

QIC•AG

WISCONSIN IMPLEMENTATION MANUAL

ADOPTION AND GUARDIANSHIP ENHANCED SUPPORT

CHAPTER 1

INTRODUCTION USING THE IMPLEMENTATION MANUAL

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

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

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

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

The manual chapters are as follows:

CHAPTER 2: OVERVIEW OF THE INTERVENTION

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

CHAPTER 3: CORE COMPONENTS:

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

CHAPTER 4: CHOOSING THE RIGHT INTERVENTION

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

CHAPTER 5: PLANNING TO IMPLEMENT

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

CHAPTER 6: ASSESSING READINESS: USABILITY TESTING

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

CHAPTER 7: TRACKING PROGRESS THROUGH WORK PLANS

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

POST PERMANENCY STRATEGIES

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

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

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

FAMILY GROUP DECISION MAKING - THE WINNEBAGO TRIBE OF NEBRASKA

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

THE VERMONT PERMANENCY SURVEY - VERMONT

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

- » **Family well-being:** To better understand the factors that can impact the family's safety, permanency, and stability.

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

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY – ILLINOIS

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

TUNING IN TO TEENS - NEW JERSEY

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

ADOPTION AND GUARDIANSHIP ENHANCED SUPPORT - WISCONSIN

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

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

THE NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT) - TENNESSEE

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

CHAPTER 2

OVERVIEW OF THE INTERVENTION

The Wisconsin Adoption and Guardianship Enhanced Support (AGES) intervention was developed by child welfare professionals from the Wisconsin Department of Children and Families (DCF) and the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) site consultants and evaluators, hereafter referred to as the Wisconsin Team. Prior to Wisconsin's involvement with the QIC-AG, the state's child welfare system did not have a systematic approach to serving post-permanency families experiencing problematic emerging issues. Adoptive and guardianship families reported they would welcome post-permanency support (i.e., after legal finalization of permanency) with the challenges they faced parenting children with histories of significant trauma and abuse. The Wisconsin Team hypothesized supporting families as they addressed the needs of their children would reduce family stress, and ultimately, increase families' capacity for post-permanence stability and improve child and family well-being.

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 Adoption and Guardianship Enhanced Support (AGES) intervention is an enhanced case management model developed by the Wisconsin Department of Children and Families and the QIC-AG to support families post permanence who are struggling with escalating stress due to emerging issues in the family caused by behaviors, the child's age, or other changes within the family. The development of AGES was informed by programs serving post-adoption and guardianship families in Pennsylvania and North Carolina.

AGES offers families individualized assessment of their strengths and needs, identification of child- and family-specific goals, personalized assistance with identifying resources and navigating services, and targeted advocacy. When developing the AGES program, Wisconsin made an important distinction between providing services and providing support. The AGES program provides enhanced case management services to the families, assists the family by making necessary linkages to external services that the family might not be aware of or know how to access, and provides support to adoptive and guardianship families.

The Wisconsin Team developed a manual for the AGES intervention. The manual details protocols to operationalize the intervention. The manual is available by contacting the Wisconsin DCF Adoption and Interstate Services Section.



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.”

CORE COMPONENT 1: AGES IS DELIVERED IN FIVE SEQUENTIAL PHASES:

AGES has five distinct phases that are delivered sequentially. Within each stage the Team identified specific tasks. Sites considering implementing AGES should consider the feedback AGES families provided to program evaluators. Family feedback is included to inform future replications.

PHASE 1: SUPPORT INITIATION

Support initiation is the process of engaging families in the intervention; this component is the foundation for building a relationship between the AGES worker and the family. Engagement begins during the initial contact with the family and continues throughout the family's involvement in the intervention. The initial meeting with the family provides an opportunity for the family to tell their story and for the AGES worker to begin the assessment process. During the initial meeting, the AGES worker provides the family with a description of the basics of the AGES program, including the purpose of AGES, the assessment and goal planning process, and the voluntary nature of the program. The AGES workers' intent in this meeting is to empower the family to make informed decisions about participating in the AGES program. Support initiation is the process of engaging families in the intervention; this component is the foundation for building a relationship between the AGES worker and the family. Engagement begins during the initial contact with the family and continues throughout the family's involvement in the intervention. The initial meeting with the family provides an opportunity for the family to tell their story and for the AGES worker to begin the assessment process. During the initial meeting, the AGES worker provides the family with a description of the basics of the AGES program, including the purpose of AGES, the assessment and goal planning process, and the voluntary nature of the program.

PHASE 2: ASSESSMENT

Assessment is the process of gathering and collecting information regarding the child, family, and other relevant persons to determine the nature of individual and family needs, strengths, and available supports. Assessment activities consist of systematically gathering information from individuals and the family. The use of assessment tools (described below) in conjunction with the AGES worker's review of clinical or school reports and any relevant materials contribute to understanding the needs of each individual within the family as well as the family as a whole. A comprehensive assessment ensures the supports put in place during the support planning component are relevant and effective in addressing the strengths and challenges of the family.

PHASE 3: SUPPORT PLANNING

Support planning is the link that ties the findings of the assessment to the identification of goals. This component also involves the selection of a set of services, including formal and informal supports to address the needs of each child, caregiver, and the family as a whole. Support planning is a collaborative, strength-based, and solution-focused process that empowers and motivates families to identify strategies that will help them address their needs and maximize their strengths.

PHASE 4: SUPPORT DELIVERY

The support delivery phase begins once a support plan is developed with tasks and activities designed to achieve the desired goals, though AGES workers will begin providing support to the family as soon as they are needed. Those tasks are the components of support delivery.

The primary focus of initial work with many families is to reduce chaos within the family. Families with emerging issues need support, understanding, and immediate strategies to reduce stress. Overwhelmingly, families report they need competent and available service providers, assistance navigating the paperwork and referral process, educational advocates, and opportunities to connect with other families with similar experiences.

PHASE 5: CASE CLOSURE

When families have achieved their goals and the ongoing assessment of the family reflects stress has been mitigated, the case should be closed. Stressors will likely remain, but if the family acquires the necessary skills and additional supports to address stressors, then the family's resilience and capacity to manage will enable the family to face future challenges without intervention support.



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 crucial.

1. Staffing

The Wisconsin Team developed an AGES worker position description that identifies the knowledge, skills, and abilities necessary for an AGES worker. Classified as a Senior Social Worker, the position requires knowledge of social work principles, practice ethics and adoption competency. In addition, extensive knowledge of the effects of trauma on childhood development and knowledge of community resources is required. The work involves the application of trauma-informed complex consultation and advocacy services for adoptive parents and guardians. This position is responsible for understanding family dynamics and the ability to determine needs based on trauma history and family stress.

2. Training, Coaching, and Supervision

Training topics included trauma-informed practice, adoption-competent and AGES-specific training, and use of assessment tools. AGES workers were trained over 5 days of in-person training. AGES workers were able to access supplemental trainings online during the initial phase of their employment.

The AGES workers were employees of a private agency. A DCF supervisor was responsible for providing ongoing supervision for the AGES workers. A high-level DCF manager provided oversight of the DCF supervisor.

3. Fidelity

Initially, the Team examined fidelity for screening, engagement, and assessment phases. As families progressed through the phases of the intervention to planning and service delivery, the focus of project monitoring shifted from a compliance perspective to a qualitative examination of case documentation to identify and

evaluate the support AGES workers delivered. Early fidelity monitoring findings hinted at the value families placed on the support and counsel they received from AGES workers.

4. Policies and Procedures

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

5. Data Systems

A data system is recommended to track referrals, eligibility factors, and family progress through the phases of the intervention.

6. Program Expert

The Wisconsin Team sought expert consultation from others who had developed interventions for similar target populations. Specifically, the Wisconsin site consulted with the Success Coach Program developed by the Department of Social Services in Catawba County, North Carolina and the Statewide Adoption and Permanency Network (SWAN) in Pennsylvania. A Wisconsin Team member had prior experience with SWAN and access to the SWAN manual, which helped the Wisconsin Team with the initial conceptualization of AGES. In addition, the Wisconsin Team's expertise in child welfare was used to develop the AGES intervention.

7. Financial and Material Considerations

The primary intervention expense was the contract with a private agency for the two AGES worker positions; these costs included the AGES workers' salaries, benefits, and related administrative expenses. Additional project costs included program supplies, resource materials, trainings, and professional development.

CHAPTER 3

CORE COMPONENTS

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

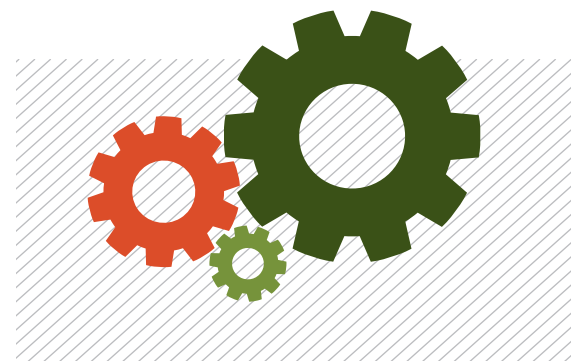
This chapter addresses the following topic:

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



INTERVENTION CORE COMPONENTS



The AGES intervention is in the Develop and Test phase and as such the Team is unable to confirm the core components of the intervention. Sites seeking to implement AGES are encouraged to consider the feedback of families who participated in the intervention and it is included for consideration.

CORE COMPONENT 1: AGES IS DELIVERED IN FIVE SEQUENTIAL PHASES:

AGES has five distinct phases that are delivered sequentially. Within each stage the Team identified specific tasks. Sites considering implementing AGES should consider the feedback AGES families provided to program evaluators. Family feedback is included to inform future replications.

PHASE 1: SUPPORT INITIATION

Support initiation is the process of engaging families in the intervention; this component is the foundation for building a relationship between the AGES worker and the family. Engagement begins during the initial contact with the family and continues throughout the family's involvement in the intervention.

When developing a support initiation process, start with the following tasks:

- » Develop screening guidelines to determine eligibility.
- » Establish a timeline for engaging with the family after a service request is received.
- » Consider the amount of time the family will likely need to explain the circumstances surrounding their request and build this time into the support initiation process.
- » Develop strategies for effective engagement with the family.
- » Determine how program goals and criteria will be communicated to the family
- » Develop a resource packet to leave with families who decide not to proceed with the intervention.

The Wisconsin Team determined early engagement with families was critical to supporting families post-permanence. The Team established a process for timely referral review and worker assignment. In addition, this process stipulated that phone contact with families was required within 3 business days of case assignment, and the initial meeting with families was required within 5 business days of the phone contact. The initial meeting with the family provides an opportunity for the family to tell their story and for the AGES worker to begin the assessment process. During the initial meeting, the AGES worker provides the family with a description of the basics of the AGES program, including the purpose of AGES, the assessment and goal planning process, and the voluntary nature of the program. The AGES workers' intent in this meeting is to empower the family to make informed decisions about participating in the AGES program.

AGES workers did attempt to initiate contact with families quickly. Most families responded to the AGES worker request to schedule a home visit, but it is important to note that 17% of families screened into the intervention did not follow through and schedule a meeting with the worker.

Some families reflected on the importance of having services available when struggles are first experienced. Having services available at the first sign of struggles would have prevented the problems families were currently facing. Having to wait for services until challenges are "bad enough" to meet the criteria for service delivery exacerbates the challenges families will face in the future.



LESSONS LEARNED

- » Timely support initiation requires dedicated staff. AGES staff did not have competing priorities, which enabled them to prioritize serving families.

PHASE 2: ASSESSMENT

Assessment is the process of gathering and collecting information regarding the child, family, and other relevant persons to determine the nature of individual and family needs, strengths, and available supports. Assessment activities consist of systematically gathering information from individuals and the family. The use of assessment tools (described below) in conjunction with the AGES worker's review of clinical or school reports and any relevant materials contribute to understanding the needs of each individual within the family as well as the family as a whole. A comprehensive assessment ensures the supports put in place during the Support Planning component are relevant and effective in addressing the strengths and challenges of the family.

WHEN CONSIDERING THE COMPLEX TASK OF ASSESSING FAMILIES, START WITH THE FOLLOWING TASKS:

- » Determine the assessment process to be used. Decide if family assessment will be based solely on worker observation and family report, formal standardized assessment tools, or both.
- » If standardized tools will be used, determine their availability and cost.
- » Decide on a format for documenting the assessment findings such as writing a report or entering findings in a database.
- » Develop a consent form to obtain collateral reports, if necessary.
- » Determine how the worker will share assessment findings with the family.
- » Determine if and when a reassessment will occur.
- » If periodic reassessments will occur, develop a reassessment process.

The Wisconsin Team developed an assessment process that includes worker interviews with all family members and standardized assessment tools. The assessment tools contributed to the evaluative process through the exploration of a specific area that affects child, parent, and family functioning such as child behavior or parental commitment. The following **assessment tools** were used:

- » **The Child and Adolescent Needs and Strengths tool (CANS):** Completed by the AGES worker with information provided by the family and school, medical or therapeutic providers to create a unified vision of each child that can be used to inform and manage planning.

- » **Family Adaptation and Cohesion Scales (FACES III):** Depicts the family's flexibility and cohesion as a family unit. Completed by each family member willing and able to complete the tool. At the time of this publication, the FACES III has a \$100 user fee that permits unlimited use.
- » **Behavior Problem Index (BPI):** Measures the frequency and type of child behavior problems. Each caregiver completes one tool for each child.
- » **Belonging and Emotional Security Tool (BEST):** Evaluates caregiver commitment to the child. Each caregiver completes one tool for each child.
- » **Duke-UNC Functional Social Support Questionnaire (FSSQ):** Measures the strength of the caregiver's social support network. Each caregiver completes one for themselves.
- » **Caregiver Strain Questions:** AGES workers use the responses to help understand the impact that caring for each child has on the parent or guardian. Each caregiver completes one tool for each child.

Once the initial assessment tools are completed, findings are shared with the family during an assessment and support planning session and again at reassessment. Assessment continues throughout the life of the case; however, a formal reassessment process is completed for families whose cases remain open after 6 months of service provision or families who experience major life changes. The FACES III tool is completed during reassessment. The AGES worker and family evaluate progress on support plan goals, and if necessary, modify the support plan to address the family's current situation.

Families' completion of the assessment tools, interviews and the AGES workers assessment process was time consuming. Initial projections were the assessment phase would be completed in 30 days proved to be unrealistic. One assessment took 60 days to complete. However it is critically important to allow sufficient time to get to know the family's strengths and challenges so the appropriate service is matched to the family's needs.

Initial concerns that the number of assessments required would overwhelm families proved to be unfounded. Families reported completing the assessment forms was not a hardship. The AGES workers sharing the assessment findings with families laid the groundwork for difficult discussions.



LESSONS LEARNED

- » Most families completed the assessment tools in a timely manner and without complaint. Concern that families would find completion of multiple assessment tools overly burdensome or a roadblock to participating in AGES proved to be unfounded.

PHASE 3: SUPPORT PLANNING

Support planning is the link that ties the findings of the assessment to the identification of goals. This component also involves the selection of a set of services, including formal and informal supports to address the needs of each child, caregiver, and the family as a whole. Support planning is a collaborative, strength-based, and solution-focused process that empowers and motivates families to identify strategies that will help them address their needs and maximize their strengths.

WHEN DEVELOPING A SUPPORT PLAN, START WITH THE FOLLOWING TASKS:

- » Determine the format of a plan that will work best for families.
- » Develop a process to prioritize support plan goals based on needs identified in the assessment.
- » Determine how frequently the plan will be updated and circumstances that necessitate an update.

The AGES support plan describes what, how, when, and by whom the identified needs will be met. The AGES support plan is developed around SMART goals, that is, goals that are *specific, measurable, attainable, relevant, and time-bound*.

Support plans are designed to reduce familial stress and increase the family's skills in managing challenging behaviors, with the ultimate goal of increasing the family's capacity for post-permanence stability and improved child and family well-being. AGES support plans incorporate the strengths of family members and identify interventions that can build on and use those strengths. Support plans are updated at a minimum every 6 months or when a significant change occurs in the family's situation.

While service provision benefits from the goal-directed activities documented in a support plan, these plans are not able to address all the challenges a family is experiencing. AGES workers often found families were urgently in need of services during their initial visit with the family and accordingly made a number of referrals at that time. Additionally, workers often helped families deal with the stressors of day to day family life. To adequately support families, AGES workers must have extensive knowledge of community resources.

When implementing AGES, consideration should be given to flexibility in the development and structure of a work plan. Wisconsin elected to use the case plan format in SACWIS, a comprehensive but cumbersome document. A simple document that outlines the reason for the service, specific service and provider, and describes the elements of successful completion are the necessary components of a support plan.



LESSONS LEARNED

- » Recognize families have emerging issues that require support, even when such support is not part of the formal support plan. During home visits, AGES workers often focused on areas of concern not addressed in the family's support plan.

PHASE 4: SUPPORT DELIVERY

The support delivery phase begins once a support plan is developed with tasks and activities designed to achieve the desired goals, though AGES workers will begin providing support to the family as soon as they are needed. Those tasks are the components of support delivery.

The primary focus of initial work with many families is to reduce chaos within the family. Families with emerging issues need support, understanding, and immediate strategies to reduce stress. Overwhelmingly, families report they need competent and available service providers, assistance navigating the paperwork and referral process, educational advocates, and opportunities to connect with other families with similar experiences.

WHEN DEVELOPING THE SUPPORT DELIVERY COMPONENT, START WITH THE FOLLOWING TASKS:

- » Determine the needs of the target population.
- » Identify supports within the community.
- » Evaluate the availability of adoption or trauma-competent supports in the targeted region.
- » Ensure the availability of resource, educational, or anticipatory guidance material for families.
- » Determine if the AGES worker will deliver supports or if the worker will make referrals to community providers.

In Wisconsin, AGES workers support the family and act as a guide for the family, helping them navigate the challenges of identifying, locating, and accessing competent services that will reduce stress and stabilize the family. AGES workers make necessary linkages on behalf of the family to external services provided by existing community resources. AGES workers advocate for families to receive needed services.

The AGES model is adoption and guardianship competent, trauma-informed, and responsive to the unique challenges faced by adoptive parents and guardianship caregivers. In Wisconsin, AGES workers help families understand the effects of past trauma on behavior and the connection and impact of traumatic experiences on a child's development across emotional, cognitive, behavioral, social, and physical domains.

Home visits were a critical part of the AGES intervention success. Families reported having an AGES worker come to their home was important in observing first hand struggles the families faced and was a major support provided by the AGES families. In addition home visits maintained the family's privacy.

Families also noted the importance of flexibility in scheduling. While much of the families previous agency contact was during normal business hours, the AGES workers were able to work a modified or flex schedule to accommodate the needs of families.

AGES participants noted the importance of having adoption-competent service providers near their home. Often AGES families had to seek necessary and services outside their immediate area. Families noted the need for additional support groups that were accessible, specifically for single parents, teens, and older caregivers.



LESSONS LEARNED

- » The type of supports AGES workers provided most often were listening to families share their experiences and normalizing the family's situation. Participating families expressed appreciation for having a professional available who understood what their family was going through.
- » The lack of adoption- and trauma-competent services is a critical barrier to delivery of essential services. For example, Wisconsin had a limited availability of adoption-competent counselors.

PHASE 5: CASE CLOSURE

When families have achieved their goals and the ongoing assessment of the family reflects stress has been mitigated, the case should be closed. Stressors will likely remain, but if the family acquires the necessary skills and additional supports to address stressors, then the family's resilience and capacity to manage will enable the family to face future challenges without intervention support.

WHEN CLOSING A CASE, START WITH THE FOLLOWING TASKS:

- » Develop a process to review the supports put in place and the change in family functioning.
- » Review a family's formal and informal supports that can provide resources and assistance after the intervention ends.
- » Develop a transition plan that includes potential risk factors; help the family identify supports that might be needed in the future.
- » Provide a list of resources, including support groups.
- » Ensure families understand the process of re-engaging with AGES.

When working with a family, the AGES worker must keep the end in mind. Discussions relative to planning for case closure occur throughout the process of working with a family. The Wisconsin Team developed a reassessment process that allowed AGES workers to determine if the family was ready for case closure. When reassessment findings reflect stress mitigation and amelioration of challenges, the AGES worker meets with the family to help determine if the family is ready for case closure.

In Wisconsin, the AGES worker facilitate a process to engage family members, service providers, and informal supports in developing a plan for identifying and meeting child and family needs after AGES involvement ended.

Once the family is ready for closure, the process of transitioning the case to closure begins by helping the family anticipate future challenges. As part of the case closure process in Wisconsin, the AGES worker and the family identify the services and supports that will be ongoing, and supports that might be needed in the future. In other words, the AGES worker supplies the family with clear information on accessing and obtaining services, including upcoming trainings, support groups and notification of available resources.

Some families in the AGES intervention were resistant to case closure. Though family stressors had been mitigated and family functioning had improved, fear that challenges would re-emerge was the root cause of the hesitancy to close. Arming families with information on connecting with appropriate supports or re-engaging with post-permanency providers is essential.



LESSONS LEARNED

- » It is important to have well-delineated guidelines for case closure. AGES workers found closing cases especially difficult because families wanted to remain open even after reaching their goals. A well-defined closure protocol helps workers make difficult decisions and explain those decisions to parents and caregivers.

CHAPTER 4

CHOOSING THE RIGHT INTERVENTION

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

This chapter addresses the following topics:

I. IDENTIFY THE PROBLEM AND THE TARGET POPULATION

II. DEVELOP A THEORY OF CHANGE

III. RESEARCH AND SELECTION OF AN INTERVENTION

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

1.

IDENTIFY THE PROBLEM AND THE TARGET POPULATION

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

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

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

The next step in determining if the intervention is right for your site is to determine the system strengths and needs. This step can be accomplished by completing a critical assessment. The Wisconsin 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 AGES 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).

Using the statewide data system (eWiSACWIS) allowed the Wisconsin Team to identify adoptive and guardianship families by county. The eWiSACWIS system collects data on many aspects of case management; however, beyond information related to adoption and guardianship subsidy, the system has limited ability to track post-adoption or guardianship cases. The Wisconsin Team also surveyed private intercountry and domestic adoption agencies to determine the number and location of those families. Once this population was identified, the Team gathered information from post-permanency service providers throughout Wisconsin to determine the number of families served by agency, and the type of challenges experienced by families. In general, most families were proactive in meeting the needs of their children. However, some families reported they were overwhelmed and under-prepared to meet the escalating needs of their children. Families identified their most pressing needs as receiving support with behavior challenges, education, and cultural issues.

A system assessment revealed a service gap for families who needed more support than a referral but who were not in crisis. In Wisconsin, services for the post-permanency population are delivered through contracts with Post Adoption Resource Centers (PARCs), located throughout the state. The PARCs act as a clearinghouse for post-permanency families by providing information, referrals, and resource materials. In addition, the PARCs track service requests. As designed, the PARCs are not able to provide enhanced support to families experiencing escalating stress.



LESSONS LEARNED

- » Data obtained from multiple sources using a variety of data collection methods should be carefully evaluated for accuracy. Because there were inaccuracies in the data, the Wisconsin Team overestimated the number of families expected to request services through AGES.

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 Wisconsin's case the AGES intervention, should facilitate the change identified in the theory of change.

WISCONSIN THEORY OF CHANGE

Research tells us that some adoptive parents and guardians express concern about feeling ill-equipped and unsupported to meet the needs of children in their families. These families feel ill-equipped and unsupported because there are emerging issues that at the time of finalization may have been within the caregiver's capacity to address, were not present, or were not causing familial stress. However, post-permanence, after child welfare oversight has ended, these families are doing the best they can to meet the needs of the child, but feel it may not be enough. Left unaddressed, these issues may result in discontinuity.

The QIC-AG work in Wisconsin will augment current services by providing support to families with emerging needs at risk for discontinuity. The additional support will help families as they address the needs of their children, which in turn will reduce familial stress, and ultimately increase post-permanency stability and improve well-being.

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



LESSONS LEARNED

- » Identifying the root cause of a problem is key to implementing an effective intervention. By “peeling the onion,” the Wisconsin Team determined a systematic strategy for supporting post permanency families was needed.



RESEARCH AND INTERVENTION SELECTION

Once a site selects one or more interventions to address the identified need, then 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.¹ Using the Hexagon Tool to explore and ask questions in broad areas will help determine if AGES 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?

The Wisconsin Team evaluated 16 interventions. Using the Hexagon Tool, the Team determined none met the needs of their population. Consequently, the Team decided to develop the AGES intervention. Because the Wisconsin Team developed the AGES intervention, they did not complete the Hexagon Tool for AGES. However, the Team did complete the Hexagon Tool for their evaluation of the 16 interventions they considered but did not use. A blank Hexagon Tool is located in Appendix D.

¹ <https://implementation.fpg.unc.edu/resources/lesson-1-hexagon-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, or is not congruent with the needs of the population.

CHAPTER 5

PLANNING TO IMPLEMENT

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

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

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

The AGES intervention was developed concurrently with the AGES manual. In lieu of an IDIP, the Wisconsin team established a plan for completing the AGES manual. As each component was refined, the Team established processes to operationalize the component to support the implementation of the intervention.

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

I.

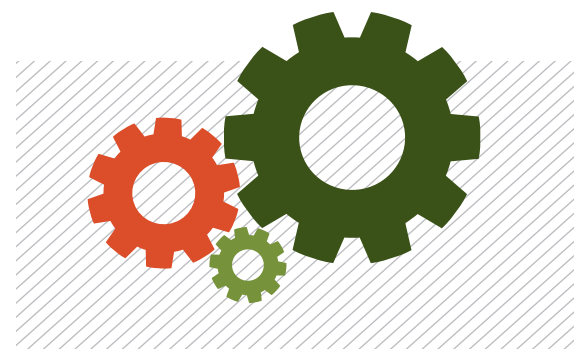
RESEARCH
CONSIDERATIONS

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.² Testa and Poertner have recommended the PICO framework, which requires careful articulation of four key components:³

- 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**



² 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.

³ 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.⁴ 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.

⁴ Fraser, M. W., Richman, J. M., Galinsky, M. J., & Day, S. H. (2009). *Intervention research: Developing social programs*. New York, NY: Oxford University Press.

Wisconsin did not have a comparison group (C), but the other elements of the PICO framework are identified below in the Wisconsin project's research question:

Will families with children residing in the Northeast Region of Wisconsin with a finalized adoption or guardianship who request services from one of the identified referral sources (P) and who receive Adoption and Guardianship Enhanced Support (AGES) (I) feel better equipped to address the needs of the children in their home, report increased levels of social support and caregiver commitment and report a decrease in child behavioral problems (O).

P

TARGET POPULATION: The Wisconsin target population for AGES was families in the 17-county Northeast Region of the state with a finalized adoption or guardianship who requested services from one of the following sources within Wisconsin: Department of Children and Families (DCF) Central Office, the Post Adoption Resource Center, or the Foster Care and Adoption Resource Center. Initial eligibility screening for AGES uses seven questions; to be eligible for AGES, families must answer at least one of the seven screening questions within the specified range.

Families are excluded from AGES if any of the following conditions exist:

- » The child is no longer residing with the family.
- » The family has an open child protective services investigation or juvenile justice case.
- » The family has an open child welfare case in which the family is receiving services other than respite.
- » The family is a licensed foster parent and has a child in placement,
- » The family is in crisis and service needs are beyond the scope of AGES such as:
 - › The family expresses that they need the child removed from the home.
 - › The level of aggression in the home has risen to the point that the caregiver believes one or more family members are in danger.
 - › The caregiver expresses no willingness to engage in the process of addressing the issues or concerns leading to crisis.

I

INTERVENTION: Adoption and Guardianship Enhanced Support (AGES)

C

COMPARISON GROUP: The Wisconsin project did not have a comparison group. AGES was offered to all families in the targeted region who met the eligibility criteria.

O

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

- » Increased proportion of caregivers who feel equipped to address the needs of their children
- » Increased levels of social support
- » Increased caregiver commitment
- » Decrease in child behavioral problems

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 Wisconsin 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.

Three agencies were the source of referrals to the AGES program. Referred families were screened by an AGES point person to assess the family's eligibility for the AGES program. Families are asked a series of screening questions. If screening criteria are met and families express an interest in the AGES program, the point person sends a referral to the AGES supervisor for additional screening and case assignment.



LESSONS LEARNED

- » Having trained staff and available points of entry for eligibility screening are critical to intervention uptake.

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.”

In Wisconsin, fidelity data was tracked by the AGES workers and data related to short-term outcomes was tracked in the DCF data collection system. The DCF data system collects information that allows program evaluators to examine pre- and post-intervention outcomes for all participants. The data are gathered through the assessment and reassessment process as well as case documentation throughout the life of the case.

The Wisconsin Team developed a spreadsheet to track key activities of an AGES worker and evaluate caseload demands. The tracking provided a glimpse of worker time commitment by intervention component, and revealed the assessment component was the most time-consuming component. This tracking helped the Wisconsin Team to determine that AGES workers could reasonably carry a caseload of 12-14 cases. The Team also developed spreadsheets to ensure time standards were met; these efforts focused on tracking data elements related to the referral, eligibility screening, and completion of tasks associated with specific phases or components of the intervention.

Participants’ identifying information was known to the evaluators and DCF. DCF has policies and procedures in place to safeguard the handling of confidential information. AGES evaluators completed training in the Collaborative Institutional Training Initiative and fulfilled all requirements of their Institutional Review Board.



LESSONS LEARNED

- » It is important to ensure that all team members have access to participant data to allow for comprehensive monitoring of the process. The Wisconsin Team used a shared file platform that housed spreadsheets and tools used to collect intervention data. Having this data available in an organized and accessible manner was essential for the Team to work in an informed and efficient manner.

II.

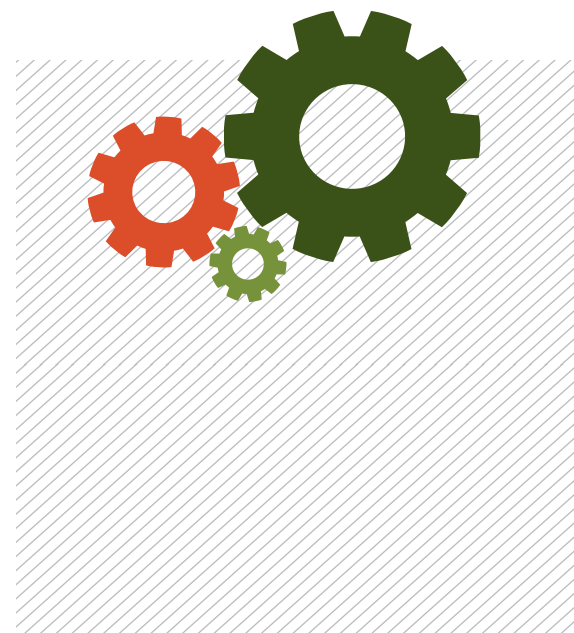
GETTING YOUR SYSTEM READY: IMPLEMENTATION SUPPORTS

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 DETERMINING A STAFF SELECTION PROCESS, 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

The Wisconsin Team developed a description for the AGES worker position, which identified the knowledge, skills, and abilities necessary for an AGES worker. The site had two options to staff the intervention: (a) add additional state positions for the duration of the project, or (b) contract with a provider in the targeted region for the AGES position. The Team decided to pursue a contract with a private agency. This decision necessitated following the State’s procurement process, and ultimately, the Wisconsin site awarded a contract to an agency with expertise in adoption and post-permanency services.

Turnover of AGES workers was experienced shortly after the intervention began accepting referrals. Initially, the Team established a low worker–family caseload ratio. As AGES staff departed, and the remaining AGES worker assumed responsibility for all AGES cases, it became apparent that AGES workers could manage a caseload of up to 12 families. As the site experienced worker stability, the maximum caseload of 14 was easily managed.



LESSONS LEARNED

- » Continually evaluate the worker–family caseload ratio in a new intervention. Initial estimates of the number of families who would accept AGES services led the team to establishing a caseload size of three families per worker. Intervention uptake was slow and AGES workers—who were trained and ready to deliver services—did not have enough work to keep them busy

2. TRAINING, COACHING, AND SUPERVISION

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

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

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

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

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

The Team developed a training plan for AGES workers, which is included in the AGES manual. Training topics included trauma-informed practice, adoption-competent and AGES-specific training, use of assessment tools, and training required by the State of Wisconsin for all child welfare staff. DCF staff delivered the AGES workers' training over 5 days of in-person training. AGES workers were able to access supplemental trainings online during the initial phase of their employment.

The AGES workers were employees of a private agency. A DCF supervisor was responsible for providing ongoing supervision for the AGES workers. A high-level DCF manager provided oversight of the DCF supervisor.



LESSONS LEARNED

- » Account for training costs that a project will incur as a consequence of staff turnover and the need to hire and train new AGES workers. Training costs rise exponentially when significant turnover is experienced. The in-person training delivered by the Team was repeated with each new hire. The team delivered these trainings four times to five AGES workers, resulting in a significant expense.
- » Consider the cost-savings through use of technology. Recorded trainings cut down on trainer time and give trainees an opportunity to review the trainings at future time points.
- » Consider the potential pitfalls when supervision is provided by an agency without line authority over the AGES workers. Wisconsin DCF had an existing partnership with the private agency contracted to provide AGES workers, and the Wisconsin project did not experience challenges with this agency. However, had disagreements arisen, the implementation of the AGES intervention could be adversely affected.

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.

Initially, the Team examined the screening, engagement, and assessment phases. As families progressed through the phases of the intervention to planning and service delivery, the focus of project monitoring shifted to support plans and service delivery.

Fidelity monitoring revealed AGES services were delivered as intended. Engagement with families was timely; assessment tools were completed as intended and confirmed the AGES workers’ findings from family interviews; and support plan goals and service delivery were driven by the assessment.

Early fidelity monitoring findings hinted at the value families placed on the support and counsel they received from AGES workers. The scope of the fidelity monitoring shifted from a compliance perspective to a qualitative examination of case documentation to identify and evaluate the support AGES workers delivered.



LESSONS LEARNED

- » Different monitoring tools were needed for different stages of the intervention.
- » When monitoring fidelity, it is not only important that workers are using the tools as intended but it is also important to make sure the tools collect the information to answer the questions the site is asking.

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 Wisconsin Team developed the AGES intervention in concert with the development of the AGES manual. All policies and procedures are addressed within the manual. The AGES manual details the following:

- » Phases of the AGES intervention
- » Training plan for AGES workers
- » Quality assurance and fidelity measures
- » Standards for practitioners
- » Training requirements for AGES workers
- » Selected tools and resources



LESSONS LEARNED

- » A manual that provides detailed descriptions of the procedural elements of the intervention is an invaluable tool to guide workers in delivering the intervention as intended.
- » Consider a review by stakeholders to identify procedural barriers that may delay or hinder families obtaining services and to ensure the primary needs of the target population are addressed. The Wisconsin Team convened a stakeholder group to review the draft manual. This review allayed the concerns of the Team relative to the number and scope of assessment tools. Additionally, stakeholders endorsed that the proposed service array was likely to meet the needs of the target population.
- » Obtain feedback from the staff who will use the intervention manual. The initial draft of the AGES manual was revised to clarify areas that the AGES workers found incongruent or unclear.

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 monitor fidelity, including outputs such as the data collected during the family's needs assessment.
- » Determine if the reports generated from the data system inform the process and outcomes.
- » Determine whether data are reliable, collected on a standardized schedule, easily accessible to the implementation support teams.
- » Confirm that the data system is backed-up regularly.

A Share Point drive, which is a secure file and data storage platform server, was established to provide Team members with easy access to intervention data. The Team tracked all phases of AGES service delivery through a weekly review of AGES intervention activity that included referrals, eligibility factors, and family progress through the phases of the intervention. The Team worked with the Wisconsin DCF-information technology staff to develop a spreadsheet for assessment data to be uploaded by AGES workers and transmitted to the Evaluation Team for analysis. To preserve confidentiality, families were identified on tracking reports using pseudonyms.

The Team generated ad hoc reports and redacted case files from the state SACWIS database that allowed reporting of data required for the site evaluation.



LESSONS LEARNED

- » Ensure all members of the team who need access to project data can easily access the data. In Wisconsin, having the project data readily accessible created efficiencies and allowed team members to analyze the data when needed.
- » Developing or modifying existing data systems takes time. Ensure adequate time is allotted when system changes are needed.

6. PROGRAM EXPERT

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

WHEN DETERMINING THE SCOPE OF WORK REQUIRED FROM 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.

The Wisconsin Team sought expert consultation from others who had developed interventions for similar target populations. Specifically, the Wisconsin site consulted with the Success Coach Program developed by the Department of Social Services in Catawba County, North Carolina and the Statewide Adoption and Permanency Network (SWAN) in Pennsylvania. A Wisconsin Team member had prior experience with SWAN and access to the SWAN manual, which helped the Wisconsin Team with the initial conceptualization of AGES. In addition, the Wisconsin Team's expertise in child welfare was used to develop the AGES intervention.



LESSONS LEARNED

- » When developing a new intervention, consulting with and enlisting the help of program experts who have experience in developing similar types of interventions can be helpful to your project. When AGES workers experienced challenges, such as the passive participation of some families, or other families' reluctance to close, the Team conferred with the Success Coach intervention in North Carolina, and Pennsylvania SWAN. Each program willingly shared the strategies they had used to address similar challenges; this help and support was instrumental in assisting the AGES workers to increase family engagement while moving other families toward closure.

7. FINANCIAL AND MATERIAL CONSIDERATIONS

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

WHEN CONSIDERING FINANCIAL AND MATERIAL COSTS, 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.

Although the Wisconsin project was funded by a cooperative agreement with the Children's Bureau, DCF professionals contributed in-kind support. The Project Manager was a DCF bureau director. The DCF out-of-home care and adoption chiefs supervised the AGES implementation managers as well as the DCF manager providing supervision to the AGES workers.

The primary intervention expense was the contract with a private agency for the two AGES worker positions; these costs included the AGES workers' salaries, benefits, and related administrative expenses. Additional project costs included program supplies, resource materials, trainings, and professional development.



LESSONS LEARNED

- » Consider all the expenses associated with implementing an intervention and look for opportunities for in-kind support from agency personnel or system advocates and champions.

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.

The AGES Project Manager was a member of the DCF executive leadership team and had widespread support within the DCF chain of command for post-permanency projects and the development of the AGES intervention. Having access to the DCF leadership allowed the Wisconsin Team to integrate and implement changes that enhanced both pre- and post-permanency supports through changes in training curricula and messaging to system partners that deliver adoption and guardianship services.



LESSONS LEARNED

- » Having project leadership with access to the agency's senior leadership is beneficial to resolving cross-system challenges.

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.

In Wisconsin, the AGES Project Manager leveraged existing relationships with the leadership of counties, tribal nations, and partner agencies to engage their participation in the initial stages of the project. These relationships facilitated communication regarding the intervention's development and subsequent implementation. The Wisconsin Team communicated information about the intervention through stakeholder presentations and a regular schedule of meetings with system partners..



LESSONS LEARNED

- » Collaboration facilitates successful implementation. The Wisconsin Team actively sought the participation of partner agencies during the first 6 months of the project; however, engagement of partner agencies decreased as the development of the AGES intervention began.

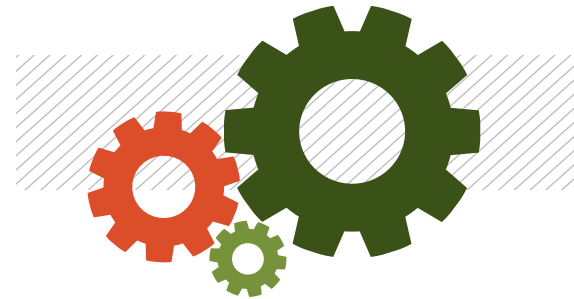


WHO WILL DO THE WORK: TEAMING AND COMMUNICATION

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

This section covers the following topics:

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



1. TEAMING STRUCTURE

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

- a. **Project Management Team (PMT).** Forming a PMT can help not only to ensure leadership capacity for the duration of the project but also to ensure the sustainability of the intervention and *Wisconsin* 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 *Wisconsin* 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 Wisconsin Project Management Team (PMT) met during the first 6 months of the project. With the decision to develop a new intervention rather than implement or adapt an existing intervention, the decision-making responsibility shifted from the PMT to the Implementation Team (IT). The IT guided the development of the AGES intervention, the AGES manual, and the implementation of the AGES intervention. Over time, as the need for program modification and additional oversight of the implementation decreased, the frequency of IT meetings was reduced from weekly to bi-weekly meetings. The Stakeholder Advisory Team (SAT) informed and vetted the AGES draft manual, providing critical feedback that was incorporated into the AGES manual used for the formative evaluation. The Wisconsin Team convened the SAT periodically to provide updates on project progress.



LESSONS LEARNED

- » When developing project teams, it is important to recognize a team’s preferred manner of work and determine the team’s comfort level collaborating with external partners. After project inception, DCF management staff primarily made decisions internally.
- » Anticipate the likelihood that team members will experience project fatigue over time. It is important to recognize the point at which the frequency of meetings should be reduced to minimize the fatigue that occurs naturally when implementing an intervention.

2. COMMUNICATION STRATEGIES

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

WHEN CONSIDERING COMMUNICATION STRATEGIES, START WITH THE FOLLOWING TASKS:

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

The Wisconsin Project Manager had established relationships with county, tribal, and provider leadership. The Project Manager communicated AGES updates during regularly scheduled meetings. DCF leadership met regularly with adoption and out-of-home care staff and delivered presentations about the AGES intervention to foster and adoptive parent organizations.



LESSONS LEARNED

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

CHAPTER 6

ASSESSING READINESS: USABILITY TESTING

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

The chapter addresses the following topic:

I. USABILITY TESTING

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

I. USABILITY TESTING

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

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

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

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

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

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

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

The Wisconsin Team tested the AGES intervention with 10 families over 9 months. During that usability testing period, the Team examined data generated by AGES workers and held several conference calls with the AGES

workers and supervisors. As usability testing ended, an on-site interview was conducted with the AGES workers and supervisor to critically examine and answer the usability questions for each core component of AGES.

The Team examined the time required to complete each phase of the intervention, concluding established time standards for screening and engagement were consistently met. The Team found the length of time necessary to complete an assessment took longer than expected. Upon closer examination, it was determined there was a training issue regarding when to consider an assessment complete. Usability testing allowed the team to course correct before implementing to the whole region.

The vacancy created by staff turnover gave the Team an opportunity to evaluate the worker-family ratio. The Team determined an AGES worker could manage a much larger caseload than initially established.

The Wisconsin Team modified processes that did not perform as intended in the usability test. For example, the time standard for completion of the AGES support plan was increased from 30 days to 45 days after the completion of the assessment. The Team recommended additional supervision or coaching was needed to ensure planning occurs as expected. The Team also modified the procedures for entering assessment data by the AGES workers to facilitate ease of entry.

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

- » Critically assessing the processes and procedures of each intervention component with a limited number of families was important to the Team's ability to determine "what worked, and what didn't." This approach allowed the Wisconsin Team to make modifications prior to full implementation of the AGES intervention.

CHAPTER 7

TRACKING PROGRESS

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

The chapter addresses the following topic:

I. TRACKING PROGRESS THROUGH WORK PLANS

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

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.

I.

TRACKING PROGRESS THROUGH WORK PLANS

A work plan should include the following components:

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

The Wisconsin Team found it useful to organize the work plan in a format that identified the tasks and time frames required to carry out each phase of the intervention. Team members frequently referred to the work plan to identify upcoming activities and the tasks needed to carry out the next steps of the intervention. During the development of the AGES manual, the work plan was reviewed weekly as manual sections were written, edited, and finalized by a timetable embedded in the work plan.



LESSONS LEARNED

- » A work plan keeps a project on schedule. The Wisconsin Team continually referred to the work plan, updating the plan quarterly as tasks were added or modified.

APPENDICES

- A. QIC-AG Population Template
- B. QIC-AG Continuum Assessment
- C. Stakeholder Focus Group Questions
- D. Hexagon Tool: Adoption and Guardianship Enhanced Support
- E. Initial Design and Implementation Plan
- F. QIC-AG Logic Model: Wisconsin
- G. Usability Testing Plan and Tracking Tool

APPENDIX A

QIC-AG POPULATION TEMPLATE

A

QIC-AG POPULATION TEMPLATE: TARGET GROUP 2

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

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

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

BACKGROUND: WHAT IS THE PROBLEM?

PRIMARY PROBLEM DEFINITION

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

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

BACKGROUND

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

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

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

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

1. SOURCE OF PROBLEM DATA

BACKGROUND

Child Welfare Adoptions and Guardianships

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

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

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

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

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

International and Private Domestic Adoptions

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

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

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

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

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

SITE SPECIFIC INFORMATION REQUEST

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

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

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

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

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

2. WHO IS AT RISK OF EXPERIENCING THE PROBLEM?

BACKGROUND

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

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

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

SITE SPECIFIC INFORMATION REQUEST

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

CHILDREN ADOPTED THROUGH THE CHILD WELFARE SYSTEM

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

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

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

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

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

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

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

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

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

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

CHILDREN EXITING FROM THE CHILD WELFARE SYSTEM THROUGH GUARDIANSHIP

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

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

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

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

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

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

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

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

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

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

INTERNATIONAL ADOPTIONS

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

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

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

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

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

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

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

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

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

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

PRIVATE DOMESTIC ADOPTIONS

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

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

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

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

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

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

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

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

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

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

APPENDIX B

QIC-AG CONTINUUM ASSESSMENT

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

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

DIRECTIONS

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

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

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

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

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

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

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

Questions to be asked for each the interval:

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

APPENDIX C

QUESTIONS FOR CAREGIVER STAKEHOLDER INTERVIEWS

C

QUESTIONS FOR CAREGIVER STAKEHOLDER INTERVIEWS

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

INTRODUCTION

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

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

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

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

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

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

OPERATIONS

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

KNOWLEDGE

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

FUNCTIONING

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

ATTITUDES

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

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

APPENDIX D

HEXAGON TOOL

APPENDIX E

QIC-AG INITIAL DESIGN AND IMPLEMENTATION PLAN (IDIP)

E

QIC-AG INITIAL DESIGN AND IMPLEMENTATION PLAN (IDIP)

INTRODUCTION

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

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

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

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

I. PROJECT OVERVIEW

A. PROBLEM

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

B. THEORY OF CHANGE

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

II. KEY COMPONENTS OF YOUR RESEARCH QUESTION

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

A. TARGET POPULATION

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

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

B. COMPARISON GROUP

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

C. OUTCOMES

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

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

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

D. LOGIC MODEL

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

E. CASE FLOW/PROJECT ENROLLMENT

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

F. DATA COLLECTION

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

III. DESCRIBING THE WHAT: INTERVENTION

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

A. PHILOSOPHY, VALUES, AND PRINCIPALS

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

B. CORE COMPONENTS

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

C. MATERIALS

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

D. FIDELITY

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

E. ADAPTATION

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

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

F. DEVELOPMENTAL PHASE OF THE INTERVENTION

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

IV. DESCRIBING THE HOW: IMPLEMENTATION SUPPORT

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

A. IMPLEMENTATION SUPPORTS

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

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

B. INTERVENTION SPECIFIC WORK PLAN

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

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

V. DESCRIBING THE WHO: TEAMING AND GOVERNANCE STRUCTURE

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

A. TEAMING STRUCTURE

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

B. TEAM CHARTERS

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

C. COMMUNICATION STRATEGIES

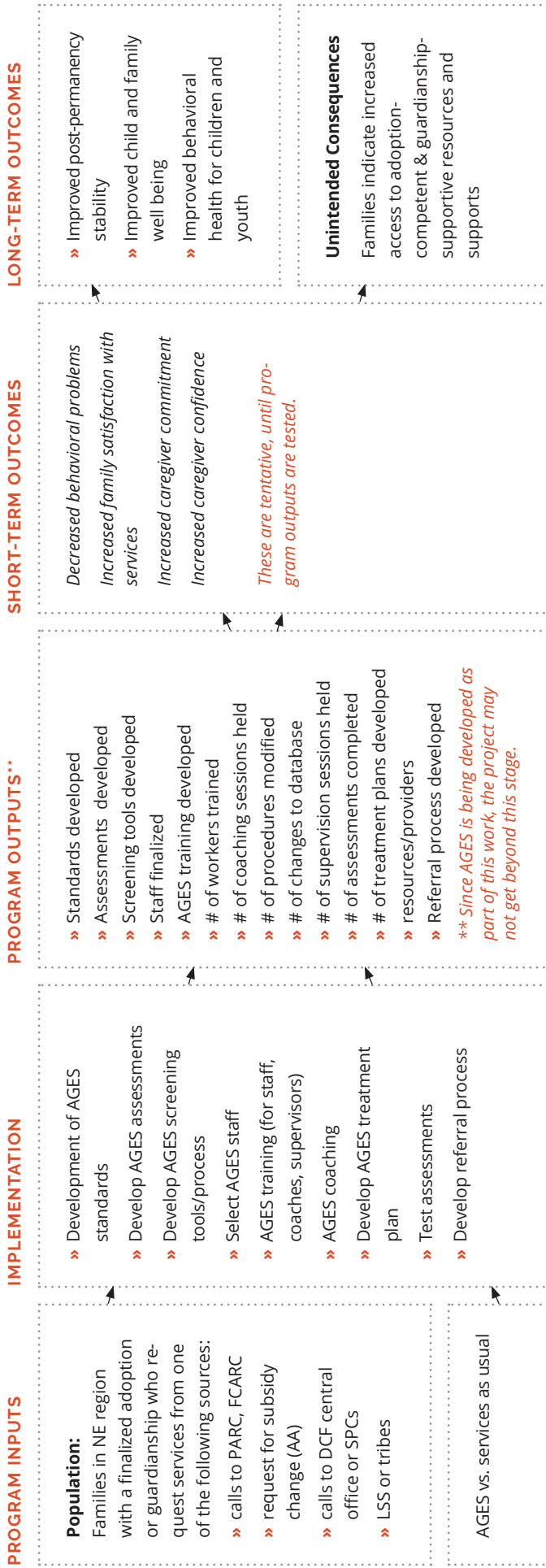
Detail the processes, procedures, and strategies for maintaining efficient and effective communication among leadership, staff, and partners who are:

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

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

APPENDIX F

WISCONSIN LOGIC MODEL



EXTERNAL CONDITIONS

- » Providers and families are working to enhance their knowledge of services to assist with issues that may arise after adoption or guardianship.
- » Service array availability to adequately address child behavioral-emotional issues post-permanence.
- » Service array varies between urban and rural communities.
- » Preparation for the complexities of managing family dynamics associated with kinship adoption or guardianship looks different with every family.
- » Limited support system post-permanence for families.
- » Currently developing a formal system to identify families most at-risk for post-permanency instability.
- » Cultural norms around reaching out for help
- » Other WI DCF initiatives: human trafficking, transfer of JJ&DCFC, TIC/Family Finding training
- » CFSR round 3, 2018
- » Availability of adoption & guardianship incentive funds
- » Staff turnover's impact on family trust in system/agencies.

THEORY OF CHANGE

Research tells us that some adoptive parents and guardians express concern about feeling ill-equipped and unsupported to meet the needs of children in their homes. These families feel ill-equipped and unsupported because there are emerging issues, that at the time of finalization may have been within the caregivers capacity to address, were not present, or were not causing familial stress. However, post permanency, after child welfare oversight has ended, these families are doing the best they can to meet the needs of the child, but feel it may not be enough. Left unaddressed, these issues may result in discontinuity.

The QIC-AG work in Wisconsin will augment current responses by providing support to families with emerging needs who are at risk for discontinuity. This additional support will help families as they address the needs of their child(ren), which in turn will reduce familial stress, and ultimately increase their capacity for post-permanence stability and improved well-being.

END VALUES

- Improved stability in adoptive and guardianship homes
- Replicable evidence-based practice, policy, services and supports
- Cost-effective intervention
- Improved well-being for children, youth and caregivers related to feelings of belonging, satisfaction with life and positive view of permanence
- Improved access to supports and services
- Improved behavioral health for the children and youth

APPENDIX G

USABILITY TESTING PLAN AND TRACKING TOOL

