGON TOOL: THE NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT)

NEED – HOW WELL DOES THE PROGRAM OR PRACTICE MEET IDENTIFIED NEEDS AS DESCRIBED IN THE TOC

GUIDING QUESTIONS

» How well does this program address the identified needs around child preparation/readiness?

› Based on what factors?

» How well does this program address the identified needs around parent preparation and support?

› Based on what factors?

NOTES

In Tennessee, there are children who have exited foster care through adoption or guardianship whose families are in need of services and may be at risk for discontinuity because there is not a comprehensive process that assesses, identifies and links families to the most appropriate type of intervention to address problem or issues. This includes families who are in crisis or at risk of crisis. *(Tennessee's Problem Statement)*

If Tennessee uses a family centered trauma informed, bio-psychosocial assessment process to identify the needs of the child and family then the most appropriate type of intervention will be identified, families will be linked to the most appropriate intervention to address their needs, and families will have the knowledge and skills needed to effectively manage issues or problems when they arise to increase placement stability and reduce the risk of discontinuity. *(Tennessee's Theory of Change)*

To address the need for a comprehensive assessment, Tennessee has identified and will implement, as an intervention, the Neurosequential Model of Therapeutics (NMT). The Neuro-Sequential approach is a neuro-developmentally informed, biologically respectful perspective on human development and functioning. The

Neurosequential Model of Therapeutic uses this approach in the clinical problem solving process. NMT is not a specific therapeutic technique or intervention; it is a way to organize developmental history and current functioning to inform neurodevelopment, developmental psychological, traumatology, sociology, and a range of other disciplines to create a comprehensive understanding of the child, family, and their broader community. *(NMT Training and Certification for Institutions and Organizations; CTA website)*

NMT aims to assess the child or young person's developmental capacity; identify the areas where the brain functioning has been negatively affected as a result of trauma or maltreatment; and makes recommendations which allows influential people involved in the young person's life (home, school, community) to positively work with them. *(UnitingCare Children, Young People and Families – February 2011)*

The goal of the NMT approach is to structure the assessment of the child, articulation of the primary problems, identification of key strengths, and application of interventions (educational, enrichment and therapeutic) in a way that will help family, educators, therapists, and related professionals best meet the needs of the child. *(Perry & Hambrick, Reclaiming Children and Youth)*

Incorporating targeted, timely, developmentally appropriate treatment, planning, and care in all aspects of the young person's life, creates a developmentally sensitive, trauma informed environment where the child and family can heal and thrive.

Implementing NMT will provide us with the tools necessary to meet the needs of children and families and reduce their risk of discontinuity post adoption/guardianship finalization.

SCORE [5 POINT RATING SCALE. HIGH=5, LOW=1]: **5**

FIT – DOES THIS PROGRAM OR PRACTICE FIT WITH CURRENT STATE AND/OR LOCAL INITIATIVES, PRIORITIES, OR OBJECTIVES?

GUIDING QUESTIONS

» To what degree does this program or practice align with current state agency initiatives, priorities, or objectives?

> › Specify the initiatives where you see alignment.

» To what degree does this program or practice align with local regional initiatives, priorities, or objectives?

> › Specify the initiatives where you see alignment.
> › Discuss fit with strategic plan.

NOTES

Currently, the Tennessee Department of Children's Services is engaged in various regional and statewide initiatives (KEEP, Transform, Harmony Adoption Training, and CASE) that align with the vision and mission of the QIC-AG project to develop evidence-based models of support and intervention in order to achieve long-term, stable permanency in adoptive and guardianship homes pre and post adoption and guardianship finalization. These initiatives also align with Neurosequential Model of Therapeutics (NMT) intervention that Tennessee has selected as our focus for the Intensive Interval in the QIC-AG project. The intervention selection supports placement stability post adoption or guardianship finalization through comprehensive developmentally sensitive assessment, training, education, services to the child, family, and other supporting adults and professionals involved in the child's life (home, school, and community). These supports and services are designed to reduce the risk of discontinuity, increase family resiliency, and increase post permanence placement stability.

KEEP: KEEP is statewide foster care support program offered by the TN Department of Children Services designed to increase placement stability by teaching foster parents evidence based tips and techniques that will assist them in working successfully with foster children placed in their home and reduce challenges that lead to disruption. Although this initiative focuses on foster care placement stability, in situations where reunification cease to be a viable option, and adoption or guardianship becomes the permanency goal, the techniques and skills gained through the KEEP program could translate into better placement stability outcomes for children pre and post adoption or guardianship finalization, since over 80 percent of the children adopted or exit foster care via guardianship achieve permanency with their foster family.

Harmony Adoption Competency Training: Harmony Adoption Competency Training is an adoption preparation training offered statewide to adoptive families in Tennessee. The goal of the training is to prepare and expand the knowledge base of adoption and guardianship families to better prepare them to manage issues or behaviors that lead to crisis, ultimately reducing the risk of post permanency discontinuity.

National Adoption Competency Mental Health Training Initiative: The National Adoption Competency Mental Health Training Initiative (NTI) is a federally-funded cooperative training initiative intended to:

» Build the adoption competent mental health capacity of child welfare professionals and mental health practitioners that serve youth moving toward permanency through adoption and guardianship as well as youth who are already in adoptive or guardianship families

» To improve the well-being outcomes for these children by addressing their mental health needs, providing support and the appropriate therapeutic interventions to assure stable and secure post-permanency experiences for these youth.

SCORE [5 POINT RATING SCALE. HIGH=5, LOW=1]: **5**

RESOURCES – WHAT EXISTING RESOURCES AND SUPPORTS COULD BE LEVERAGED TO SUPPORT THIS PRACTICE OR PROGRAM?

GUIDING QUESTIONS

» To what degree could existing resources and supports be leveraged to implement this intervention?

» Consider the following leverage points:

> Public vs private agency

> Training resources

> Legislation or regulations that support or would need waived or adapted?

> State data systems

> Technology supports

> Human resources/staffing (at regional and local level)

> Other

NOTES

With the implementation of the Neuro-Sequential Model, there should be an adequate amount of existing resources, between the Department and Harmony Family Center, to support the practice/program. There will be a pool of staff from Harmony and TN DCS that we would want to build expertise and knowledge within, including ASAP Clinicians, DCS Psychologists, and Permanency Specialists to mention a few. The training resources to develop expertise in the NMT and direction on use are expected to be shared by the Department and Harmony in conjunction with the purveyor of the model. Any additional or long-term support to users and Subject Matter Experts (SME's) would need to be agreed upon at the time of implementation.

As a part of the planning and implementation phase, decisions will be made on on how to complete and house the instrument. It is our understanding that the NMT assessment tool can be completed on-line from the NMT website, scored, printed, and used for discussion with the child and family and their supports. The idea of using or getting a "print out" of the tool is similar to the Department's use of the CANS instrument, where there is an expectation to communicate the findings of the assessments with the child and family team. By using the NMT tool, there will not be a need to leverage any state data system or technology supports to integrate the tool into the Department's SACWIS system. We would want to work with the owner of the tool to determine reporting capacity and what type of reports would be helpful to the agency.

The development of policy, process, and procedures would be undertaken by DCS and Harmony staff so that clear expectations and guidelines are in place to support the completion and use of the tool by staff. For use with families post-adoption, the Department would work with Harmony to develop policy and procedure; but at a later time, the Department may want to consider use of the tool during the pre-adoption phase, which would be the sole responsibility of TN DCS. It is not expected that pre-adopt use would occur prior to completion of the QIC-AG project.

SCORE [5 POINT RATING SCALE. HIGH=5, LOW=1]: **5**

EVIDENCE – WHAT IS THE EVIDENCE OF POTENTIAL BENEFITS OF THIS PRACTICE OR PROGRAM?

GUIDING QUESTIONS

» What research or evidence exists to demonstrate the benefit of using this intervention?

» Are there examples of other jurisdictions that have used this intervention with the target population that we have identified?

NOTES

There are multiple sets of outcome data from various programs and sites that have introduced the NMT. Some of the data has been presented in various peer-reviewed venues (e.g., professional meetings, dissertations, journal publications, edited conference proceedings) but much of it remains as part of the institutions internal QI/QA process and outcomes. As more individuals and sites become certified, the number of independent evaluations is increasing. The general findings – both subjective and objective- are that the NMT is a useful, practical and effective way to help create and implement "trauma-informed" clinical practice. *(FAQ Article – NMT Implementation and Site Certification Information; Child Trauma Academy website)*

The Neurosequential Model of Therapeutics is an evidence-based practice (EBP), which currently meets criteria for Level III, Level II-3, Level II-2, and Level II-1 based on the various rankings indicating how much "evidence" on the effectiveness of a particular treatment or approach. Additionally, there have been numerous studies conducted with regard to the NMT - particularly within the past 5 years.

The NMT is being used with a wide range of clients – ranging from early childhood to adults. To date, more than 1000 clinicians and over 50 organizations and programs throughout the U.S. and abroad have completed the NMT Certification Process and are using the NMT metrics.   Using the NMT metrics, certified clinicians demonstrate high fidelity and interrater reliability when "evaluating" and scoring the same client data. *(Article: Overview of the Neurosequential Model of Therapeutics; CTA website)*

The CTA has worked with multiple sites to collect and report outcomes. A multi-site, multi-year review of restraint/critical incident rates (9 sites in 7 states and 3 countries) over a multi- year process shows a significant and persisting improvement (60%) following the introduction and implementation of the NMT. *(FAQ Article – NMT Implementation and Site Certification Information; CTA website).*

The cost effectiveness data based on the review mentioned above indicates there was a significant financial savings ($1,478,235) from the reduction in restraints as a result of NMT implementation. It would be advanta-

geous to have access to cost effectiveness data from jurisdictions that are more closely aligned to Tennessee's target population (i.e. children who exited foster care to a familial setting via adoption or guardianship).

Below are examples of jurisdictions where the NMT is being used with maltreated children, however Tennessee's target population is specific to children (and the families who are caring for those children) who have exited foster care through adoption or guardianship.

» Illinois (via the Board of Education and DCFS)

» New Mexico (via Health and Human Services)

» Norway (via their Regional Trauma Centers)

» Franklin County, Ohio

While the populations served in the areas identified above most likely include some children and families who have experienced adoption or guardianship it was not the main common denominator as is the case in Tennessee.

SCORE [5 POINT RATING SCALE. HIGH=5, LOW=1]: **5**

READINESS – WHAT IS OUR STATE'S AND/OR LOCALS' LEVEL OF READINESS TO IMPLE-MENT/REPLICATE THIS PRACTICE OR PROGRAM?

GUIDING QUESTIONS

» Do we have access to program developer/purveyor?

NOTES

Dr. Bruce D. Perry, MD, PhD, is a world-renowned psychiatrist and researcher in the area of neuroscience and trauma with specific emphasis on children who have experienced maltreatment and trauma. His work in this area culminated in the development of the Neorosequential Model of Therapeutics. Dr. Perry is the Senior Fellow of The ChildTrauma Academy and adjunct professor in the department of psychiatry and behavioral sciences at the Feinberg School of Medicine at Northwestern University.

As the developer and purveyor of the NMT, Dr. Perry is aware of and supportive of Tennessee's desire to pursue the NMT training and certification process for TN DCS staff and clinicians within Harmony's ASAP Program. The purveyor has indicated a willingness to work with our staff to expedite the training process in order to meet identified project deadlines. Additionally, the purveyor would be available to provide expert technical assistance to the Tennessee team throughout the life of the project.

GUIDING QUESTIONS

» Are there mature sites that have used the intervention/program?

» How many places has the program been replicated?

» What support exists within the local area for this program/practice? At the staff, supervisory, administrative level?

NOTES

The following are mature sites that have attained the NMT-Certified Flagship Program status as per the CTA (Child Trauma Academy) website.

Mount Saint Vincent Home: Denver, Colorado

www.msvhome.org

NMT Clinical Contact Person: Kirk Ward

Contact Email: kward@msvhome.org

Alexander Youth Network: Charlotte, North Carolina

www.alexanderyouthnetwork.org

NMT Clinical Contact Person: Joe Heritage

Contact Email: jheritage@alexanderyouthnetwork.org

It would be highly beneficial for Tennessee's team to pursue contact with the sites listed above to discuss their experience with the NMT specific to implementation, outcomes, and replication. The NMT has been replicated in over 30 sites throughout the world.

SCORE [5 POINT RATING SCALE. HIGH=5, LOW=1]: **5**

CAPACITY – WHAT IS OUR STATE'S AND/OR LOCALS' CAPACITY TO IMPLEMENT PRACTICE OR PROGRAM?

GUIDING QUESTIONS

» Does our state agency have sufficient foundational staff competency to implement this practice?

NOTES

TN DCS in partnership with Harmony's ASAP Program have a statewide pool of seasoned clinicians who have a solid knowledge base in numerous EBT's including ARC, TBRI, and TF-CBT. A minimum of a Master's degree in social work, counseling or a related field is required of all ASAP clinicians. Additionally, both TN DCS and Harmony have a sufficient pool of support staff (i.e. IT, data analysis, administrative, etc.) as well as key leadership to assist with implementation.

GUIDING QUESTIONS

» Are there any staff qualifications that are need for the program or practice that will be challenging to secure?

NOTES

Depending on the scope of the geographic implementation area and in preparation for greater capacity building potential, it may be necessary to identify and secure additional Master's level ASAP clinicians to be trained in the NMT.

The training and capacity building component (i.e. certification process) of NMT involves a minimum of 90 hours. Certification incorporates didactic teaching with web based sessions using clinical cases presented by participating clinicians. The purveyor has indicated the NMT training and certification process can be expedited, which will be necessary In order to ensure implementation by the identified goal of June 2016.

GUIDING QUESTIONS

» To what extent do we believe that youth would "buy-in" to this program/practice?

» To what extent do we believe that parents "buy-in" to this program/practice?

NOTES

It is anticipated that there will be a moderate to high level of "buy in" to incorporation of the NMT from children, youth, adoptive/guardianship families, and practitioners. Currently, there are no providers in Tennessee (individually or organizationally) who are utilizing the NMT approach of offering a developmentally sensitive, neurobiology-informed approach to clinical problem solving. It is expected that practitioners would readily embrace the opportunity to enhance their therapeutic approach and comprehensive understanding of children served by incorporating the NMT.

Additionally, the NMT approach necessitates the involvement of everyone who is influential in the child's life (i.e. parents, caregivers, teachers, therapists). By expanding the number of people who are providing positive, nurturing interactions with the child, the weight of responsibility that rests solely on the parent or caregiver may decrease resulting in reduced individual and familial stress as well as the risk for discontinuity.

SCORE [5 POINT RATING SCALE. HIGH=5, LOW=1]: **4**

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).

QIC-AG LOGIC MODEL: TENNESSEE

PROGRAM INPUTS

Population:

Families with children who have been adopted and are referred (or self-refer) to ASAP's post-adoption services in the Shelby, East, Northeast, Tennessee Valley, Knox, Smoky Mountain and Upper Cumberland regions

NMT vs. services as usual

IMPLEMENTATION

» Modify existing ASAP assessments
» Modify consent process
» NMT Training
» Training supervision and tracking
» NMT Coaching and Supervision
» ASAP procedures (as needed)
» DCF Procedures (as needed)
» ASAP Database Changes
» Hire 2FTE (hiring protocols already developed)
» Therapeutic web education materials
» NMT Assessment
» NMT Treatment Plan
» ASAP supervision
» NMT coaching
» Fidelity measures (inter-rater reliability for NMT metric, treatment plan execution, case worker tasks)
» NMT mentoring (with flagship site)
» IRB submitted

PROGRAM OUTPUTS

» # of consents signed
» ASAP assessments modified
» # of workers trained
» # of NMT coaching sessions held (Bruce)
» # of NMT training support (Keith)
» Staff hired
» # ASAP procedures modified
» Training schedule developed
» Training tracking tool developed
» Therapeutic web educational materials developed
» #of DCS procedures modified
» # of changes to ASAP database
» # of NMT assessments completed
» # of treatment plans developed
» # of staff completing NMT metric with fidelity
» # of treatment plans executed with high fidelity
» # of ASAP supervision sessions held (weekly)
» # of mentoring sessions with flagship site
» IRB approved

SHORT-TERM OUTCOMES

» Decrease in familial stress
» Decrease in child behavioral issues
» Improved educational outcomes
» Increased staff satisfaction with delivery of services
» Improved familial relationships
» Improved caregiver commitment

LONG-TERM OUTCOMES

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

Unintended Consequences

Greater awareness in school system and therapeutic community awareness of trauma focused practices

END VALUES

A family-centered trauma-informed, bio-psychosocial assessment process

Families receive developmentally appropriate treatment

THEORY OF CHANGE

There are children who have exited foster care through adoption or guardianship and are in crisis and at risk for discontinuity.

In times of family crisis, if Tennessee uses a family-centered trauma-informed, bio-psychosocial assessment process to identify the needs of the child and family then the most appropriate interventions will be identified.

If Tennessee is able to identify the most appropriate interventions then they will be able to target the specific needs of the parents, guardians and children.

If the needs of the parents, guardians and children are addressed then families will increase their ability to understand, manage and resolve issues.

If these issues are addressed then there will be an improvement in the parents, guardians and children's ability to understand and manage crisis episodes and or lessen crises in the future.

If crisis within the family is reduced then families will experience increased stability and be at a reduced risk of discontinuity.

EXTERNAL CONDITIONS

» Limited community resource/providers to provide supportive services
» Lack of adoption competent and trauma informed supportive services
» Lack of integrated service provision with community resources/providers
» Rural nature of Tennessee impacts ability to access services
» Adoptive Parent lack of knowledge about ASAP services
» No ASAP services for guardians
» High use of substance use in East Grand Region
» Extent of need not met by 6 mos service time frame/limited nature of services.

USABILITY TESTING PLAN AND TRACKING TOOL

IMPLEMENTATION COMPONENT	QUESTIONS	METRICS	WHAT DID WE LEARN	WHAT CHANGES WERE MADE	RESULTS FROM CHANGES (SHORT OR LONG-TERM)