

ASAP Program Manual

Adoption & Guardianship Support & Preservation Services

July 1, 2021

Illinois Department of DCFS Children & Family Services

Path Beyond Adoption
Partners Available To Help after adoption and guardianship



Contents

Funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1122-01-00. The contents of this manual do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain. Readers should credit the Illinois Department of Children and Family Services, developer of the Adoption and Guardianship Support and Preservation Program.

Purpose of This Manual

This Program Manual is intended to describe the specific activities associated with Adoption and Guardianship Support and Preservation (ASAP) services. Having a clear description and guidelines about the delivery of the program is necessary to help ensure the quality of post adoption and guardianship service delivery is equitable and consistent across the state.

This manual:

- Provides a clear description of the context for the program including the problem that the program intends to address and the needs of the target population
- Includes a Theory of Change, which is a description of the assumptions about how a desired change will occur
- Describes the philosophical principles and values that undergird the program
- Includes a definition of the population for whom the program is intended as well as exclusionary criteria
- Defines assessment and treatment planning steps to ensure that the program population is receiving the appropriate services
- Provides clarity about what level of flexibility staff have with regard to implementing various elements of the program
- Recognizes individual racial and cultural differences of clients and their adoptive parents/guardians when providing services

It is recommended that all ASAP program staff review this manual during their initial orientation and that ASAP staff refer to this manual frequently in their work.

Program Overview

Families created through adoption or guardianship may experience problems that require services to help a family gain stability and to reduce the risk of out-of-home placement. ASAP recognizes that families built through adoption or guardianship may have characteristics significantly different from those created through birth. This can result in unique challenges for the family. ASAP helps families who often feel they need assistance to meet their family's needs by offering family-centered support and services.

As professionals, we have historically seen our job as being done when adoptions and guardianships were finalized. The thinking was that finalization was the last chapter in the journey, rather than a new chapter to a lifelong journey. Because of this kind of thinking, most systems were not designed to offer post adoption and guardianship services, and professionals did not talk to families about the challenges they might encounter in the future or how to access services if they needed them. Families often took on some of this same kind of thinking. Some families were happy or relieved to end their relationship with the child welfare system and did not see this entity as a place to obtain support in the future. Some families felt, and continue to feel, shame or a sense of failure about the need for services and support. Many did not know services were available to them or how to access those services. Now we know that even though the finalization of an adoption or legal guardianship is an important step, it is by no means the final step or the end of the journey. We now see the importance of education, particularly education that focuses on breaking down the myths surrounding adoption and guardianship, so that families will feel better about accessing supports as they need them.

Research on the short- and long-term impact of trauma by leaders in the field like Dr. Bruce D. Perry at the Neurosequential Network (formerly known as the Child Trauma Academy) help raise awareness that children who have experienced developmental trauma can demonstrate typical challenging child behaviors but often at a frequency, intensity, and duration that can stress families beyond their capacity to cope. We have learned that these kinds of difficulties do not disappear once an adoption or guardianship is finalized, and families may need support long after permanence is achieved and as they reach different milestones and transitions in life. For example, research by Dr. Mark Testa and Dr. Nancy Rolock has shown adoptive families are most likely to experience difficulties during the teen years, regardless of the age at

adoption. As a result, a continuum of post adoption and guardianship services is needed because of the differences in families' service needs.

ASAP provides a continuum of family-centered interventions intended to empower and strengthen families in becoming self-sufficient in their communities. The interventions include:

- Completing a broad assessment of families' issues, needs, and strengths
- Developing a plan of service
- Providing therapy, case management, support, and advocacy services

Post adoption and guardianship services can be proactive and preventative, providing support as early as at the time of adoption finalization or guardianship transfer through subsidized guardianship. Services can also be provided when families are experiencing more challenging issues as well as in times of crisis. ASAP providers can help to prepare the members of the adoption or guardianship triad (i.e., the child, the birth parent, and the adoptive parent or guardian) for obtaining information about each other (provided all parties involved agree to release such information) and navigating their connections to one another.

Families created through adoption and guardianship have unique characteristics that differ in significant ways from families created biologically, and the challenges faced by these families are best addressed through a family-centered approach. The primary purpose of post adoption and guardianship services is to support the permanency of adoption or guardianship. ASAP services are designed to promote permanency by maintaining, strengthening, and safeguarding the functioning of families to:

- Prevent substitute care placement
- Promote family unification
- Stabilize families
- Facilitate child and family development
- Ensure the safety, permanency, and well-being of children

There is no cost to the family for services provided by ASAP. Services are provided through contracts between the Illinois Department of Children and Family Services and private agencies.

Program History

The Illinois ASAP program was mandated by the Illinois Family Preservation Act of 1988. Section 302.5 includes, among those eligible for intensive family preservation services, “any persons who have adopted a child and require post adoption services.” Since 1991, Illinois has developed and implemented a statewide system for providing ASAP services. Over the years since its inception, the Illinois ASAP program has grown and evolved to keep pace with the needs of post adoption and guardianship families. For example, the designated service period was extended from three to six to 12 months over the early years of the program, with provisions to get approval from the Department of Child and Family Services (DCFS) to extend it further.

DCFS Procedures 309 (Adoption Services For DCFS Wards) outline protocols and expectations related to Post Adoption and Guardianship Services (Section 309.170). In addition to DCFS policies and procedures, private provider agency contracts (referred to as *program plans*) provide detailed information about expectations for service delivery.

ASAP services are offered to all families with adopted children, including families who adopted privately or internationally. Families with a subsidized guardianship are also eligible for services. Each region of Illinois has at least one ASAP provider to which families can self-refer.

Understanding the Needs of the Adoption and Guardianship Population

DCFS and the ASAP providers use a variety of methods to aid in understanding the needs of the adoption and guardianship population. These methods allow the ASAP community of providers and its partners to continually assess the needs of the adoptive parent and guardianship caregiver community.

Illinois Adoption Advisory Council (IAAC)

The Illinois Adoption Advisory Council (IAAC) was established by the DCFS director for advising and consulting with the director (of DCFS) or his/her designee(s) on all matters involving or affecting the provision of adoption and guardianship services. Council members are all appointed by the DCFS director. Members consist of adoptive parents and adoptees representing each DCFS administrative region, as well as experts in child welfare and adoption, some of whom are employed by

contract agencies. Two adoptive parent members also hold joint appointments to the Child Welfare Advisory Committee.

Responsibilities of the IAAC	Providing input on the issues that affect adoption and guardianship services received by children and their families
	Identifying, analyzing, and recommending solutions to any issues concerning adoption and guardianship services
	Interpreting to the public and the General Assembly the need for adoption and guardianship and the important service that adoptive and guardianship parents provide
	Promoting the statewide exchange and pooling of information in the area of adoption and guardianship
	Participating in statewide planning and promoting adoptive and guardianship parent involvement in local planning, including adoption and guardianship services
	Reviewing and making recommendations on DCFS adoption, guardianship, and child welfare service delivery policies, guidelines, procedures, and practice
	Developing recommendations concerning adoption and guardianship training to improve the quality of services families receive
	Reviewing and advising DCFS on pending or enacted legislation, primarily as it concerns adoption and guardianship services, and on the Department's responses or positions regarding that legislation
	Advising the Department on activities to recognize Adoption Month each November and assisting in developing and presenting such activities

Needs Assessment Across ASAP Providers and DCFS

Representatives of the ASAP providers are encouraged to participate in client-based clinical meetings within the community. The ASAP managers and supervisors provide regular reports (monthly, quarterly, and annually) on the needs of adoptive and guardianship families. The statewide ASAP program supervisors meet quarterly to review this information and discuss with DCFS how to best meet the needs of this population.

Participation in Conferences and Community-Based Trainings

ASAP providers send staff to the Statewide Adoption Support and Preservation Conference, other community trainings, and national conventions such as the Adoption Support and Preservation Conference sponsored by Harmony Family Center and the North American Council on Adoptable Children, a forum for both adoptive parents and their providers.

Involvement in Federal-Level Initiatives

Illinois has also remained engaged at the federal level to leverage resources to help support the ASAP program. Illinois participates in initiatives such as National Quality Improvement Center for Support and Preservation (QIC-AG), National Training Initiative (NTI), Critical and On-going Resource Family Education (CORE Teen), and National Training and Development Curriculum for Foster/Adoptive Parents (NTDC), national programs that that help support continued enhancements to the ASAP program and the broader child welfare service delivery system.

Theory of Change

While research tells us that most families who have adopted or assumed guardianship are able to meet the needs of their children, there is a subset of families who struggle.[2,3,4] Families who have adopted or assumed guardianship and who exhibit increased post-finalization familial stress may be at a higher risk of discontinuity.

Some families may not have the support needed to address emerging issues on their own. This may be because service systems are complex and cumbersome, service referrals may not be enough, or because families often feel isolated. Making it more challenging is the perception (by the family or the system) that the family should be able to address the needs of the child on their own. The ASAP program provides support to families with emerging needs that might threaten a commitment to

Advance Your Knowledge

Post-permanency discontinuity is a term used to describe situations where children leave their homes after adoption or guardianship, prior to becoming an adult.[1]

[1] *From* Rolock, N. (2015). Post-permanency continuity: What happens after adoption and guardianship from foster care? *Journal of Public Child Welfare, 9*(2), 153-173. https://doi.org/10.1080/15548732.2015.1021986

[2] Festinger, T. (2002). After adoption: Dissolution or permanence? *Child Welfare, 81*(3), 515-533.

[3] Fuller, T., Bruhn, C., Cohen, L., Lis, M., Rolock, N., & Sheridan, K. (2006). *Supporting adoptions and guardianship in Illinois: An analysis of subsidies, services and spending*. University of Illinois at Urbana-Champaign, School of Social Work.

[4] McDonald, T. P., Propp, J. R., & Murphy, K. C. (2001). The postadoption experience: Child, parent, and family predictors of family adjustment to adoption. *Child Welfare, 80*(1), 71-4.

permanence. These needs could be triggered by a change in family dynamics resulting from the child's age or developmental stage (such as entering the teen years), a change in family functioning, or a family member feeling overwhelmed and unable to meet their child's needs.

Support provided to families is designed to reduce family stress, stabilize relationships, and increase the family's skills in managing challenging behaviors and maintaining felt safety and positive relationships in the home. This additional support seeks to help families as they address the needs of their children, which, in turn, will help to reduce familial stress and ultimately increase their capacity for post-permanence stability and improved well-being.

Adoption Support and Preservation Program Logic Model

Target Population	Inputs	Program Activities	Service Outcomes	Treatment Outcomes
Families formed through adoption and subsidized guardianship, including both DCFS adoptive and guardianship formed families and other adoptive families such as those formed through private and intercountry adoption	DCFS Post Adoption Unit ASAP providers Community providers Other DCFS units working with families prefinalization	– Assessment and treatment planning – Referrals for external evaluations – Crisis intervention – Support/therapy groups – Family and individual counseling – Linkages to community services – Respite – Case management – Advocacy activities	– Provider shall increase accessibility of services for 100% adoptive and guardianship families served by the program – Provider shall increase the use of community-based services to support families, where appropriate, and to prevent the out-of-home placement of children, for at least 95% of families served by the program – Provider shall prevent the entry/re-entry of a child into the child welfare system for at least 95% of the children served by the program	– Establish a range of services that address the needs of an adoptive or guardianship family, while responding to their immediate needs, for at least 95% of families served by the program – Increase the family's level of functioning in at least 80% of families served by the program – Maintain the child in the adoptive home, or when placement outside the home is appropriate and necessary, maintain parent/child relationship in at least 85% of families

External Conditions	Theory of Change
– History of DCFS involvement – Internationally or privately adopted – At risk for out-of-home placement – Trauma – Prenatal drug and alcohol exposure – Attachment and trust issues – Significant emotional and behavioral issues – Psychiatric diagnoses – Adjustment issues – Grief and loss associated with adoption – Medical and neurological disabilities – School and socialization issues	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. 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. Providing support to families with emerging needs who are at risk for discontinuity will help families as they address the needs of their child(ren), which in turn will better equip parents and guardians to address the needs of their children through increased social supports, decreased behavioral problems, and increased caregiver commitment, and ultimately increase their capacity for post-permanence stability and improved well-being.

Educating Families About ASAP Services

The permanency worker who is preparing the child in care and the family for adoption or subsidized guardianship is required by DCFS Procedures Section 309 to provide the family with information about post adoption and guardianship services. A Post Adoption and Guardianship Services Acknowledgement form is provided to the family, along with the Post Adoption and Guardianship Services Booklet, which can be found on the DCFS website. This booklet contains information on services/support available to families along with contact phone numbers. Approximately 15 days after the post adoption or guardianship case is opened, DCFS sends out a welcome letter to all families that adopt or obtain guardianship through the child welfare system. The letter contains the name of the post adoption staff member they have been assigned as well as the toll-free Adoption/Guardianship Support phone line. This post adoption staff member can assist with subsidy-related issues and refer families to services. Illinois requires all private domestic and international adoptive parents be informed by their licensed adoption-only agencies of the availability of ASAP services.

Illinois has state agencies that provide ASAP services, but private agencies providing ASAP services also promote the program in brochures, agency websites, and agency newsletters. Many adoption preservation agencies hold events several times a year for adoptive and guardianship families. These events allow the families to meet the staff and hear about the services that are being offered.

In 2019, Illinois developed a web-based portal (*click the logo in the margin to visit the Path Beyond Adoption website*) which provides resources specifically selected and vetted for adoptive and guardianship families. The portal interface was developed as a website managed by DCFS, but it has a unique domain so that families do not have to navigate multiple pages of the DCFS website to access the information they need. The Path Beyond Adoption Content Committee provides oversight of the web-portal and is a collaboration between DCFS Communications, the Illinois Adoption Advisory Council, and the DCFS Post-Adoption Unit.

The Illinois Post-Adoption unit within DCFS can be reached through the Adoption/Guardianship Support phone line (1-866-538-8892), where families can connect to the resources they need. By calling this number, families can access information about subsidies, or they can be directed to ASAP or other agencies to address more specific needs. The Adoption/Guardianship Support phone line, which is a critical entry point for adoptive and guardianship families, was enhanced in 2019 so that families could more quickly be directed to needed supports.

Partners Available To Help
after adoption and guardianship

Outreach Strategies

Illinois DCFS Newsletter

Illinois DCFS produces a newsletter: Illinois Now and Forever. It is a statewide newsletter with information on services, events, and resources for foster and adoptive parents throughout the state. The newsletter contains region-specific pages with customized content. Illinois Now and Forever has a circulation of approximately 35,000. Families are automatically put on the distribution list as long as they are licensed or have an active subsidy.

ASAP Meetings and Support Events

ASAP staff provide information about post adoption and guardianship services at child-family team meetings, foster care staff meetings, family support plan meetings, networking events, and foster care support social events. ASAP staff also network with providers in all service areas to inform them of services provided through ASAP. Some providers also put together family events, which adoptive parents are invited to attend to learn more about available support and services.

PATH Beyond Adoption (PBA)

In 2020, Illinois began offering PATH Beyond Adoption (PBA) events for families. These live events were coordinated and facilitated by the ASAP providers that serve each catchment area of the state. During the events, providers cover topics such as the importance of staying connected to services and the importance of reaching out early for support. Each provider also provides region-specific descriptions of the START services offered through ASAP and highlights other services offered to post adoption and subsidized guardianship families. PBA workshops are scheduled on a quarterly basis by each ASAP provider based on their availability. Once these dates are decided, they are forwarded to the Statewide Post Adoption Program Manager, who then disseminates fliers to the Path Beyond Adoption website, DCFS announcements, and social media postings. The information is also sent to Agency Performance Managers for distribution to all private agencies (both DCFS and private/international adoption agencies), DCFS staff who work with families, the Statewide Adoption Team, and the Adoption Attorney panel. The main audience is the potential and current adoptive and guardianship parents, so we attempt to find all routes to get the information to them.

Other

The ASAP supervisors train staff within their own and other agencies to ensure that they are providing a full overview of adoption support and preservation services (including the local respite programs) to the families who are adopting or obtaining subsidized guardianship. ASAP staff members participate in the IAAC which further supports promotion of ASAP services in partnership with stakeholders.

In addition to these activities, ASAP providers use tools such as newsletters, social media, mailings, and email distribution lists to share upcoming educational and support events being sponsored at their agencies. ASAP providers are also invited to present information at the DCFS adoption quarterly informational meetings for permanency staff.

Target Population

Definition

The ASAP program is designed to serve a special population: Families formed through adoption and subsidized guardianship. The program serves both DCFS adoptive and guardianship formed families and other adoptive families such as those formed through private and intercountry processes.

Important Note

In the ASAP program, *clients* are defined as all members of the household including a child under the age of 18 (or up to 21 with DCFS approval for children who have current DCFS subsidies) who has been adopted privately or through DCFS or for whom subsidized guardianship has been awarded through DCFS, and:

- who is residing in the home at the time of referral; or
- a family in which an adopted child or child under subsidized guardianship lives in another home as part of an informal caregiving arrangement; or
- for whom the plan is to transition back into the home (e.g., a child in a psychiatric placement); or
- whose permanency was disrupted either because of the death or disability of the adoptive parent or guardian and who is residing in the home of an adult who expresses interest in becoming the successor adoptive parent or guardian at the time of the referral; or
- whose family is requesting a comprehensive assessment for the purpose of determining the need for out-of-home placement.

ASAP providers are committed to respecting diversity and providing equal opportunity for services. The ASAP program does not discriminate on the basis of:

- Race
- Creed
- Color
- Ethnicity
- National origin
- Religion
- Sex
- Sexual orientation
- Gender identity and expression
- Age
- Height
- Weight
- Physical or mental ability
- Veteran status
- Military obligations
- Marital status
- Socioeconomic status

Service planning and delivery takes place in a culturally appropriate manner to meet the needs of racial, ethnic, and culturally diverse groups and includes:

- Active recruitment and employment of racially, ethnically, and culturally diverse personnel
- Service accessibility in rural and remote areas
- Service accessibility for persons with visual, hearing, and physical impairments
- Ongoing cultural competence training opportunities for the supervisors, personnel, and volunteers

ASAP providers can access TTY to address any hearing impairments, interpreter services to address linguistic barriers, or other necessary communication-related services. In some cases, families who experience barriers to accessing services may be provided with additional support such as assistance with transportation.

Inclusion Criteria

To be served, a family must have either a child who was adopted or for whom they are named as the subsidized guardian, and they must either accept the service or express a willingness to begin receiving services. Some of the problems that would be appropriate for ASAP services include:

- Child or children experiencing significant emotional or behavioral issues that are symptomatic of the adoption/guardianship placement or placement history such as:
  - chronic lying and/or stealing
  - aggression
  - eating or sleeping disturbances
  - fire-setting
  - sexual acting out
  - ADHD
- Child experiencing loss/grief/separation issues
- Medical/organic/neurological disabilities (e.g., fetal alcohol syndrome/effects, mood disorders, attachment disorders, and other psychiatric diagnoses)
- Adjustment issues relating to adoption/guardianship

In addition, subsidized guardianship (KinGap) is a permanency option provided to youth in care (children under the legal custody of the state). Subsidy assistance is provided to support the guardian with meeting the needs of children for whom the permanency goals of reunification or adoption have been ruled out. ASAP services are available to relatives and/or fictive kin who have cared for youth in care as a foster parent, who are committed to continuing to care for the child on a permanent basis, and who assume the legal guardianship of the child.

Illinois families meeting the eligibility criteria will be accepted on a no-decline basis unless the contract is at capacity or services are deemed to be inappropriate based upon client needs and family participation. If the contract is at capacity, clients will be placed on a wait list for services.

In addition to the above inclusion criteria, parent support groups are open to clients and nonclients including foster parents if they intend to adopt. Parent psychoeducation classes are also open to parents, adoptive parents, foster parents, and professionals to enhance the community care of our client base.

Finally, services can also be provided to support parents of a child who is not amenable to services or is unwilling or unable to participate in services.

Exclusion Criteria

Any family may be excluded based on noncooperation of the adoptive or guardianship parent(s). If parent(s) are cooperative and accepting of the program, at least one adopted or guardianship child in the family must also cooperate with the program. Conditions within the family that may cause exclusion from the program include:

- A child who chronically runs away, who is on the run at the time of the referral for service, and whose whereabouts are unknown
- A child who is involved in criminal or gang activity and there are known or suspected safety issues
- Severe cognitive impairment of parent or child resulting in their inability to benefit from service
- Parent or guardian who is no longer willing/able to parent and has ruled out any services to stabilize the placement
- Substance abuse of parent/child, when referral to a substance abuse program has been refused and which results in their inability to benefit from service

In addition to the above exclusion criteria, it should be noted that private guardianship is also a basis for exclusion. Private guardianship is an arrangement entered without the assistance of DCFS. Private guardianship can be a short- or long-term arrangement appointed through probate court.

Frequency and Duration of Services

The intention of the ASAP program is to provide services in a manner that allows sufficient time for clients and their families to learn new skills and for treatment gains to be made. The assessment and treatment planning process is intended to identify strengths and needs and develop a set of strategies to enhance strengths and meet those needs.

Ongoing assessment and consultation with the family during service delivery will reveal when strengths have been enhanced, when needs have been mitigated, and when sufficient progress has been made to move toward case closure. In every family, needs will likely remain, but if the family acquires the necessary skills and builds support to address those needs, the family's resilience and capacity to manage in the future will be improved.

The ASAP program has been developed with the understanding that the effects of developmental trauma take time to mitigate, and the transitional issues associated with adoption and guardianship can resurface along a continuum of development. While ASAP providers must follow established policies surrounding service periods within which families access services, there are protocols in place to allow for additional service if deemed necessary.

Service Periods

Families are approved to receive services in 180-day service periods. DCFS approves the first 180-day period and the ASAP provider working with the family can approve the second 180-day period. After one year of service, an extension request must be submitted to DCFS for subsequent service periods.

A service period begins on the date the case is first opened.

A "full service period" is considered to be 24 months. A family may receive up to 24 months of continuous service. The cases of families who do not receive the full 24 months of service prior to closure may be reopened and service provided for a period not to exceed a total of 24 months from initial opening date. For example, there are families who may experience periodic crises where short-term service may be required to meet their immediate needs. In such instances, cases may be opened for the short-term service, closed, and reopened again when service is again required.

Note

An Extension Request Form (see Resources in this manual) must be submitted for an exception to the maximum time frames for any family who requires more than the approved 24-month period. The ASAP provider must receive approval for this extension before continuing services.

Example: Family A received 365 days of service and the case was closed. Two months later, Family A again requests service as a result of a current crisis. The agency may provide service for up to an additional 365 days. The total service time received by the family is 24 months without submitting an Exception to Maximum Time Frames.

Click here
Extension Request Form

A family may request additional services after their ASAP case has been closed. A family's case can be reopened after having been closed for six months without requesting approval. In these instances, a family is eligible for another full-service period. If the family requests services prior to six months following a previous closing, approval for reopening must be requested from the Statewide Post Adoption Program Manager.

Service Period Extension Requests

If the agency determines after two 180-day service periods that the family is still in need of continued support, the agency supervisor should submit an Extension Request Form to the DCFS Statewide Post Adoption Program Manager at least 30 days prior to the end of the second 180-day period and should include the following information: The reason for the request, the types of service required, and the anticipated length of time the service will be required.

A suggested outline for the request includes:

What is the reason for the request? What are the problem areas preventing the case to close out?

- Give a complete description and summary of the issues of the case.
- List the interventions that have been put into place.
- Discuss the progress or lack of progress toward goals and the factors that have prevented case closing.
- Explain, in detail, why additional time is needed.

What types of services will be provided to the family, and what is the anticipated length of time service will be required? (Attach the most recent progress report.)

- Provide a very specific list of services that will be provided to the family members (parent/guardians/children).
- Document the anticipated length of time the services will be required.

What attempts have been made to locate other resources for the family? Why would it be detrimental to discontinue service at this time? (Name the resources that have been sought, dates, and whether these resources have been useful to the family.)

- Are the parents requesting continuation of services?
- Are parents actively involved in services?
- Is focus child requesting continuation of services?
- Is focus child actively involved and interested in services?
- Would the family stabilization/placement be in jeopardy if preservation services ended?

A response to the request will be made within 10 business days of receipt. Determining factors for approval include the inability to locate other resources for the family to help deal with additional problems that may have arisen or the resurfacing of prior problems. An updated assessment completed by the agency documenting the current situation and service needs should accompany the Extension Request Form. A copy of the approved form will be sent to the agency.

Exceptions will be approved in 180-day increments with the maximum length of time being 180 days for which an exception can continue. The agency will be required to submit an update on the case prior to the end of each 180-day segment up to the maximum of the six-month time limit for the extension. The 180-day updates shall contain reasons for the continued request for service and any attempts to locate other service providers/resources.

Exception to Maximum Time Frames

In rare circumstances, a family may require an additional period of service in excess of the 24-month period allowed because there have been changes in the family situation. In those instances, the agency shall submit an Exception to Maximum Time Frames to the Statewide Post Adoptions Program Manager. The Statewide Post Adoption Program Manager will review each request individually and will determine approval.

Average Length of Services

Mason (2019) notes, "the brain requires sufficiently frequent, patterned, repetitive activation for change to occur…[a]n hour of time with a client each week is simply insufficient to create meaningful change in our most vulnerable clients; at best, progress is very slow."[5] Perry and Dobson (2013) describe a case study for one child where comparisons of an assessment of the child's functioning one year apart showed that the child had not yet achieved typical age-level functioning but had progressed to a level that allowed him to be ready for participation in more cognitively based interventions. This progress was attributed to a period of coordinated and intentionally timed strategies to support establishing a healing environment.[6] This case study is reflective of the experience of ASAP providers for many cases, in that progress takes time and patience to achieve, with estimates by ASAP providers that 12-18 months of services tends to more often be the period of time necessary to start to see meaningful change.

Flexibility in Service Delivery

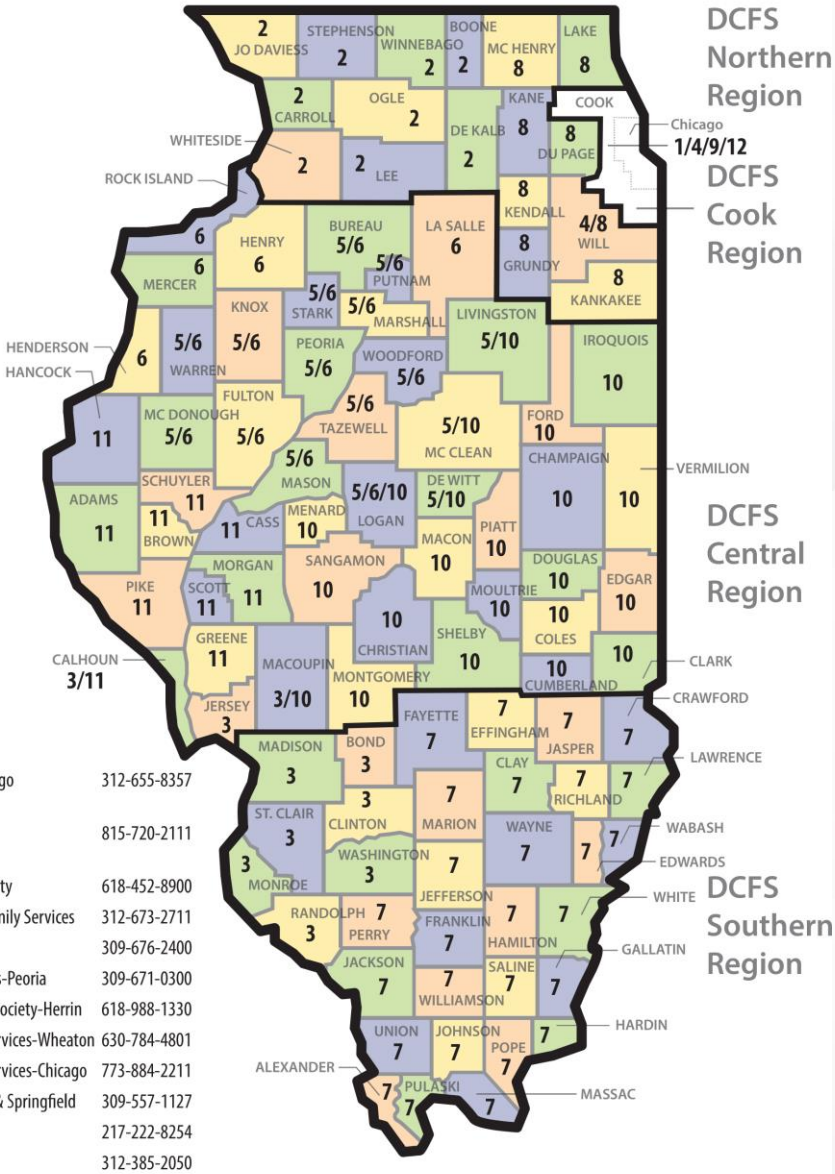
Services delivered in the ASAP program are intended to be flexible and tailored to meet the needs of the child and family. This may include providing services in new and innovative ways as tools and techniques are developed over time. For example, using video conferencing technologies to connect with families when in-person meetings are not possible can be an effective way to maintain engagement and momentum in the therapeutic process. Another example of flexible service delivery is when an ASAP provider refers a family to an ASAP

[5] Mason, C. (2019, January 1). The neurosequential model of therapeutics (NMT): Helping clients move beyond trauma. *The New Social Worker*. Retrieved from https://www.socialworker.com/feature-articles/practice/the-neurosequential-model-of-therapeutics-nmt-helping-clients-move-beyond-trauma/

[6] Perry, B. D. & Dobson, C. L. (2013). Application of the neurosequential model of therapeutics (NMT) in maltreated children. In J. D. Ford & C. A. Courtois (Eds.). *Treating complex traumatic stress disorders in children and adolescents* (pp. 249-260). New York, NY: Guilford Press.

provider in another service area to access a unique service. This crossing of coverage areas allows the ASAP program to meet the needs of the children and families served.

Illinois Sites: Adoption and Guardianship Preservation Providers



1. Catholic Charities-Chicago 312-655-8357
2. Children's Home & Aid Society-Rockford 815-720-2111
3. Childrens' Home & Aid Society-Granite City 618-452-8900
4. Jewish Children and Family Services 312-673-2711
5. Family Core 309-676-2400
6. Lutheran Social Services-Peoria 309-671-0300
7. Childrens' Home & Aid Society-Herrin 618-988-1330
8. Metropolitan Family Services-Wheaton 630-784-4801
9. Metropolitan Family Services-Chicago 773-884-2211
10. The Baby Fold-Normal & Springfield 309-557-1127
11. Cornerstone-Quincy 217-222-8254
12. Ada S. McKinley 312-385-2050

• 12 •

Click here
Downloadable Map

Service Delivery Location

Geographical Areas

The ASAP map highlights service delivery agencies by county. Families are served by the ASAP provider that is contracted by DCFS to provide service in each region. An ASAP provider must obtain prior authorization from the DCFS Statewide Post Adoption Program Manager to service families outside their assigned region. This type of request may be made in instances where a family has an established relationship with the preferred ASAP provider (such as when a family who has previously been served by the provider moves out of the provider's service area) or when the preferred ASAP provider offers a service that is not offered by the ASAP provider serving the region where the family resides. In these situations, the family must live within reasonable proximity to the agency and be willing to travel to the agency. In addition, the provider must not have an active wait list. If the agency has questions about the readmission of the family, they should contact the Statewide Post Adoption Program Manager.

Hours of Operation

ASAP staff have flexible schedules to meet the changing needs of the client. To accommodate the needs of the population, hours of operation include daytime, evenings, and occasional weekends for certain planned events.

Service Delivery Settings

The ASAP program uses a home-visiting structure as the basis to promote a relationship between the family and staff. Families report that home visits are essential to post adoption service provision.[7] "Home visits allowed the ASAP staff to get to know the family in a way that is different from if it occurred in an office. They stated that home visits respect the families' privacy and allowed support to be provided in a relaxed and familiar setting."

> "We were under so much stress that it helped tremendously that she came to the home and that we didn't have to drag him out because we were having difficulty getting him to places without having severe meltdowns…I also thought it helped for her to see how he's as cute as can be until he's raging. She got to see that happen because she was in the home."

[7] Rolock, N., Diamant-Wilson, R., Blakey, J., Zhang, L., White, K., Cho, Y., Fong, R. (2019). Evaluation results from Wisconsin—Final evaluation report. In N. Rolock & R. Fong (Eds.). *Supporting adoption and guardianship: Evaluation of the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG)—Final evaluation report*. (pp. 7-1–7-68). Washington, DC: Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

The home is considered the least restrictive environment and there are many benefits to providing services in the home, including:

- Enhancing the development of the therapeutic relationship[8,9]
- Helping to better identify strengths and needs by observing the situation described by the family
- Providing opportunities for staff to witness, first-hand, some of the issues and struggles families are facing[10,11]
- Allowing support to be more targeted and effective[12]
- Increasing inclusion of family members who might not otherwise participate in sessions[13,14,15,16,17,18]
- Allowing for a better assessment of parenting skills and relationships in the family's natural environment
- Helping the child and families feel safer, more comfortable, and more relaxed
- Making it easier for the child and family to practice new skills in their natural environment and to determine what does and does not work

> "I think home visits are good because…it's more private…when you're talking about pretty personal stuff you don't necessarily want other people to hear."

> "She came to the house and I think it was two hours that she was here…I enjoyed it…She made me feel relaxed. I was able to talk to her and I don't know I just liked talking to her… Having someone to bounce ideas off."

[8] Christensen, L. (1995). Therapists' perspectives on home-based family therapy. *The American Journal of Family Therapy, 23*(4), 306-314. http://doi.org/10.1080/01926189508251361

[9] Woodford, M., Bordeau, W., & Alderfer, C. (2006). Home-based service delivery: Introducing family counselors in training to the home as a therapeutic milieu. *The Family Journal: Counseling and Therapy for Couples and Families, 14*(3), 240-244. https://doi.org/10.1177/1066480706287272

[10] Slattery, J. & Knapp, S. (2003). In-home family therapy and wraparound services for working with seriously at-risk children and adolescents. In L. VandeCreek & T. Jackson (Eds.). *Innovations in clinical practice: Focus on children & adolescents. A volume in the innovations in clinical practice series* (vol. viii, pp. 135-149). Sarasota, FL: Professional Resource Press/Professional Resource Exchange.

[11] Snyder, W. & McCollum, E. (1999). Their home is their castle: Learning to do in-home family therapy. *Family Process, 38*(2), 229-242. https://doi.org/10.1111/j.1545-5300.1999.00229.x

[12] Macchi, C.R. & O'Conner, N. (2010). Common components of home-based family therapy models: The HBFT partnership in Kansas. *Contemporary Family Therapy, 32*, 444-458. https://doi.org/10.1007/s10591-010-9127-1

[13] Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. *The Family Journal: Counseling and Therapy for Couples and Families, 12*(2), 184-188. https://doi.org/10.1177/1066480703261980

[14] Cottrell, D. (1994). Family therapy in the home. *Journal of Family Therapy, 16*(2), 189-197. https://doi.org/10.1111/j.1467-6427.1994.00788.x

[15] Schacht, A., Tafoya, N., & Mirabla, K. (1989). Home-based therapy with American Indian families. *The Journal of the National Center*, *3*(2), 27-42. https://doi.org/10.5820/aian.0302.1989.27

[16] Woodford, M. (1999). Home-based family therapy: Theory and process from "friendly visitors" to multisystemic therapy. *The Family Journal: Counseling and Therapy for Couples and Families*, *7*(3), 268-269. https://doi.org/10.1177/1066480799073010

[17] Zarski, J., Greenbank, M., Sand-Pringle, C., & Cibik, P. (1991). The invisible mirror: In-home family therapy and supervision. *Journal of Marital and Family Therapy*, *17*(2), 133-143. https://doi.org/10.1111/j.1752-0606.1991.tb00876.x

[18] Zarski, J., & Zygmond, M. (1989). Negotiating transitions: A supervision model for home-based family therapists. *Contemporary Family Therapy*, *11*, 119-130. https://doi.org/10.1007/BF00892077

- Increasing the family's ownership in the treatment process[19]
- Allowing the family to avoid having to set aside travel time for services

Because the home environment is the context in which new skills and communication patterns will be used, being present for some of the family's routines serves as a meaningful and functional opportunity for learning communication, social interaction, and other developmental skills.

While service provision in the home is most frequently the case, services can be provided in community settings or in the office if determined to be more appropriate based specifically on family needs. Many ASAP providers have also found that families have benefited from virtual groups, which have allowed them to participate when they otherwise could not have due to challenges related to transportation or lack of childcare. These types of remote modalities may be considered in extenuating circumstances to ensure continuity of service and reduce barriers to delivery during times when in-person sessions are not possible.

[19] Macchi, C.R. & O'Conner, N. (2010). Common components of home-based family therapy models: The HBFT partnership in Kansas. *Contemporary Family Therapy*, *32*, 444-458. https://doi.org/10.1007/s10591-010-9127-1

Referral and Admission Procedures

Referral Sources

Referrals for therapeutic services to ASAP come through a variety of sources including DCFS and its Subsidy Post Adoption Workers. A DCFS case manager may call or email a referral request for services or have the family call directly themselves. Families can also self-refer and be referred through community service providers.

Processing Requests for Service

When requests for service are received directly by the ASAP provider, the agency will process the request to determine the most appropriate action. When the request for service is for purposes of assessment only or referral to another service resource, the agency will make every effort to ensure that linkage occurs between the family and the appropriate service. If the agency determines that they will open the case for ASAP services, DCFS is notified of the case opening.

Calls received in a DCFS office requesting post adoption or guardianship services will be directed to the appropriate DCFS post adoption worker (assigned by region), who will gather information, assess eligibility, and make a referral to ASAP if this is the most appropriate service for the family. If the referral is appropriate for

service, it shall be forwarded to the appropriate ASAP provider no later than one working day following a phone intake using the official Intake Referral Form.

Referred families are contacted by the designated staff in each ASAP provider office. The assigned preservation staff will initiate contact by phone within 24 hours to gather information regarding the family and need for services, assess for eligibility, and complete a referral. When a family calls requesting services, information is gathered to include information about adoption/guardianship status, county, and the problems leading to the request for services. This information enables the agency to determine if the family meets criteria for the program. If the family does not meet criteria for the program, the supervisor refers the family to community resources. Acceptance of the referral will be made by the agency designee based upon the criteria of the contract. Upon acceptance of the referral, a follow-up with an in-home visit is expected within three days.

Referral Decision-Making Criteria

Referrals and admissions to ASAP services require that an assessment be completed. The assessment must result in a determination that ASAP services are the most appropriate.

In situations where children are in need of hospitalization, the ASAP provider may make a referral for Screening, Assessment and Support Services (SASS; see Learn More box) and also open a case. Cases in which children need residential care are typically opened by the ASAP program to provide support in obtaining a higher level of service and to provide support that can stabilize the family and divert the child from that higher level of need.

Learn More

In an effort to provide improved coordination in the delivery of mental health services to youth, Illinois developed the Screening, Assessment and Support Services (SASS) program for children and adolescents experiencing a mental health crisis. This initiative rolled out on July 1, 2004, as part of the implementation of the Children's Mental Health Act of 2003 (pdf) (html) (Public Act 93-0495), which was signed into law on August 8, 2003.

The SASS initiative is a cooperative partnership between the Department of Children and Family Services (DCFS), the Department of Healthcare and Family Services (HFS), and the Department of Human Services (DHS). The development of the tri-department SASS program created a single statewide system to serve children experiencing a mental health crisis whose care will require public funding from one of the three agencies. This program features a single point of entry (Crisis and Referral Entry Service, CARES) for all children entering the system and ensures that children receive crisis services in the most appropriate setting.

Once the preliminary assessment is completed, if the referral is not appropriate for the services provided by the program, a referral will be made to other appropriate resources (where such referrals are applicable and when services are available) to meet the needs of families who are not accepted for this program.

Admission Notification Procedures

All referred families meeting the above criteria are accepted for service on a no-decline basis except when the program services are deemed to be inappropriate based on the child's needs and family participation. If the program is at capacity, the ASAP provider may negotiate with DCFS to accept additional cases (if they have current cases which will be closed in the near future) or the family has the option to be put on the wait list. The ASAP provider will obtain written consent for release of information from the referred family that specifies an exchange of information between DCFS and the ASAP provider.

Wait List

A wait list is maintained for those families who qualify for service but for whom an opening is not currently available. ASAP providers regularly report to DCFS the number of people on the wait list.

A triage model is utilized with families on the wait list. Each ASAP provider is responsible for making triage decisions regarding the order in which cases are opened. Cases that appear to be at highest risk for family disruptions and where safety is an issue are prioritized first. Supportive services are provided while families are on the wait list and may include:

- Providing families with information on other possible resources
- Offering group services to the family while they wait for an opening
- Providing reading recommendations and some limited parenting skill suggestions
- Maintaining periodic contact to let them know their status on the waiting list

Respite services may also be made available more quickly if needed to provide a break to the families in order to stabilize their situation. The Resources section of this manual includes some examples of resources that can be offered to families while they await service.

Caseload Assignment

Decisions regarding assignment of caseloads may include consideration of staff competencies, qualifications, experience, and current status of workloads to ensure the staff have the time and abilities to accomplish assigned tasks and job responsibilities. Case weights may also include various activities that involve large amounts of time other than basic case management and therapy, such as time traveling to family's homes, families with special needs or in crisis, and support group responsibilities.

Specialized Training for ASAP Providers

The Need for Specialized Training

Because of traumatic life experiences and early losses, many children who are adopted, in guardianship, or in foster care, experience elevated risks for developmental, social, health, emotional, relational, and behavioral challenges. The impact of these experiences and challenges compromises well-being and family stability, for example:

- The American Academy of Pediatrics (2015) estimates up to 80% of children come into foster care with a significant mental health need
- 40% of youth adopted from foster care are diagnosed with ADD/ADHD with a high incidence of prenatal drug/alcohol exposure[20]
- Adoptive families utilize clinical services at triple the rate reported by families formed by birth[21,22]
- Foster/adoptive parents reported 1/3 of children had emotional problems and 40% had educational problems[23]

[20] Smith, S. L., Howard, J. A., Garnier, P. C., & Ryan, S. D. (2006). Where are we now? A post-ASFA examination of disruption. *Adoption Quarterly*, *9*(4), 19-44. https://doi.org/10.1300/j145v09n04_02

[21] Howard, J. A., Smith, S. L., & Ryan, S. D. (2004). A comparative study of child welfare adoptions with other types of adopted children and birth children. *Adoption Quarterly, 7*(3), 1-30. https://doi.org/10.1300/j145v07n03_01

[22] Vandivere, S., Malm, K., & Radel, L. (2009). *Adoption USA: A chartbook based on the 2007 National Survey of Adoptive Parents.* Washington, DC: The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[23] Festinger, T. (2006). Adoption and after: Adoptive parents' service needs. In M. M. Dore (Ed.), *The postadoption experience: Adoptive families' service needs and service outcomes.* Washington, DC: Child Welfare League of America & Casey Family Services.

These problems are magnified by the fact that many behavioral health professionals do not receive adequate training in the needs of foster, adoptive, and guardianship children.

Historical Approach to Training in the ASAP Program: The Silver Box

In 2004, the Center for Adoption Studies at Illinois State University and DCFS published the *Best Practice in Adoption and Guardianship Preservation Guided Curriculum*. The curriculum was designed to be used as a training resource to complement the in-service training and supervision provided in each individual ASAP provider. Disseminated to all ASAP providers, it became known as the "Silver Box," describing the container that housed the curriculum materials. It included a guided curriculum book, videotape library, case studies, and supplemental readings.

Description of Required ASAP Training

Since the dissemination of the Silver Box, DCFS has continued to promote consistency in the level of training and expertise of the agencies and staff serving families across Illinois. While each ASAP provider varies in the specific training that is provided for staff in various positions within the program, there are several trainings that are universally required by all ASAP providers. Each of these is described below.

The National Adoption Competency Mental Health Training Initiative (NTI)[24]

Click here
NTI

The National Adoption Competency Mental Health Training Initiative (NTI) for Mental Health Professionals is a 30-hour, web-based training that provides the foundational knowledge, values, and skills needed to enhance adoption competency for mental health professionals providing or interested in providing therapeutic or clinical services to children, youth, and families experiencing adoption or guardianship. Core competencies include:

- Understanding and addressing the complex and often nuanced mental health needs of children experiencing adoption and guardianship
- A focus on the impact of grief and loss, trauma, attachment, identity challenges
- The impact of race, ethnicity, culture, class, and diversity on adoption and guardianship, especially for transracial and transcultural families

In addition to sharing clinical best practices in assessment and treatment and therapeutic parenting strategies, NTI provides an overview of evidence-based and evidence-informed treatment models that have been shown to be effective in helping children and youth heal from trauma and strengthen attachments.

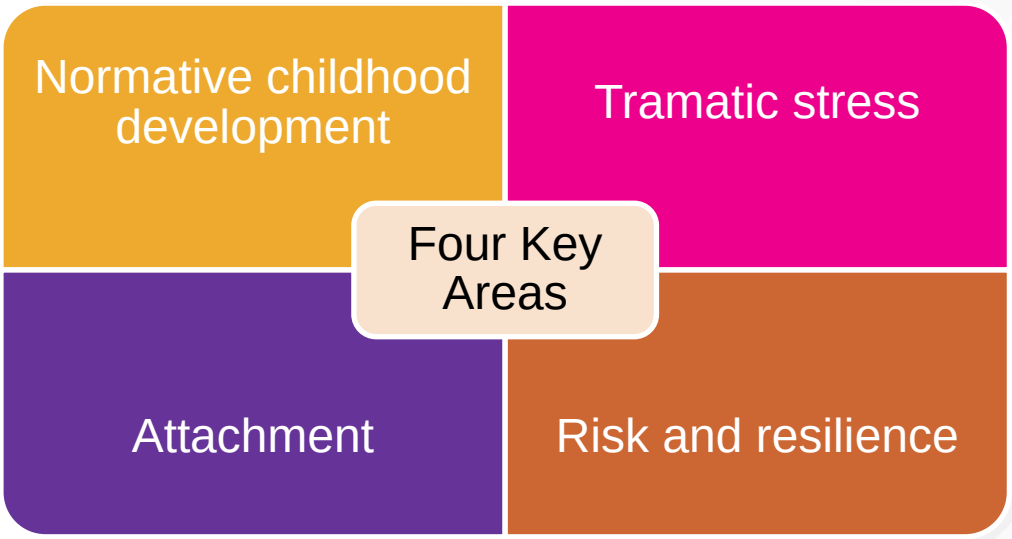
NTI was established in October 2014 through a five-year, $9 million cooperative agreement (#90CO1121) between the Children's Bureau and the Center for Adoption Support and Education (CASE) working alongside the University of Maryland School of Social Work, Institute for Innovation and Implementation. NTI is free in all US states, tribal lands, and territories. Illinois was one of the first states to pilot the NTI curriculum.

[24] National Adoption Competency Mental Health Training Initiative. (2021). NTI Curricula Overview. Retrieved from https://adoptionsupport.org/nti/nti-curricula/

Attachment, Regulation and Competency (ARC) Framework[25]

Click here
ARC

The Attachment, Regulation and Competency (ARC) Framework is a flexible, components-based intervention developed for children and adolescents who have experienced complex trauma, along with their caregiving systems. ARC's foundation is built upon four key areas of study.



Drawing from these areas, ARC identifies important childhood skills and competencies that are routinely shown to be negatively affected by traumatic stress and by attachment disruptions, and that—when addressed—predict resilient outcomes.

[25] Attachment, Regulation and Competency Framework. (2016). What is ARC? Retrieved from https://arcframework.org/what-is-arc/

ARC is organized around three primary domains of intervention (attachment, regulation, and competency) and identifies 8 key treatment targets. These domains and targets are briefly described below.

- ***Attachment.*** The framework focuses on strengthening the caregiving system surrounding children through enhancing supports, skills, and relational resources for adult family members. In many families and systems we work with, family members as well as children have been exposed to multiple stressors and traumatic experiences. Even in caregiving systems that have experienced little or no prior adversity, the effect of a child's relational trauma is likely to impact ongoing attachment relationships. Family supports and the family-child relationship are addressed through an emphasis on three primary targets:
  - Supporting families in recognizing, understanding, accepting, and managing their own emotional and physiological responses, particularly as relates to and impacts parenting or childcare
  - Enhancing rhythm and reciprocity in the family-child relationship and helping families deepen their understanding of child behavior
  - Building effective, trauma-informed responses to child and adolescent behavior
- ***Regulation.*** Many young people who experience trauma are referred for treatment services or struggle in settings like school as a result of difficult behaviors, out-of-control emotions, and impulsive or disorganized bodies. Underlying these challenges is often a difficulty with regulation: of feelings, of thoughts, and of physical experience. Treatment emphasizes cultivating youth awareness and skill in identifying, understanding, tolerating, and managing internal experience. Regulation is addressed through these targets:
  - Supporting youth in developing an awareness and understanding of feelings, body states, and associated thoughts and behaviors
  - Helping youth develop increased capacity to tolerate and manage physiological and emotional experience
  - Enhancing tolerance for and skill in building relational connection

- ***Competency.*** The framework addresses key factors associated with resilience in stress-impacted populations. A goal of intervention utilizing ARC is to go beyond pathology reduction and to increase positive/resilient outcomes among youth receiving intervention. Competency goal targets include:
  - Increasing opportunity for choice and empowerment and skill in recognizing choice points and in effective decision-making
  - Identifying and exploring a range of aspects of self and identity and building coherence through development of narrative around key life experiences, including traumatic exposures

Trust-Based Relational Intervention (TBRI®)[26]

Trust Based Relational Intervention (TBRI®) is an attachment-based, trauma-informed intervention designed to meet the complex needs of vulnerable children. TBRI® uses empowering principles to address physical needs, connecting principles for attachment needs, and correcting principles to disarm fear-based behaviors. While the intervention is based on years of attachment, sensory processing, and neuroscience research, the heartbeat of TBRI® is connection. TBRI® is designed to meet the complex needs of children who have experienced adversity, early harm, toxic stress, and/or trauma. Because of their histories, it is often difficult for these children to trust the loving adults in their lives, which often results in perplexing behaviors. TBRI® offers practical tools for parents, families, teachers, or anyone who works with children, to see the whole child in their care and help that child reach his highest potential.

Click here
TBRI

[26] Karyn Purvis Institute of Child Development, Texas Christian University. (2021). Trust-Based Relational Intervention® Retrieved from https://child.tcu.edu/about-us/tbri/#sthash.ZcbOyVSs.dpbs

Theraplay®

Theraplay® is a structured play therapy for children and their parents. Its goal is to enhance attachment, self-esteem, trust in others, and joyful engagement. Theraplay® sessions are fun, physical, personal, and interactive, and they replicate the natural, healthy interaction between parents and young children. Theraplay® was developed in the late 1960s by Dr. Ann Jernberg, a clinical psychologist, to meet the mental health needs of young children in the Head Start program in Chicago. Since that time, Theraplay® has been used successfully in:

- Early intervention and parenting programs
- Day care and preschools
- Special and regular education programs
- Residential, community mental health, and private mental health practices

The typical age range of children is from birth to 12 years, although the method has been adapted for teens and even for the elderly.

Parent-child relationships are the primary focus in Theraplay®. Clinicians using the techniques work to ensure that the positive connection between parents and children that is the basis of good mental health is firmly established. If a family has experienced loss, trauma, or separation, clinicians work on re-establishing the connection. Because of its focus on attachment and relationship development, Theraplay® has been used successfully for many years with foster and adoptive families. Theraplay® also serves as a preventive program to strengthen the parent-child relationship in the presence of risk factors or the stresses of everyday life.

Other Training

Other Training	
Adoption and the stages of development	Communication and conflict resolution skills
Adult attachment interviewing	Crisis intervention
Life cycle of development and adoptive and guardianship families	How trauma affects kids in school
Cultural diversity	Eye movement desensitization reprocessing
Domestic violence	Art therapy techniques
Addiction	Play therapy techniques
Sexual abuse	Group therapy techniques
Mental illness	

These trainings assist personnel in understanding child development, individual and family functioning, and needs of adopted children with developmental trauma who may have experienced abuse and neglect. They focus on the following key issues in order to encourage success and healing within families:

Safety	Trust	Transparency	Empowerment
Voice	Choice	History	Culture
Interracial adoption	Gender	Identity issues	The need for community and peer support

DCFS Required Trainings

All ASAP staff are required by DCFS to complete Mandated Reporting, Ethics, and Psychological First Aid training.

Program Staff Qualifications

Education and Experience

Supervisory Staff

All supervisory staff must possess a master's degree in social work, psychology, counseling, or related field and at least three years of experience in social work and/or administration. An LCSW, LCPC, or other clinical license is required. Supervisory staff should have experience with family-based services that embrace the concepts of family-centered and strength-based service provision. Supervisors take an active role in supporting ASAP staff, particularly in families that have high risk factors.

Supervisors observe, train, and monitor staff to ensure that personnel both develop and demonstrate competence in the following:

- Utilizing methods of crisis prevention and intervention
- Identifying the needs of abused and neglected children and adults
- Understanding child development and individual and family functioning
- Determining criteria to identify the need for more intensive services
- Having knowledge of evidence-based practices and relevant emerging bodies of knowledge
- Understanding ecological or person-in-environment perspectives
- Working with difficult-to-reach, traumatized, or disengaged individuals and families
- Collaborating with other disciplines and community resources

Supervisors demonstrate a commitment to providing structure and support to direct staff in order to:

- Address and reduce stress, anxiety, secondary traumatic stress, and vicarious trauma
- Process and debrief following a crisis or traumatic event
- Create an atmosphere of problem-solving and learning
- Build and maintain morale
- Provide constructive ways to approach difficult situations with families
- Facilitate regular feedback, growth opportunities, and a structure for ongoing communication and collaboration

Professional Staff Delivering Clinical Services

Clinical services include but are not limited to counseling and therapy. Minimum qualifications for professional staff who deliver clinical services include knowledge of normal developmental stages and issues that are specifically related to adoption and guardianship. Examples include knowledge of child welfare adoptions where abuse, neglect, and/or dependency may have a significant impact on the intervention; knowledge of separation and attachment; and knowledge of the resurfacing of issues that may have been resolved at an earlier time.

Education and professional requirements include a minimum of a master's degree in Counseling or Social Work from a Council on Social Work Education (CSWE) accredited program or a master's degree in a field related to social work or counseling from an accredited college or university plus three years of subsequent work as a therapist. If a staff member is not licensed at the time of employment, he/she shall be supervised by a licensed employee and be working toward licensure.

Therapists are selected based on their past experience and qualifications. During the interview process, the following personal qualities and practical skills are considered:

- Education in trauma and trauma-informed services
- Educational preparation for position
- Relevant child welfare/clinical experience
- Professional demeanor
- Verbal skills
- Written skills
- Therapy skills (including family and child interview skills)
- Ability to relate to a culturally diverse population
- Flexibility
- Ability to deal with stress and frustration
- Ability to work as a team member

References are also completed on potential candidates and background checks are completed on prospective candidates and interns/volunteers according to DCFS policy and as mandated by the Childcare Act.

Professional Staff Facilitating Group Service Delivery

The majority of the staff have had experience prior to their position in group facilitation but each new staff member is provided education in group facilitation and the group curricula used in the program. In the case that a new staff member does not have previous training and experience, that person is mentored and more closely trained to ensure that they have a positive and supportive experience in learning to facilitate groups. Staff are trained in Theraplay® groups, support groups, and TBRI® Caregiver Training and Nurture Groups, as well as special topics pertaining to current needs of children. New staff members are eased into the workload and not given groups right away but are paired with other staff members to ensure they are well supported as they learn their new job duties.

Personnel leading education and support groups are trained to have the competence and support needed to:

- Engage and motivate group members
- Advocate for individuals and families
- Understand group dynamics
- Lead discussions
- Facilitate group activities

Professional Staff Delivering Other Services

For professional staff who deliver services other than clinical services (i.e., case management, advocacy, and support group co-leader), minimum qualifications include knowledge of normal developmental stages and issues that are specifically related to adoption and guardianship. Support group co-leaders may only co-lead when the supervising therapist is present. Additional expectations for staff that provide case management, advocacy, and support group services are knowledge of services available in the community they serve and the ability to establish good relationships and networking capabilities with other agencies providing services to families in the communities they serve.

Education and professional requirements include a bachelor's degree in social work from an CSWE-accredited program plus two years of subsequent experience in social work, or a bachelor's degree in a field related to social work from an accredited college or university with three years of subsequent experience in social work.

Staff Who Transport Families

The minimum qualifications for transporting families include possession of a valid driver's license and proof of insurance.

Qualification Exceptions

DCFS may make exceptions to staff qualifications upon receipt of a written variance request on a specific individual from the ASAP provider. The request will state reasons the proposed employee is considered qualified to function in a specific job title in the program. Plans for enhanced supervision and training will be identified in the request. The request should be directed to the DCFS Statewide Adoption Program Manager.

Staff Development

Provider Required Trainings

A staff development plan for each staff member will be formulated, identifying individual competencies and training needs. Each staff member will participate in the formulation and implementation of his/her plan.

Shadowing With Purpose

During the initial orientation process, many ASAP providers have a process to allow new therapists and counselors to shadow experienced staff to gain knowledge in regard to providing therapy and counseling. The shadowing process is facilitated through the development of specific goals, such as:

- Case opening (explaining family rights and completing intake paperwork)
- Completing a mental status exam
- Conducting an individual or family session
- Learning a new therapy technique
- Participating in a school meeting to demonstrate how ASAP staff perform in an advocacy role
- Case closing with closing paperwork

Following the session shadowed, staff are asked to engage in critical reflection to consider what their role during the session was, how it made them feel, and what they took away or learned from the session.

Shadowing with purpose can happen not only in the orientation phase of ASAP staff onboarding but also throughout the professional career as new skills are learned and enhanced. Staff supervisors will assess when and how much shadowing would be beneficial for each staff member's development and readiness for conducting various activities independently. In addition, family needs are considered to ensure that the presence of another individual will not interfere with the therapeutic process.

Minimum Staffing Expectations

Family Capacity

The number of staff determines the family capacity at any one time. The ratio of staff to clients is 1 full-time employee (FTE) to 10-12 families, depending on the intensity of service required by the families served. Caseload sizes are often impacted by travel time, which may mean in some cases that a lower caseload is more appropriate (8-10 families per 1 FTE).

Staffing levels shall assure the adequate supervision necessary to provide therapeutic treatment to families. The supervision shall require a minimum of half an hour per clinician per case per month.

Description of Services

Resource Library

ASAP providers maintain lists of resources that have been vetted and curated for use with adoptive and guardianship families. In addition, they assist families in obtaining resources such as books, videos, and other educational materials as needed. ASAP providers can lend or rent materials (such as videos) for families for short-term use. In some situations, books and other resources may be given to families to keep.

ASAP providers also maintain a collection of therapeutic games and sensory tools that can be used during sessions.

Information and Referral Services

In some cases, families may be able to benefit from services outside of those provided directly by the ASAP provider. When a family becomes connected to the ASAP provider, staff can begin providing information and referrals for community-based services as determined necessary to meet identified needs. ASAP providers maintain up-to-date files with:

- Names
- Locations
- Phone numbers
- Contact persons when available
- Services offered
- Languages offered
- Fees expected
- Eligibility requirements for counties that are served

ASAP has access to other resource databases as well, including local directories (for example, the PATH Resource Directory is an online service directory covering Livingston, Dewitt, and McClain counties) and the Service Provider Identification & Exploration Resource (SPIDER; see Learn More box) that is accessible by the supervisors and staff of the ASAP provider and any person who contacts DCFS through their on-line access portal, https://spider.dcfs.illinois.gov/.

Learn More

The Service Provider Identification & Exploration Resource (SPIDER) application and its predecessor, the Statewide Provider Database (SPD), is a collaborative effort sponsored by the Illinois Department of Children & Family Services, with data maintenance and user support provided by the Northwestern University/Hospital Feinberg School of Medicine, technology resources provided by the Illinois Department of Innovation and Technology, and information provided by countless child and family welfare service providers across the state of Illinois. Since 2002, this resource has been a key resource for the department, human service provider staff, other state agencies, city and county human services personnel, nonprofit service organizations, and a variety of behavioral health and insurance organizations.

Linkages to services outside of ASAP can be made after an assessment or upon closure of ASAP services.

Possible Linkages/Referrals
Respite services
Camps
After-school services
Specialized therapy
Educational resources
Budget counseling
Homemaker services
Community Residential Services Authority

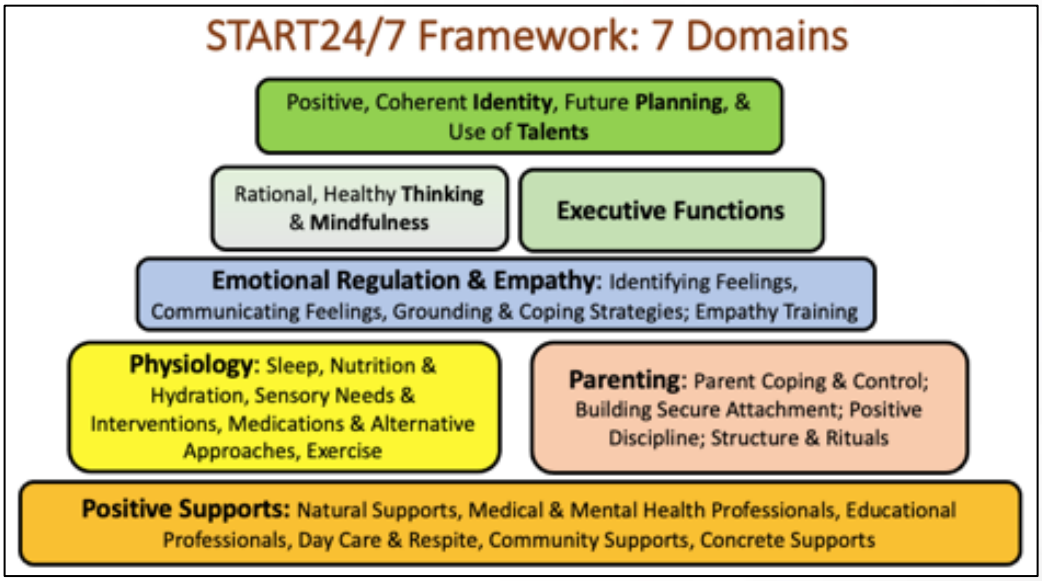
In some cases, a more formal linkage, such as a formal referral, will be made by ASAP staff, while in other cases, families will be provided with the necessary information to obtain services without further assistance from ASAP staff.

START

START stands for **S**tart early, **T**rauma-informed, **A**ttachment-focused, **R**esiliency-building, **T**herapeutic services. The program modification, made in 2019 at the request of DCFS, was designed to allow for quick assessment and more immediate services for families that were requesting less intensive and more preventative services. The initial assessment is done at the point of referral to ensure that the child needs prevention versus more in-depth treatment. A more detailed assessment and treatment planning process is purposely brief but also very broad, in order to capture strengths and areas of development. The START philosophy revolves around the idea of providing support 24/7. Thus, there are 24 areas of foci within 7 domains to examine during this assessment process. The broad assessment is meant to last just a few sessions to allow for services to begin more quickly. Services that fall within the START program are not the traditional therapy services but rather short-term interventions, such as:

- Biofeedback
- Safe and sound protocol
- Neurofeedback
- Psychoeducational or affect regulation programming
- Trauma-informed parenting approaches (e.g., TBRI®, MindUP)

Case management is another important piece of START services, as connection to community-based resources assists in developing family resiliency. Families are encouraged to participate in local support groups and respite, as well as any other appropriate services available within the community. Families who access these services are able to move into services as usual whenever a need for more intensive therapy is identified. START services meet all the same contractual requirements of ASAP and are considered an embedded program.



Agencies providing ASAP services were provided with a START Tool Box to assist the staff with the delivery of support.

START Tool Box Resources

The C.A.T. Project Workbook For The Cognitive Behavioral Treatment Of Anxious Adolescents by Philip C. Kendall Spiral-bound	The MindUP Curriculum: Grades PreK–2: Brain-Focused Strategies for Learning—and Living
The C.A.T. Project Manual For The Cognitive Behavioral Treatment Of Anxious Adolescents by Philip C. Kendall Spiral-bound	The MindUP Curriculum: Grades 3-5: Brain-Focused Strategies for Learning—and Living
Coping Cat Workbook, Second Edition (Child Therapy Workbooks Series) by Philip C. Kendall Spiral-bound	The MindUP Curriculum: Grades 6–8: Brain-Focused Strategies for Learning—and Living
The Handbook for Helping Kids with Anxiety and Stress	Treating Traumatic Stress in Children and Adolescents: How to Foster Resilience through Attachment, Self Regulation and Competency, 2nd edition
Sensory Connections	How Does Your Engine Run? A Leader's Guide to the Alert Program for Self-Regulation
Zones of Regulation—A Framework to Foster Self-regulation and Emotion Control	

The goal of START is to provide families with supports and services immediately upon finalization of an adoption or guardianship. The hope is that those working with the family pre-finalization will help to communicate the availability of START and other ASAP services so that families are not waiting until a point of crisis to reach out for assistance.

Crisis Intervention

When a referral that meets the eligibility requirements is received, ASAP staff will respond by phone within 24 hours. When the request requires crisis/emergency service, a staff member will contact the family and arrange an in-home meeting between the therapist and the family within 3 days. ASAP staff must be available 24 hours a day, seven days a week for after-hour and crisis services either by individual staff assignment or through a rotation schedule.

The crisis intervention services may differ depending on the nature of the referral (e.g., adoptive or guardianship family requesting intervention resulting from a crisis with their child's behavior; adoptive or guardianship family requesting assistance with out-of-home placement; or assessment required as a result of the death or disability within the adoptive or guardianship family).

24-Hour Crisis Intervention Counseling

ASAP providers maintain a 24-hour crisis hotline for current families. ASAP staff members monitor the on-call hotline on a rotating basis and are available to provide emotional support, intervention and stabilization, decision-making guidance, and referrals. The crisis response provided by ASAP staff most typically occurs by phone. In cases where the needs exceed the capacity of phone support, families are instructed to contact the appropriate emergency response agencies and they are given contact information for the appropriate agency.

ASAP staff provide the family with contact numbers for families to reach back out. In addition, the staff also checks back in with the family member who called to ensure that their needs were met. The on-call staff member always has the option of contacting his or her own supervisor or the program manager for additional support and ideas. Following the phone call, the on-call therapist will then forward a report to the therapist on the case (usually in the form of a detailed email that the supervisor is also copied in on) so that they can follow up in the next business day.

During business hours, designated ASAP staff provide crisis counseling as needed. Referrals for immediate emergency support may include recommendations to call for police or emergency support or for SASS services (when the child has a state-sponsored insurance benefit card, commonly referred to as the medical card) as well as other resources that may be available within the community of the client. In addition, staff assigned to the case also provide crisis support, and clients are made aware of the availability of crisis supports when their case is opened with the ASAP provider.

Emergencies may also occur while ASAP staff are already in the home for their family visits. In these cases, ASAP staff take a more hands-on approach to helping the family, such as making phone calls to support programs or therapeutic interventions, as appropriate. The ASAP staff will report any crisis issue to their supervisor for additional support as soon as immediate safety measures are established and emergency agencies are contacted.

Families are provided with community referrals as needed from the beginning of services to encourage stabilization and the development of a system of support for the family. The ASAP staff will assist the family in connecting with the referral source. The mental health assessment and ongoing assessment of needs throughout the service period assists in identifying services that will benefit the client and family and assist them in developing a community support system.

Assessment of Safety Risks

During the assessment of the family, issues of risk for safety are assessed fully. When a child is the victim of complex developmental trauma that includes abuse, neglect, assault, or other violence, the staff provide trauma-informed care, mandated reporting when applicable, safety planning with the child and family, and referrals to appropriate emergency services as well as other supportive services if the issue is beyond the scope of the design of ASAP services.

Safety plans will look different depending on the specific needs of the child and family. For example, safety plans for adult survivors of domestic violence focus on helping individuals prepare for immediate escape, and appropriate referral and support in accessing that resource (i.e., arrangements for transportation made through the local police, etc.) will be made by the ASAP staff with the family as needed. Referrals will be made to programs that specialize in needed supports that are not within the expertise of the ASAP staff.

Safety plans for individuals at risk for suicide focus on warning signs, coping strategies, and lethal-means restriction. When children are at this level of risk, emergency services are called in for support for hospitalization. ASAP staff should report the issue to their supervisor for additional support, and the staff member or supervisor will document the incident, any interventions, and plans within 24 hours of notification of the incident. Incident reports are reviewed according to each ASAP provider's established protocols to ensure the incident or issue is being managed appropriately, with the safety of the child and family in mind, and to help provide overall risk analysis and program improvement.

Comprehensive Assessment

In order for the ASAP provider to complete a comprehensive assessment to prepare for the development of a plan for clinical services, families will be asked to sign consents for release of information to current and past treatment providers, to agencies with pertinent records, and to other service providers. Family members will participate in assessing their own strengths and needs and in developing treatment goals. The therapist will complete a written assessment form and family treatment plan within 30 days of the family's referral to the program.

When clinically indicated, additional time may be needed to complete an initial assessment. ASAP staff are asked to use their judgment, in consultation with their supervisor, to determine if extending the time spent on assessment would be beneficial. Delays in obtaining records and variations in response times from families may also be factors that delay the completion of an assessment. It is more important that the assessment is accurate than it is to meet a timeframe. Additional information about the assessment process is provided in the *Evaluation, Assessment and Treatment Planning* section of this manual.

Clinical Services

The therapist conducting the assessment of the family will provide clinical services (relating to the adoption or guardianship issue) to the family in the form of individual and family therapy if prescribed by the treatment plan that is developed. Each family comes with their own set of strengths and needs, and, therefore, ASAP providers must have a breadth of knowledge that will help them conceptualize family and child needs. ASAP providers often use multiple treatment modalities and select specific strategies in a way that is timed and organized to best meet these specific needs.

Therapists engage families through meeting them where they are, building rapport, meeting in their homes, being accommodating to their needs, and spending time using empathetic, reflective listening to ensure that the therapist has a comprehensive understanding of the issues and concerns facing the family. Therapists use a balance of structure and nurture along with exhibiting respect, authenticity, genuineness, empathy, acceptance, and unconditional positive regard throughout the services they provide. Therapists will maintain appropriate boundaries to foster the therapeutic relationship.

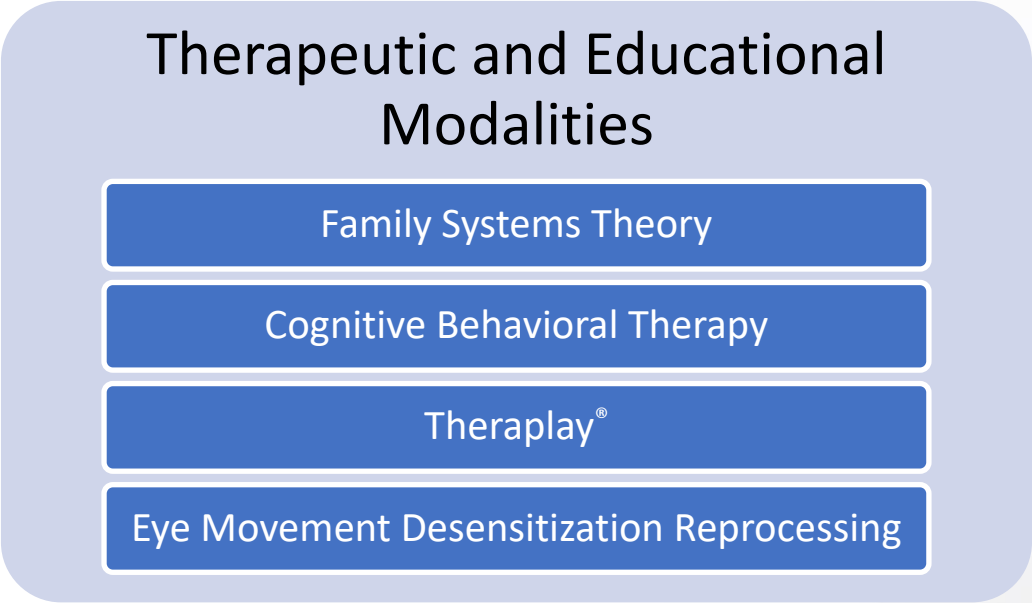
Therapy is provided based on family needs and therapist availability. Frequency of sessions varies based on identified needs and may be weekly, biweekly, or more frequently if indicated. The therapist, being attuned to the child's needs, may facilitate shorter sessions depending upon the child's tolerance for therapy. Family sessions may last longer than two hours with the therapist coming alongside the parent to discuss progress and provide feedback and support with parenting skills and family interactions. Family sessions may also be held by phone as parents seek additional support in-between sessions. As therapy cases come to a close, they may wean to once- or twice-a-month sessions. Decisions about frequency and duration of sessions are determined collaboratively with the family, are based on the assessment results, and are written into the treatment plan, which is reviewed and adjusted as needed at least every six months.

In-Home Family and Individual Counseling/Therapy

At case opening, each family is provided with educational material regarding adoption. Additional information is presented to families as appropriate, including but not limited to:

- Education on specific mental health diagnoses
- Positive and therapeutic parenting skills, including:
  - Proactive interventions to prevent negative behaviors
  - Responsive interventions to effectively correct children's negative acting-out behaviors and assist in coregulating children's emotional responses, such as:
    - TBRI®
    - Information on ARC
- Stress management and resiliency
- The effects of trauma
- Child development

Therapists use a holistic child-centered approach and employ various evidenced-based therapeutic and educational modalities.



Therapists recognize and respect individual, family, and sociocultural values. The therapy services provided are educational, supportive, and preventative. They are intended to:

- Increase the functioning of the child in the home, school and/or community
- Increase the family's stability and level of functioning
- Increase the use of community-based supports and services by the family to prevent out-of-home placement of the child
- Improve family relationships
- Increase self-awareness
- Decrease parental stress and facilitate change in the family's environment

Therapists work to build positive relationships between the children, the family members, other adults, and their peers. Treatment is provided in the least restrictive or intrusive manner possible to meet the needs of the family. Therapists use trauma-informed assessment and evidence-based trauma-informed interventions whenever appropriate.

Therapists emphasize normalizing experiences for the child and families to help them feel less isolated in their current functioning and to reduce any feelings of guilt or shame the family may have regarding the issues

they are experiencing and their need to seek help. ASAP staff also assists the family in recognizing treatment gains made in the child's environment, such as within the home, at school, and in the community. Interventions often emphasize the building and practice of adaptive skills and on transition and linkage to the child's community, using natural supports whenever possible. ASAP staff work with children to develop attachment-focused skills that empower the child in letting the family assist in the healing process and be able to recognize what healing would look like. These skills assist the child in developing the following:

- An understanding and sense of felt safety
- Identifying and having a secure base
- Building supportive relationships
- Developing a sense of hope
- Experiencing maximum social inclusion
- Creating and effectively using coping skills
- Having a positive sense of themselves and where they fit in this life.

The therapist is aware of the child's developmental level in a variety of domains (e.g., cognitive, academic, social, emotional, spiritual), recognizes that conceptualizations and interventions must take developmental level(s) into account, and understands that adjustments must be made as the child matures. The therapist assists the family in aging the child's brain in different levels of functioning. For example, the child might have a high IQ and not be able to succeed in school due to early trauma leading to a lack of regulation skills needed to attend to school.

Group Services/Support Groups

Clinically Based Groups

Each ASAP provider offers groups for both parents and children/teenagers at times and locations that meet the needs of the participants. The group structure is either an open-ended model (where sessions are ongoing and individuals may enter or exit the group at any time) or a group series (such as 8-week sessions). ASAP providers often provide a variety of groups that can be focused on parents, teens, or younger children and address different topics. These opportunities are advertised by each agency using social media advertising, newsletters, mailings, and other methods. The groups are developed and held in areas where there is an identified need. Some groups are ongoing when there is an identified population that would benefit from that level of support.

ASAP agencies ensure that there are sufficient groups operating to allow for client participation during the client's service period. Options include:

- Support groups offered to families regardless of whether or not the family is receiving services and offered at the time of referral if the need is indicated
  - Offered as needs arise in the client population
  - Allow for as many clients to participate as possible
- Child therapy groups offered, but limited to children who are engaged in the program due to the need for consent required for the therapeutic service

The type of group is often based upon the number of children or parents in the same area with similar needs. Typically, groups meet either weekly or biweekly. However, some parent groups may only meet monthly. The average number of participants in a child therapy group tends to be between 3 and 6. Parent support groups tend to be similar in size but can grow to 12 as needed.

The focus of the groups is to aid the families in:

- Coping with life transitions
- Dealing with crisis
- Developing and identifying networks of support and supportive resources
- Understanding the patterns of community and family living
- Anticipating and coping with daily stressors
- Improving role competency
- Improving family and social functioning

The majority of groups are designed to allow for new members, except for the isolated group designed around issues of histories of abuse, which might necessitate a closed group.

Psychoeducational Groups

Other groups are time limited and might have a psychoeducational aspect. Parent support groups tend to be open models, while psychoeducational groups are often designed to be followed in entirety from start to finish. The psychoeducational groups are offered for parents and children and may be offered to the general public, depending on the topic.

Case Management and Advocacy Services

ASAP staff provide case management and advocacy services to families who can benefit from such services. The need for case management and advocacy is addressed in each family's treatment plan and reviewed periodically.

Examples of case management and advocacy services

Case Management Services	Advocacy Services
Making referrals for community services	Assisting the family in coordinating with the child's school to ensure that all applicable services are received
Providing assistance to a family in accessing camp and respite	Referring the family to the DCFS educational advocate serving their region for more complex educational issues
Making linkages to after-school services	Linking the family with other service providers to ensure they are able to receive specific services

ASAP staff may also coordinate child and family team meetings to assist service providers in delivery of services. In addition, the staff may provide information and education, when requested, to assist providers in becoming more trauma-informed and better able to meet the needs of the adoption and guardianship population.

The Family Support Program (FSP), formerly known as the Individual Care Grant program, provides access to intensive mental health services and support to youth with a severe emotional disturbance. The goal of the FSP is to support eligible youth and their families by strengthening family stability, improving clinical outcomes, and promoting community-based services.

ASAP staff also provide advocacy for accessing mental health services when children are experiencing significant and/or complex mental health needs. ASAP staff serving as mental health advocates primarily interact with the following individuals and/or assist with applications to access the following services:

- DCFS Regional Clinical Manager
- Family Support Program (FSP)
- Wrap-around services through the local area networks (LAN)
- SASS

- Family stabilization, sexually aggressive child or youth (SACY) assessments[27] and services
- Other public or private agencies with applicable services

Prior to termination of services, provisions will be made for families to continue to receive any necessary advocacy services within their local communities.

NOTE

The Case Management/Advocacy Services noted above are supplemental to the other core services available through the ASAP program and are not meant to be the intense case management services available through DCFS when the child is under the guardianship of the department and has an assigned staff member to perform all case management services required.

Cash Assistance

The ASAP provider will provide cash assistance payments for a family who faces economic hardships that jeopardize the placement or may purchase specialized services for which no other resource is available. Funds may be used for sensory items, mental health aids (such as a light box), or items for families with developmental delays (swings or other resources that help them calm). In some cases the agency may loan a larger item first (such as a light box) to determine effectiveness and then use funds to purchase the item for the family if there is a financial need.

The family may request up to $500 per fiscal year as funding allows. The therapist is responsible for working with the family in crisis, identifying the need, and completing the request for cash assistance when needed. The agency shall maintain records of the cash assistance amounts expended and the reasons for each of the expenditures.

[27] DCFS contracts with agencies around the state that specialize in these types of assessments.

Other Support Services

The agency may provide other types of support services (which cannot be provided utilizing the $500 cash assistance) at their discretion. Such services would include respite, homemaker service, camping experiences, weekend retreats, aftercare services, etc. Funding for such additional services would be covered by the agency through existing funding sources available to the agency. Funding for other support services as described here cannot be counted as an additional billable unit through the ASAP contract.

Respite

An adoptive family that may have used neighbors or relatives for childcare in the past may now discover that their child requires a higher level of care than an extended family member or neighborhood babysitter feels comfortable providing. Respite can provide regular caregiving breaks for these families that can be beneficial to the health of the family and can help to replenish the family's capacity to cope with the challenges and stressors of parenting. Respite assists families in:

- Sustaining the family's health and well-being
- Reducing rates of out-of-home placements
- Reducing the likelihood of abuse and neglect
- Giving the family an opportunity to provide care to other children in the home that don't have as many needs as the child receiving services
- Reducing the likelihood of parental separation
- Helping support strengthening of the parental relationship

An initial assessment is completed on the family and child to develop a service plan which will offer the appropriate type of respite for that family.

Types of Respite

Respite services are defined as short-term temporary care provided for children accepted for service to give some relief to the adoption or guardianship family. Respite components may include any or all of the following: Hourly in-home, out-of-home, and overnight respite care; mentoring; and specialized camp experiences. The respite care may be regularly scheduled or may be requested on an emergency basis.

Hourly In-Home, Out-of-Home, and Overnight Respite Care

Traditional forms of respite care are those that are provided through an in-home setting or an out-of-home setting. In-home respite is provided in

the residence of the adoptive family and allows for the child to remain in the comfort of their home. During such care, parents may stay home or go out. Out-of-home respite occurs in the home of the respite provider. Respite providers may be selected by the adoptive family or may be identified by the ASAP provider.

Mentoring

Mentoring is a type of respite that provides the child a safe and positive one-on-one interaction with an adult. The mentor serves as an example/role model for the child. The mentor engages the family in activities in the community that the mentee enjoys and that provide the mentee a positive outlet. Mentoring typically has a therapeutic focus; all mentees have goals that their mentor supports them in working toward. For example, some mentees have goals like practicing physical activities they can use for regulation, and mentors can take them to do things like play basketball, go hiking, etc. Other common mentoring goals include practicing assertive communication skills with community members or trying new skills in order to build confidence. Mentoring can also be used as a way to help transracially adopted children connect with racial mirrors (i.e., pairing a child with a mentor of the same race so that child can benefit from a relationship with a supportive adult who shares their racial background). All mentors have received training related to adoption and trauma. As part of the process of setting up mentoring, a safety plan is developed for each mentee to address any risky behaviors, so there are agreed-upon steps to follow if those risky behaviors occur with the mentor.

Specialized Camp Experiences

Camping experiences are typically designed as a therapeutic camp that offers children a fun experience while giving parents a weekend break. Staff members are highly trained and have extensive experience working with children with a range of needs, including emotional and behavioral problems. Activities typically include things such as: hiking, swimming, crafts, games, sports, movies, and community outings. There are other camp opportunities available that can be paid for by ASAP providers such as the TBRI® Family Camps that have been offered in Chicago.

Other

Respite services are also available through purchase of service contracts between DCFS and licensed child welfare agencies in Illinois. Reimbursement for other community-based services to obtain respite can be requested through the ASAP program. These services can include:

- Provision of substitute caregivers arranged by parent for respite (cannot be day care)

- Attendance at therapeutic camps/group that address specific issues (i.e., autism day camps)
- Purchase of items required for participation in group/camps (e.g., hygiene supplies, tent, sleeping bag, etc.)
- Assistance with transportation

In order for families to be eligible for financial assistance related to respite services, they must be participating in ASAP services, their adoption and/or guardianship was completed through DCFS, and there is a demonstrated need. In addition, the family must be able to acquire services initially (e.g., locating an appropriate respite provider), and, in some situations, they may have to pay up front for the initial delivery of respite services and then be reimbursed. Therapists work with the family to access these respite options.

What Respite Providers Should Know

Respite care is intended to provide parents a break in order to relieve the accumulated stress and tension caused by the constant demands of parenting children with special needs. Because having a child with challenging behaviors is often unfairly blamed on the style of parenting that the child receives, a family may feel they are under the microscope of the staff and family from whom they receive services. Allowing a respite provider to learn the details of the child and family situation can feel intrusive. It is important for respite providers to remember that things they see or hear should not be shared with anyone (with the exception of reporting current issues of abuse or neglect). Establishing a level of trust between child, family, and respite provider will enhance the care that the child receives and ensure a trusting and meaningful relationship between the adoptive and respite family.

It is crucial that the permanency of the adoptive home is fully supported. The notion that the child may live with the respite family is never an option and it should always be reinforced that the child belongs to their adoptive family. Respite providers can accomplish this by being supportive of the family's rules and preferences; communicating with the adoptive family in a positive, constructive, and friendly manner when in the child's presence; refraining from any suggestion that the child could live with the respite family; and avoiding criticizing, blaming, or questioning the adoptive family.

Respite providers need to remember that their role is to provide a break for the family while establishing friendships with the children. The role of respite providers is not to "fix" what they perceive as deficient or wrong with the family. For example, if a family maintains a standard of living

that does not feel appropriate or comfortable to the respite provider, it is not the role of the respite provider to try to enhance or raise that standard of living to their own satisfaction. That belief is an intrusion of the family and beyond the boundary of delivering respite.

The manner in which respite is introduced to a child can have a great deal of impact on their response to the experience. The reasons for the respite should be explained in an honest manner, without blaming or shaming the child for negative behaviors. It is important to remain positive about the experience and provide as many details regarding the respite plans as possible. Respite should not be punitive in nature; it is acceptable for the child and respite family to enjoy their time with one another. All parties should encourage the child to view the respite as an opportunity to meet new people and enjoy new experiences, but it is also important to acknowledge any fears or concerns that the child may have. It will also be helpful if the child and respite family have the opportunity to meet one another prior to the respite. Even a brief meeting beforehand may serve to reduce the anxieties and fears associated with the respite.

Children who have not yet fully developed a sense of trust and safety in their adoptive home environment may have difficulty trusting that their parents will return for them following the respite. The adoptive and respite family must assure the child that their parents are not rejecting them, and they will be returning home at the conclusion of the respite. For this reason, sudden changes in respite plans, especially those that extend the period of time should be considered carefully.

In addition to feelings of confusion, the child may experience feelings of guilt or anger in regard to respite planning because they may believe that they are responsible for causing stress in the family. If children perceive that parents cannot handle them anymore, which is the reason they believe the respite is needed, this perception may limit the parents' ability later on to establish themselves as being the leaders of the family. Both the adoptive and respite parents must repeatedly assure the child that the respite is not a punishment or retaliation but rather an opportunity for family members to enjoy a break from one another. In order for children to learn to have healthy relationships, it is important to not only spend quality time together with their parents but also to be able to spend time with others.

Adoptive parents using respite services often experience feelings of guilt related to their need for respite services. They may believe that their own needs are insignificant. They may experience feelings of inadequacy when asking for help, or they may worry that using respite services signifies that they have not lived up to their parenting responsibilities. It is important to recognize the power of guilt and convey

the message to the parent that utilizing respite can help them be more effective as a parent. An adoptive family seeking respite must be able to develop trust in their respite provider in order to be comfortable with and benefit from their decision to access respite services. Respite providers must convey an attitude of understanding of the family situation from the onset and assure that the unique needs of the child and the family will be addressed.

Remember that it is common for respites to go well. Children who in their homes display challenging and difficult behaviors often display the opposite kinds of behaviors during respite. This is because the demands for intimacy and permanency in the parental/child relationship do not exist in the respite provider/child relationship, and, thus, the child's insecurities, angers, and fears may not surface.

Supplemental Services

In addition to the services described so far, families can also access services from agencies that are available both statewide and in their local communities and through the ASAP program.

Greenlight Family Services

Greenlight Family Services has been serving families in Illinois since 2003. The agency assists families who have gone through adoption and guardianship with legal, therapeutic, and case management services. They provide:

- Backup planning direction and assistance
- Adult guardianship for adults with disabilities
- Minor guardianship
- Educational advocacy
- Transference assistance of adoption after death or incapacitation of a caregiver
- Crisis clinical services
- Adoption (Service area: Statewide)

Midwest Adoption Center

Midwest Adoption Center (MAC) supports efforts such as birth and relative search and reunion work. The DCFS Closed File Information and Search program facilitated through MAC provides information from DCFS files and can help adoptive and guardianship families locate birth

relatives. MAC will attempt to locate DCFS files and prepare a written report that can include information about biological relatives, medical and social history, a description of how the child came into care and a record of placements before adoption or guardianship. The law does not permit DCFS to release identifying information from the files such as the names and addresses of others. However, families can request search services to help locate relatives including birth parents, siblings, grandparents, and others. This program is not intended to provide in-depth counseling, but assistance and support are offered to families throughout the process. (Service area: Statewide)

Maintaining Adoption Connections Programs

These agencies provide an array of services to support adoptive and subsidized guardianship families who are experiencing challenges. The agencies offer expertise in a range of family issues. The model of each program varies; however, the purpose of these programs is to eliminate barriers in accessing assistance, thus providing services at a variety of locations and in a variety of ways.

Ada S. McKinley

The Ada S. McKinley Maintaining Adoptions Connections Program covers the Chicagoland area and provides a range of services to families including but not limited to:

- Assessment of the current situation and functioning of family members
- Crisis intervention
- Securing of resources (e.g., medical care)
- Referral to other existing post adoption services
- Respite care
- Case management community referral services
- Advocacy
- In-home counseling/therapy

The mix of services and frequency will depend upon the needs of the particular family as established through the assessment process. Services are available to families for 6 to 12 months. The main focus is family advocacy and case management. The program works directly with the family to ensure that outstanding needs are met or appropriate assistance provided (e.g., assistance with clinical and nonclinical services, guidance on navigating the DCFS system and community resources). Ada S. McKinley also provides some mentoring services for families where a need is determined.

FamilyCore

The FamilyCore Maintaining Adoption Connections Program covers Central Illinois counties in the Peoria area and offers a range of services available to families including but not limited to:

- Assessment of the current situation and functioning
- Crisis intervention
- Linkage and facilitation to resources (e.g., medical care)
- Referral to other existing post adoption services
- Center-based respite care
- Summer/winter/spring respite camp
- Case management
- Community referral services
- Advocacy counseling
- Limited follow-up services
- In-home, brief solution-focused therapy/counseling

The main focus is family advocacy and case management. The program works directly with the family to ensure that outstanding needs are met, or appropriate assistance is provided (e.g., assistance with clinical and nonclinical services, any guidance on navigating the DCFS system and community resources).

FamilyCore also provides a program for children who have been suspended from school. They provide a safe space for the children on the days they are suspended along with the opportunity to work on the reasons that led to the suspension and different ways to prevent recurrence. This program works directly with the community schools in the immediate area.

Other

Referrals may also be made to therapists in private practice as deemed appropriate.

Orienting Families to the Program Philosophy

For generations, the conventional wisdom was that the adoption decree or guardianship order was all that was needed to assure the well-being of the child. Most believed that once the child was adopted there was no need for any further services and supports. In fact, any post-finalization contact by the child welfare system or a private adoption agency was often regarded as intrusive. In an effort to ensure privacy, the court typically sealed adoption records and information related to the child's pre-adoptive identity was intentionally withheld.

Today's adoptive and guardianship families look different from what they looked like in the past, and so do their children. Older children once deemed "unadoptable" because of their age are now routinely being adopted. Changes in services and supports for adoptive and guardianship families have included things like federally supported guardianship and permanency planning with relatives. In addition, adoptive parents are encouraged to have child-led, open, and ongoing contact with members of the child's biological family when safe. And just like in society at large, it is not uncommon for parents and guardians to be unmarried, single, have diverse sexual orientations, or be of a different ethnicity than their child.

Families newly formed through adoption and guardianship might occasionally need support, or even more intensive services at times, to remain together and build secure attachments. Preventative services can help families redefine relationships, nurture resilience, and address the many issues that might arise before and after finalization. Preventative services also create early linkages to agencies that can provide ongoing support to families. An existing connection with an agency often allows for quicker access to more intensive services if and when the need arises.

Families are provided the following explanation of the ASAP program:

- We believe that all healing takes place within relationships. We will do what we can to create a strong relationship between you and your child.
- We understand that people try to meet their needs in the best way they know how at the time. Many of the children that we work with have experienced scary things in the past. These difficulties have been part of shaping them and their brain development—even if those difficulties happened in utero or during infancy. These children learned survival skills and therefore learned to meet their own needs in ways

that sometimes cause harm and confusion for others around them. We will be partnering with you to figure ways to increase your child's felt safety, to help your child learn how to trust healthy adults, and to learn skills to be able to get their needs met in different ways.

- Adoption means there was relational trauma due to the child being placed outside of their biological family. Sometimes children have been hurt by those adults who were supposed to be caring for them; therefore, they may stop trusting anyone. They may not believe relationships can be a source of help and can be counted on. Instead, they come to see relationships as scary or unreliable. So, it is important that we try to show the children we work with that relationships can be trusted, and other people can help.
- Because our program focuses so much on relationships, we will be asking you to be involved in meeting with your family therapist—both with your child and without your child. We need your help in order to help your child heal! Your child experiencing a secure relationship with you gives them the best outcome for successful treatment. Relational trauma is healed in relationship.
- A lot of children in our program do not know how to manage their feelings. They have a hard time noticing their feelings, naming them, or getting through them without making things worse. We will ask you to join us in coregulating your child and teaching them how to understand and react to feelings, including teaching them skills to calm down and get through hard situations.
- The more the mental health field learns about the brain and the nervous system, the more it is clear that for children who have experienced developmental trauma and loss, talking is often not enough to heal. Your family therapist will talk with you and your child but will also likely use play, art, movement, and other activities. Our therapists have received special training in using these techniques to help families reach their goals. If you ever have questions about what your family therapist is doing, or what the purpose is, please feel free to ask.

Many ASAP providers use a letter or working agreement to explicitly communicate the philosophy of the ASAP program, the models of service delivery that are used, and the expectations for families participating in ASAP services, such as the level of family engagement necessary to promote successful outcomes.

Evaluation, Assessment, and Treatment Planning

Assessment

Content

Murray & Sullivan (2017)[28] assert that "...adoptive families have unique clinical needs, including the need for postadoption mental health services that are adoption competent, trauma informed, and evidence based" and that "…the assessment process is the gateway to the provision of trauma-informed, adoption-competent services…". Unfortunately, adoption-related issues may not be evident in routine intake and clinical assessment protocols, which may also not capture important information about adoption.[29] Adoption-competent assessment should include: (1) A thorough examination of the impact of pre-adoptive risk factors known to impact post-adoptive functioning; (2) a biopsychosocial perspective that examines functioning within multiple systems; and (3) assessment of the unique issues that commonly impact adoptive families. Important domains to assess include:[28]

- Child trauma exposure and traumatic stress
- Child functioning
- Parent-child relationship and attachment
- Parent functioning
- Adoption-specific adjustment
  - Grief and loss
  - Unmet expectations
  - Openness in adoption
  - Understanding of adoption
  - Race and culture
  - Perception of permanence

In addition to working with the specific emotional challenges related to adoption (i.e., race, loss, identity, rejection), many children are also exploring their sexual orientation, gender identity, and gender expression (SOGIE). Given this, ASAP staff should also assess the challenges and needs associated with SOGIE issues that may be impacting the child.

[28] Murray, K. J. & Sullivan, K. M. (2018). Using clinical assessment to enhance adoption success. *Families in Society, 98*(3), 217-224. https://doi.org/10.1606/1044-3894.2017.98.29

[29] Center for Adoption Support and Education (CASE), (2020). Training for Adoption Competency (TAC). Retrieved from https://adoptionsupport.org/adoption-competency-initiatives/training-for-adoption-competency-tac/

The seven core issues in adoption and permanency are widely known as a cornerstone in understanding the experiences inherent in adoption for all those involved, including the child, the adoptive parent(s), and birth parents. “These issues [loss, rejection, shame/guilt, grief, identity, intimacy, and mastery/control] create dynamics in people’s and family’s lives that must be acknowledged and addressed in order for healthy authentic relationships to unfold.”[30] Loss is sometimes referred to as not only a core issue but as the key issue in understanding clinical issues in adoption. Clinicians working with adoptive families must be attuned to the behavioral, developmental, and emotional manifestations of loss and grief, especially because unresolved grief and loss can lead to profound grieving that can interfere with daily living; negatively impact current relationships; and lead to depression, anxiety, and other clinical problems.[29] Individual variables that are important to understand as part of the assessment process include:[30]

- Temperament
- Level of resilience
- Gender
- Age
- Cognitive and language ability
- Mental, intellectual, or physical disabilities
- Genetic factors impacting personality type such as:
  - One’s motivational system
  - Level of curiosity
  - Sensory sensitivity

In order to identify cultural and ethnic issues that may impact delivery of services, assessment interviews are conducted in a culturally responsive manner to identify resources and support that can increase service participation and support the achievement of agreed-upon goals.

[30] Roszia, S. K. & Maxon, A. D. (2019). *Seven core issues in adoption and permanency: A comprehensive guide to promoting understanding and healing in adoption, foster care, kinship families and third-party reproduction*. Philadelphia, PA: Jessica Kingsley Publishers.

Tools

Depending on the needs of the child and family, specific instruments may be used during the assessment process.

Some potential assessment tools used by ASAP staff:

Title	Description
Adult Attachment Interview	Assesses parent attachment
Beck Depression Inventory 2nd Edition	Self-report inventory measuring the severity of depression in adolescents and adults https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-ASsessments/Personality-%26-Biopsychosocial/Beck-Deppression-Inventory-II/p/100000159.html
Behavior Assessment System for Children 3rd Edition (BASC-3)	Diagnostic tool designed to assess the behavior and self-perceptions of children and young adults ages 2 to 25 years Includes a Parent Relational Questionnaire https://www.pearsonclinical.co.uk/Psychology/ChildMentalHealth/ChildADDADHDBehaviour/basc3/behavior-assessment-system-for-children-third-edition.aspx
Chldren's Depression Inventory 2 (CDI 2))	Brief self-report test that helps assess cognitive, affective, and behavioral signs of depression in children and adolescents https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-%26-Biopsychosocial/Chldren%27s-Depression-Inventory-2/p/100000636.html
Brief Psychiatric Rating Scale-Child (BPRS-C)	Provides a concise profile of childhood behavioral and emotional symptomatology https://candapediatricmedicalhomes.files.wordpress.com/2017/02/bprsc-9_training_manual.pdf
Current Feelings about Relationship with Child Survey/Pre-Post Feelings Questionnaire	Survey completed by parents that rates their overall feelings around their attachment, commitment, and parenting abilities toward their adopted child
Devereux Early Childhood Assessment (DECA)	Identifying key social and emotional strengths https://centerforresilientchildren.org/infants/assesments-resources/devereux-early-childhood-assessment-deca-infant-and-toddler-program/

Extended Play-Based Developmental Assessment (EPBDA, Gil)	Provides an understanding of children's unique functioning, identify problem areas, rule clinical symptoms in or out, and understand children's perceptions of their important relationships http://www.gilinstitute.com/services/assessment/epbda.php
Family Advocacy and Support Tool (FAST)	Identifies needs of families who are at risk of child welfare involvement https://praedfoundation.org/tools/the-family-advocacy-and-support-tool-fast/
Giliam Autism Rating Scale (GARS-3)	Assessment of autism spectrum disorder hhttps://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Behavior/Gilliam-Autism-Rating-Scale-%7C-Third-Edition/p/100000802.html
Marschack Interaction Method (MIM)	Structured technique for observing and assessing the overall quality and nature of relationships between caregivers and children https://theraplay.org/training/training-programs/theraplay-modules/module-three-marschak-interaction-method-administration-scoring-and-feedback-for-theraplay-practice/
Moods and Feelings Questionnaire (MFQ)	Assesses mood symptoms in children ages 7-18 Mood and Feelings Questionnaire (MFQ) | Developmental Epidemiology (duke.edu)
Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales)	Assesses outcomes for youth ages 5 to 18 who receive mental health services https://sites.google.com/site/ohioscales/home
Parent Stress Scale	A self-report scale that contains 18 items representing pleasure or positive themes of parenthood (emotional benefits, self-enrichment, personal development) and negative components (demands on resources, opportunity costs, and restrictions)
Screen for Child Anxiety Related Disorders (SCARED)	Assesses anxiety symptoms in adolescents ages 12-18 https://www.midss.org/content/screen-child-anxiety-related-disorders-scared
Sensory Processing Checklist	To explore sensory patterns and to help assess if a referral for an occupational therapy evaluation is appropriate https://www.sensorysmarts.com/sensory-checklist.pdf

Trauma Symptom Checklist for Children (TSCC)	Self-report measure evaluates posttraumatic stress and related psychological symptomatology in children ages 8-16 years who have experienced traumatic events, such as physical or sexual abuse, major loss, or natural disasters, or who have been a witness to violence https://www.parinc.com/WebUploads/samplerpts/Fact%20Sheet%20Trauma%20family.pdf
Western Michigan University Children's Trauma Assessment Center (CTAC) Trauma Symptom Checklist (Ages 0-5, Ages 6-18, and Adult version)	Comprehensive checklist helps pinpoint emotions, behaviors, attachment concerns, and school problems the child may be experiencing https://wmich.edu/traumacenter/resources-0
The Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)	A comprehensive lifespan tool for assessing the needs and strengths of individuals who require mental health treatment in Illinois Required by some funding sources

Each agency has also developed an assessment for START. The START assessment may be used as a baseline assessment and/or as a tool to help guide treatment planning regardless of whether families are accessing START services.

Previous Records

If the child's family has other documents from past service providers or adoption history, these are used as well to provide additional detail and background to aid in the completion of the comprehensive assessment. With the adoptive parent/guardian permission, records may be obtained from previous service providers to aid in the assessment process. A consent for release of information is required for information obtained from former providers or from DCFS. Individual providers often have their own protocols to be followed related to the sharing of information.

Process

The assessment process serves a variety of purposes and the types of tools used in the assessment process vary based on these purposes. After referral of a family is accepted and the case is opened, the therapist has 30 days to complete a mental health assessment (in some cases, the therapist will be given additional time to adequately assess the family with specific permission by the supervisor).

The assessment process identifies:

During assessment, ASAP therapists are especially aware of factors related to developmental trauma and attachment. The strengths-based assessment of the child will include at least one face-to-face contact as well as an assessment interview with the family. The therapist generally meets with the parent and child two to four times in order to gather information that will be used in the assessment.

If applicable, a DSM-5 (ICD 10) diagnosis is developed using the information gathered throughout the assessment process.

A mental health assessment (MHA) is completed and signed by the licensed supervisor within 30 days of the admission date.

Treatment Plan Development

The Individual Treatment Plan (ITP) (sometimes referred to as a service plan) is developed together with the child and family in an ITP development session. The ITP is based on the child's strengths and incorporates the child's own measurable objectives/goals. It also recognizes individual racial and cultural differences of clients and their adoptive parents/guardians. The ITP goals and objectives are reviewed with the child and parent(s) and changes are made in response to requests of the child and family. The ASAP staff responsible for the development, review, and modification of the ITP must have the licensed supervisor providing clinical direction during this process approve and sign the ITP. The ASAP staff will complete this within 30 days of the

initial child face-to-face contact, unless given permission by the supervisor to take more time in completing the plan. The ITP contains goals, intermediate objectives, a DSM-5 diagnosis (if applicable), and a description of services to be provided for that child. A copy of the completed ITP is provided to the child and family.

The ITP uses a strength-based approach and goals are based on realistic expectations of the child and identification of the child's strengths, preferences, and supports. Along with the child and their family, ASAP staff determines which modality or set of modalities would best serve the family's needs. The ITP provides individualized care for each child and family served with consideration of values, disabilities, lifestyles, and cultural backgrounds. The ITP identifies strategies, outcomes, treatment goals, and objectives to better serve that particular child and family. The ITP will identify goals that the child and family want/need to address in:

- Psychosocial functioning
- Adaptive and coping behaviors
- Interpersonal relations
- Problems associated with conduct, identity, self-esteem, anxiety, affect, adjustment, and impulse control
- Other mental disorders.

If necessary, the treatment goals will address safety issues resulting from trauma, which may include a safety plan or referrals to outside agencies. If domestic violence or abuse of any kind is suspected, ASAP staff will provide the family with information about reporting abuse and other agencies that provide services for specific issues. Amount, frequency, and duration of services and who will be responsible for providing those services will be specifically reflected in the ITP.

Involvement of Families in Goal Setting and Decision-Making

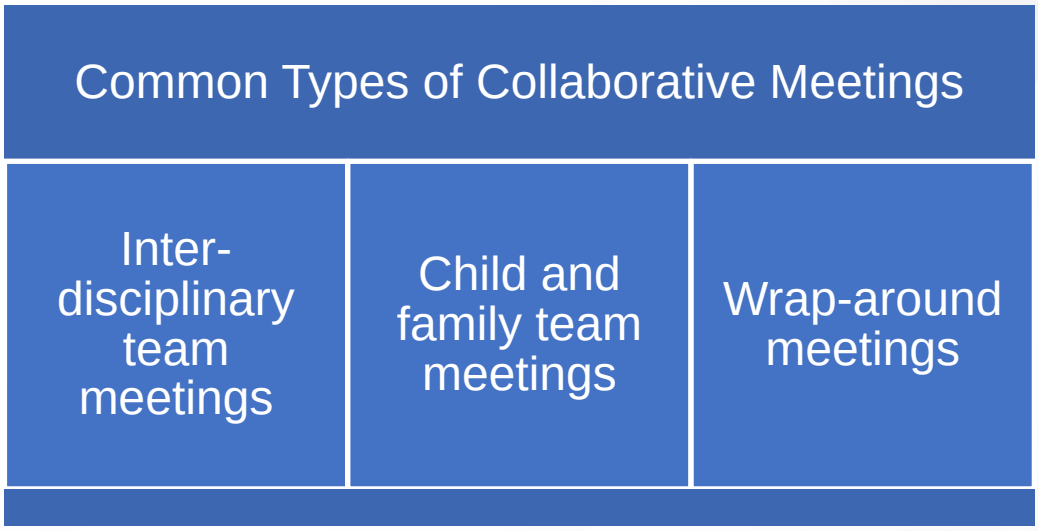
Families should be involved in the service and treatment planning for their children and themselves. Meetings should occur with the family regularly to jointly develop solutions. We want our families to drive our interventions as much as possible. We are committed to actively increasing family input and involvement in the decision-making process. We want to help equip our families to be the ongoing decision-makers for themselves and develop the skills needed to continue supporting their child between therapy sessions and after services end.

The family should be involved in all service decisions in order to reinforce their commitment to the preservation of the adoption/guardianship and to address those issues they see as challenging to that preservation. The ASAP staff will seek feedback from the family regularly to ensure services are meeting the child and family's needs.

Collaboration

Families are often involved with various types of services across several systems to meet the needs of family members. Collaboration is important to ensure trauma-informed, adoption-competent modalities are used, and services provided are not working against each other. ASAP providers are encouraged to collaborate as much as possible with others who are working with the child and family.

Child welfare systems use various types of meetings to facilitate coordination of services and promote collaboration.



Ideally, the ability to effectively coordinate services is a skill that adoptive parents and guardians should develop so that they are empowered as the expert in their families and can have confidence in communicating their child and family needs. However, in many cases these meetings are facilitated by professionals to include the participation and development of parents/guardians to empower them to take charge with future situations by modeling and explaining the importance of this role. When facilitating team meetings, ASAP staff should work intentionally to partner with the adoptive parent or guardian in having a lead role in the process, providing a model that the adoptive parent or guardian can follow after ASAP involvement ends.

Treatment Plan Review/Reassessment

The ITP is reviewed quarterly to evaluate progress toward achieving goals and maintaining improvement, and it is updated at least every six months. The plan may also be modified more often to accommodate treatment needs that were not initially evident. The ITP is developed based on the recommendations for services within the assessment in collaboration with the child and the child's parents. Goals are evaluated using outcome measures developed at the time of the treatment development with the support of the child. As the child makes progress, the treatment is modified to enhance the maintenance of gains and generalize and promote mastery of these gains as well as focusing on additional gains. Until the child is discharged from ASAP services, the ITP is updated regularly. These updated plans ensure that information is current and accurate. The ITP is reviewed with the child (if over the age of six) and parent(s) involved, signed by all adults and children 12 and over, and the process is overseen and signed by the licensed supervisor at least every six months.

A natural part of the ITP is the consideration of additional information gathered by ASAP staff during their engagement with the family. Quarterly reports are written for each child every three months. This report is a review of the child's progress on their goals and any changes to the ITP or items from assessments, such as medical changes or diagnostic changes, as well as a review of other issues of the family that might impact the child's ability to make progress.

The frequency of service delivery can be modified in between treatment plan revisions through the supervision process.

Supervision of ASAP Staff

Guiding Framework of Supervision

In the ASAP program, there is an interest in ensuring that services are delivered in a manner that supports family participation in services. Supervision will help to ensure that services:

- Are family based and engage the entire family, rather than just an individual within the family.
- Consider the development of family relationships, including how relationships are impacted by the length of time a child has been living in the family and the experiences of the child prior to living with the family.
- Support building on strengths and upon what is going well for the family.

- Are informed by the impact of trauma and loss, and how those factors influence developmental trajectories.
- Recognize the impact of separation and loss on individuals and families and the importance of attachment in creating healthy relationships.
- Are shaped by the unique challenges and strengths associated with adoption and guardianship families.

Types of Supervision

There are three types of supervision: Administrative, clinical, and reflective.

Administrative

- Ensures work is being performed as expected
- Examples of the topics covered include:
- Paperwork compliance
- Billing
- Other administrative procedures

Each ASAP agency uses its own systems to track and monitor paperwork, billing, and other administrative procedures. These systems may differ across ASAP agencies and are not described in this manual.

Clinical

- Teaches the knowledge, skills, and attitudes important to clinical tasks
- Examples of child issues, addressed include:
- Assessment
- Diagnosis
- Treatment options
- Barriers to care
- Other related issues

Information Included in Clinical Case Consultations				
Basic demographic information of the client	Reason for coming into services	Length of stay and progress made	Strengths	Questions for the consultation: • What additional inteventions may be helpful? • How to manage certain challenges when working with client? • Questions related to diagnosis • Questions related to potential ethical dilemmas

Reflective

- Typically not separate from administrative or clinical supervision, but emphasizes support for the staff person
- Has the function of increasing job performance and decreasing burnout

Reflective Supervision

ASAP providers utilize reflective supervision practices as part of the clinical supervision process.

Reflective Supervision

"Reflective supervision is an approach that supports various models of relationship-based service delivery. The approach includes regular meetings, a collaborative relational approach, and an emphasis on reflection. Reflective supervision can be used across disciplines, systems of care and service models for children and families.[31] The ultimate goal of reflective practice is to improve the quality of services for children and their families. Often providers are faced with trauma of the families they work with and this trauma can trigger their own pain and suffering. The experience the provider brings to the relationship can get in the way of working effectively with families unless there is a venue to explore, understand, and distill the negative or difficult emotions elicited from the work.[32]

Research shows that reflective supervision practices are associated with better outcomes for staff (related to turnover and burnout) as well as better outcomes for children.[33]

ASAP therapists and their supervisors set up agreed-upon weekly prescheduled times to discuss child and family issues and problems encountered, use reflective practices to enhance staff competencies, and give feedback regarding various work-related issues. The therapists and their supervisors also utilize supervision time to review files and discuss program quality assurance/enhancement issues as well as weight and manageability of caseload. Group supervision is also provided for ASAP staff to address skill development of the team, provide updates on referral resources, and additional child and family case consultation. The supervisor is also available on a daily basis outside of regularly scheduled supervision times to provide necessary support and to discuss crisis situations that may arise.

[31] Heffron, M. C. & Murch, T. (2010). *Reflective supervision and leadership in early childhood programs*. Washington, DC: ZERO TO THREE Press.

[32] Shahmoon-Shanok, R. (2009). What is reflective supervision? In S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision*. Washington, D.C.: ZERO TO THREE Press.

[33] Berckelaer, A.V. (n.d.). Using reflective supervision to support trauma-informed systems for children. Multiplying Connections Initiative. Health Federation of Philadelphia. Retrieved from: https://www.multiplyingconnections.org/sites/default/files/field_attachments/RS%20White%20Paper%20%282%29.pdf

Supervision Tips

Supervision is a reciprocal process between ASAP staff members and their supervisors. Each is expected to prepare for supervision sessions in order to ensure they are productive and contribute to improved practice and outcomes.

Preparation Tips for the ASAP Staff
Come to each supervision session prepared to present cases; it may be helpful to take notes during the week so that you don't forget what you want to cover at the next meeting.
Identify any issue(s) where more guidance is needed and bring any relevant documentation and information related to the issue to the session.
Openly disclose all relevant information about each case.
Seek feedback and evaluation from the supervisor.
Seek additional resources and references from supervisor.
Be mindful of what is going well and what you would like to improve upon; chances are discussions of those positive occurrences can lead to learning something new.
Consider topics that may not be directly family related, such as an interaction with a colleague or a relevant news item.
Comply with supervisor recommendations and directions and be prepared to discuss the status of action steps taken at the next session.
Take notes during each supervision meeting, making sure to note any action steps to complete.

Click here
Preparation Tips for the ASAP Supervisor

Supervision as a Support to Staff Development

The process of supervision is critical in supporting the ASAP staff's ability to integrate the philosophical principles and essential functions into the delivery of ASAP services.

During supervision sessions, the supervisor should:

- Review cases and assist the ASAP staff to identify their own strengths and areas of growth during interactions with families.
- Review whether the principles and functions of the support services are being implemented as intended.
- Provide conceptual feedback (a way to give feedback focusing on the concepts first, rather than an account of what occurred) that relates to the essential functions and then illustrates the feedback with examples (e.g., observations, case reviews, etc.).
- Regularly assess training needs and areas of desired growth.

- Use strategies to enhance staff confidence and the ability to deal with various family issues in the field.
- Support continual learning by providing ongoing education about services and resources that are available to families.
- Help staff be mindful and assess their own biases to be able to provide services that best meet the family's needs based on evidenced based research.
- Reflect with staff on their own unmet needs that may affect their ability to meet the needs of families (e.g., unresolved trauma in their own histories that is triggered by issues within families) and refer staff to outside support services when needed.

Reviewing the Work of ASAP Staff

In addition to providing ongoing opportunities for staff development, the supervisor's role is to ensure that key functions of the ASAP program are being carried out as intended. ASAP staff can benefit from the feedback of their supervisor in all phases of service delivery, with specific attention on the following areas:

- Strengthening initial engagement and contact with the family
- Reviewing assessments to ensure ASAP staff are using assessment tools as intended
- Assisting ASAP staff in conceptualizing treatment goals
- Assisting ASAP staff in maintaining healthy boundaries with families, including recognizing there may be some needs that the ASAP staff cannot address
- Confirming that required documentation is completed based on agency-specific procedures

Guidelines for Contact

Times when contact with the supervisor MUST be made
Any time, 24 hours a day, seven days a week, when there are safety concerns for a child, the child's family, or yourself. If your direct supervisor cannot be located, contact must be made with the next level of agency staff.
Any case in which a child or family member presents a serious threat to self or others should be discussed daily with the supervisor during periods of instability.
Any time a child is arrested; immediately if there are safety issues, violent offenses, weapon offenses, or media coverage.
Any time a child has run away, has been locked out, and/or is missing.
Any time a child is hospitalized.
Any time it is believed there is a need to make a hotline report.
When a verbal or written request for records is made by the child or family.
When you are requested to testify in court.

Times when contact with a supervisor is RECOMMENDED
When a child, family member, or other professional is not satisfied with services.
Any time you lie awake because you are worried about a case or yourself.
Any time you feel pressured to decide immediately and feel a better decision could be made with help.
You are having difficulty defusing a family/situation.
You are having trouble getting people to meet with you in person.
You are triggered by the family/child.
No progress is being made or there is lack of progress.
You feel overwhelmed, tired, depressed, or anxious.

Discharge Policy and After Care

Voluntary Closure

The ASAP program believes in the importance of self-determination—the right of families to determine their own future. Promoting self-determination is a family-centered, empowering approach that aligns with practicing in a trauma-informed environment. The informed consent process includes being informed about the conditions or situation requiring intervention, the options in services or treatment, and the consequences or probable consequences of each option. With this information, families have the right to choose one course of action in lieu of another. This choice includes decisions about the frequency and duration of their involvement in ASAP services. A family may determine at any time that services are no longer desired and request that their case be closed.

The Good-Enough Level (GEL) model of understanding dose-response relationships describes that patients may terminate services when they believe the treatment outcome is satisfactory,[34] or when they determine in consultation with their therapist that they have sufficiently improved to a "good-enough level."[35] When determining the appropriate length of service or treatment, there are many variables to be considered. These include things like the severity of issues, the complexities associated with the presenting problems, and even the family's level of motivation. It can be hard work to reach the initial therapeutic goals that are established, and some families determine that a break from therapy is needed when these initial goals are met. This is true even when additional goals could be achieved, especially when additional issues are not perceived as having a significant impact on the family's functioning.

[34] Falkenström, F., Josefsson, A., Berggren, T., & Holmqvist, R. (2016). How much therapy is enough? Comparing dose-effect and good-enough models in two different settings. *Psychotherapy (Chicago, Ill.)*, *53*(1), 130-139. https://doi.org/10.1037/pst0000039

[35] Baldwin, S. A., Berkeljon, A., Atkins, D. C., Olsen, J. A., & Nielsen, S. L. (2009). Rates of change in naturalistic psychotherapy: contrasting dose-effect and good-enough level models of change. *Journal of Consulting and Clinical Psychology*, *77*(2), 203-211. https://doi.org/10.1037/a0015235

Definition of Grounds for Discharge

Termination of services is most often considered when treatment goals have been substantially met and services are no longer needed. Successful discharge does not necessarily mean that all goals have been achieved. The treatment planning process is collaborative in nature, and, as part of this process, the family may prioritize goals as they are developed. In some cases, discharge may be appropriate when a break in therapeutic services would be clinically beneficial. For example, some therapies may be more appropriate when the child reaches a new developmental phase.

If the ASAP staff determines that a family is unable to cooperate with the services, the staff will discharge the family and make notification to the appropriate party at DCFS.

Services also terminate when the family moves out of state. Referrals to services in the family's new area of residency will be facilitated by ASAP staff.

Transition/Discharge Plan Components

- Transition/discharge plan reason
- Discharge narrative (summarize presenting problem, course of treatment/overall progress, recommendations, current mental health status, crisis plan)
- Summary of services provide
- Level of functioning
- Goal review
- Medications
- Referrals made
- Reason referrals made
- Dates/times of appointments with transition providers

Transition/Discharge Summary

Some of the topics that may be included in a transition/discharge summary are:

- Who referred the family to services and why
- How long they were in treatment, and what did they accomplish during that time (progress made/not made?)
- Explain why closing (e.g., no contact for such and such time, moved, parent/child requested to close, treatment goals met)
  - If closing due to no contact, explain both:
    - The extent of no contact: "Family did not show up for the last two scheduled appointments."
    - Your attempts to reengage them: "Licensed supervisor attempted three contacts via telephone and sent a letter to family requesting contact if still interested in services."
- Note your recommendations for family post-discharge:
  - What should/can they work on in order to maintain/grow progress made?
  - If no progress was made, what do you recommend in order for that to change?
- If there were safety concerns during treatment, note their status at discharge and safety plan for client post-discharge
- Indicate whether or not the family has agreed with the discharge plan

Aftercare Services

ASAP providers are required to develop a maintenance plan with the family for services following discharge.

Families are discharged with an aftercare plan that is developed or refined in the last six months of their services. This plan ensures that families have increased or improved community engagement/awareness prior to closing. The closing form entails recommendations to follow and contact information for referral resources for families to access. Families are given a copy of this information at case closing. Families are provided phone numbers and email to reconnect with ASAP staff. Some families choose to remain in close communication with ASAP staff, usually by email or text. Parents are invited to support groups that are open to families who are not currently in services. ASAP providers may send materials to former ASAP families that entail tips, resources, and support group notifications.

Families are also given the URL for the Path Beyond Adoption website and the Adoption/Guardianship Support phone line so that they can keep in touch and reach out to DCFS as they need it.

When there are interactions with former ASAP families that are extensive or the intervention is determined to be significant enough to document, staff will document this in a case note and retain this information in the family's record. Some examples of when families may call the ASAP provider in the aftercare period include requests for written document of recommendations or requests for attendance at an IEP meeting at school. Brief intervention can deflect a need to reopen the case. ASAP providers have flexibility in their contract with DCFS to provide such support.

Aftercare services may be provided through other Illinois programs.

Programmatic Reports

Case Reports Completed by ASAP Providers		
Report name	Due date	Where submitted/maintained
Intake Form	At case opening	Maintained in the ASAP provider agency file
Treatment Summary/Plan	30 calendar days after case opening	Submitted to DCFS Statewide Post Adoption Program Manager within 30 calendar days of report completion and maintained in the ASAP provider agency file
Mental Health Assessment	30 calendar days after case opening	
Quarterly Progress Reports	Quarterly	
Case Closing Summary	30 calendar days after the final session with the family	

Treatment summaries provide a comprehensive compilation of the interventions and progress of the child and family. The final case closing summary includes a treatment summary, as well as the child's emotional and behavioral status at case closing, the reason for discharge, and recommendations for services needed by the child and family in the future, if applicable. Copies of the above programmatic reports are maintained in the official case file.

Program Outcomes and Metrics

Service Outcomes

- Provider shall increase accessibility of services for 100% adoptive and guardianship families served by the program.
- Provider shall increase the use of community-based services to support families, where appropriate, and to prevent the out-of-home placement of children, for at least 95% of families served by the program.
- Provider shall prevent the entry/reentry of a child into the child welfare system for at least 95% of the children served by the program.

Treatment Goal Outcomes

- Establish a range of services that address the needs of an adoptive or guardianship family, while responding to their immediate needs, for at least 95% of families served by the program.
- Increase the family's level of functioning in at least 80% of families served by the program.
- Maintain the child in the adoptive home or, when placement outside the home is appropriate and necessary, maintain parent/child relationship in at least 85% of families.

Quality Improvement

Family Satisfaction Surveys

ASAP providers are required to develop and administer a family satisfaction survey to all families upon completion/discharge from services. The results of these surveys are compiled on a quarterly and annual basis and submitted in narrative reports to the assigned program monitor.

Midservice Survey

At about 3-4 months after the start of services, the family is offered a midservice survey. This survey can provide information to the agency working with the family about the family's initial experiences. The survey may help the agency identify families who are not engaging well due to conditions such as a mismatch between the family and assigned ASAP staff, and it can provide information to the agency about the family's perceptions with regard to the level of quality in the services being provided. Identifying these conditions early in the process allows the agency to make adjustments to improve service delivery as needed and supports the family's sense of choice in the process. A midservice survey can help families express their desire for increased service intensity for those who don't feel they have the right to change their minds and ask for more.

Click here
Mid-Service Survey

Closure Survey

The closure survey is given to the family at the end of service delivery. This survey provides the family with an opportunity to share what was and was not helpful about services and to share any concerns or compliments that the family has regarding the staff they were working with. The survey also asks about the impact of services from the family's perspective. Responses are used for program improvement purposes.

Click here
Closure Survey

Six-Month Follow-Up Survey

The six-month follow-up survey is distributed to families when six months has passed since case closure. The survey asks about the impact of services from the family's perspective and can help the ASAP provider begin to understand the possible longer-term impacts of service delivery. The survey also asks about the use of referrals that were provided at case closure and about current unmet needs.

Click here
Six Month Follow-Up Survey

Other Surveys

ASAP providers may use other surveys to assess immediate concerns, such as gathering information about needs associated with emergency conditions in the community like natural disasters.

Survey Administration

Some ASAP providers have administered surveys by delivering them to families or mailing them with a self-addressed stamped return envelope. Some agencies have used web-based survey tools such as Survey Monkey to administer surveys. The research regarding response rates is mixed, and response rates depend on many factors, including the platform used for the completion of the survey and the number of questions being asked. Ranges of response rates have been reported to be between 13% and 57%.[36] Regardless of the rate of return for satisfaction surveys, responses can provide important feedback for the ASAP program when considering program improvements.

Contract Monitoring Visits

Your assigned program monitor from DCFS will schedule at least two yearly in-person or telecommunication monitoring visits. The first visit of the fiscal year will include all staff, in which a verbal consult of cases, update on any changes, and reports of any concerns or follow-ups from staff will occur. Throughout the year, your monitor will also conduct other visits for quality assurance and to confirm that services are being properly followed in accordance with the contract/program plan. These visits may include activities such as trainings, quarterly meetings, quality assurance calls to families, etc. There will also be a yearly file review scheduled. At least ten (10 days) prior to your scheduled file review you must submit the program monitoring report, personnel list, and caseload list. If you had a program improvement plan from a previous monitoring visit, this should have been previously submitted within 30 days of receipt of the program monitoring report results. This program improvement plan will be reviewed during the upcoming monitoring visit.

Click here
Program monitoring report

Click here
Personnel list

Click here
Caseload list

Click here
Program improvement plan

[36] Lindemann, N. (2019, August 8). What's the average survey response rate? [2019 Benchmark]. Survey Anyplace Blog. Retrieved from https://surveyanyplace.com/average-survey-response-rate/

For monitoring visits, the following must be available:

Personnel files (Required for each staff member)	Case files (Required for each open case)
– Start date – Termination dates, if applicable – Resume – Credentials/transcripts – Clinical license (must not be expired), if applicable – Nonexpired driver's license, if travel for work – Nonexpired drivers' insurance, if travel for work – Yearly personnel evaluation, with goals – Yearly CEUs, must always include updated mandated reports and ethics training – Other trainings (e.g., certification or documentation of completion for NTI and ARC completion and evidence of ongoing training) – Background check clearance, must be updated every 5 years	– Consent for treatment with appropriate signatures – Any consent for release of information and/or documentation that family is aware DCFS will have access to files for monitoring and billing – Referral – Intake – Initial mental health assessment – Initial treatment plan (with measurable goals) – Mental health assessment, every 6 months – Treatment plan, every 6 months – Updated case notes to reflect billing hours – Supervision notes, at least monthly – Billable hours – Quarterly reports – Extension reports – Outcome measurement tools – Any other supplementary documents – Closing summary – Aftercare plan

Research Associated With the Illinois Adoption Support and Preservation Program

In the 1990s, there were two phases of formal research conducted by Susan Livingston Smith and Jeanne Howard on adoption preservation services in Illinois. In between the two periods there were some evaluations of the individual sites for DCFS to determine whether to rebid the contracts. Below are primary publications or monographs during Phase 1:

1. Howard, J.A. & Smith, S.L. (1995). *Adoption Preservation in Illinois: Results of a Four-Year Study*. Springfield, Illinois: Illinois Department of Children and Family Services.
2. Smith, S. & Howard, J. (1999). *Promoting successful adoptions: Practice with troubled families.* Thousand Oaks, CA: Sage.
3. Smith, S.L., Howard, J.A., & Monroe, A. (2000). Issues underlying behavior problems in at-risk adopted children. *Children and Youth Services Review*, *22*(7), 539–562.
4. Smith, S.L., Howard, J.A., & Monroe, A. (1998). An Analysis of Child Behavior Problems in Adoptions in Difficulty, *Journal of Social Service Research*, Vol. 24, No. 1/2, 61-84.

The first phase of research yielded insights into the nature of problems in families seeking services and factors associated with problem severity. Staff and parent evaluations provided feedback on outcomes as well. However, more in-depth research using standardized measures was needed in order to develop a greater understanding of the dynamics of problems in these families, the types of changes occurring over the course of intervention, and the types of children and families served whose situations improve or fail to improve.

In phase two, the evaluators began what they called the Stress and Coping Study in 2002, which ended abruptly when DCFS' funding of the Center for Adoption Studies ended in July 2004. Evaluators asked staff to continue to submit closing forms on open cases and have kept these data, but there was no analysis of all data collected. The following are publications resulting from the work done in phase two:

1. Smith, S.L., Howard, J.A., Woodman, K., & Zosky, D. (2004). *The Dynamics of Child Problems, Parenting Stress, and Coping in Child Welfare Families Receiving Adoption Preservation Services*. Normal, IL: Center for Adoption Studies.
2. Zosky, D.L., Howard, J.A., Smith, S.L., Howard, A.M., & Shelvin, K.H. (2005). Investing in adoptive families: What adoptive families tell us regarding the benefits of adoption preservation services. *Adoption Quarterly*, *8*(3), 1–24.
3. Howard, J.A., Smith, S.L., Zosky, D., & Woodman, K. (2006). A comparison of subsidized guardianship and child welfare adoptive families in adoption preservation. *Journal of Social Service Research*. 32(3), 123–134.

Resources

Wait List Resources

Resources that other families found helpful are given to families while they are on the wait list. Some options include:

- https://gobbelcounseling.wordpress.com/ Blog on parenting, adoption, and adoptive parenting. This site also has low-cost webinars on topics relevant to adoptive parents
- Facebook has many parent groups, though unfortunately some of them can be sources of a lot of misinformation. If you are interested in Facebook groups as a resource, a couple that tend to be helpful and well moderated are Parenting with Connection and TAP 101 (Transracial Adoption Perspectives). Keep in mind that Facebook groups are ever-changing social forums, and it is important to use caution when gathering information from these types of platforms
- Handout(s) relevant to family based on intake information may also be provided

Resource Library

Books

- Purvis, K., Cross, D., & Sunshine, W. L. *The Connected Child: Bring Hope and Healing to Your Adoptive Family*.
- Buckwalter, K. D. & Reed, D. *Raising the Challenging Child: How to Minimize Meltdowns, Reduce Conflict, and Increase Cooperation.*
- Rodwell, H. & Norris, V. *Parenting with Theraplay®: Understanding Attachment and How to Nurture a Closer Relationship with Your Child.*
- Siegel, D. J. & Bryson, T. P. *The Whole-Brain Child: 12 Revolutionary Strategies to Nurture Your Child's Developing Mind.*
- Siegel, D. J. *Brainstorm: The Power and Purpose of the Teenage Brain*.
- Siegel, D. J. & Bryson, T. P. *The Yes Brain: How to Cultivate Courage, Curiosity and Resilience in Your Child*.
- Kranowitz, C. S. *The Out-of-Sync Child*.

Recordings

- Trust-Based Relational Intervention DVDs by Texas Christian University:
  - Trust-Based Parenting
  - A Sensory World: Making Sense of Sensory Disorders
- Parenting After Trauma: Minding the Heart and Brain self-paced online parenting course by Robyn Gobbel
- Robyn Gobbel recorded webinars for parents, including
  - Loving and Feeding the Child with a History of Trauma
  - FASD & Other Drug Effects
  - Lying as a Trauma-Driven Behavior

Sensory Tools

- Weighted blankets, lap pads, etc.
- Fidgets and putty
- Chewable fidgets and/or jewelry
- Noise-cancelling headphones
- Body socks
- Rice bins
- Suckers and chewing gum

CORE Teen

CORE Teen is a training curriculum developed through a three-year cooperative agreement with the Children's Bureau. Spaulding for Children worked with several partners to create the curriculum:

- The ChildTrauma Academy
- The Center for Adoption Support and Education
- The North American Council on Adoptable Children
- The University of Washington

The curriculum was tested in four pilot sites over 18 months.

In 2020, ASAP Providers and Foster Parent Support Specialist (FPSS) were trained to use both the classroom modules and Right Time materials with families. The seven classroom sessions cover core skills, knowledge, and competencies families need to understand to successfully parent older children from foster care who have moderate to severe emotional

and behavioral challenges. The classroom training provides content specific to teens with behavioral and emotional needs, provides opportunities for participants to learn from each other, stimulates conversations among parenting partners and/or support networks, develops best parenting strategies, and builds knowledge and skills.

CORE Teen Right Time training is video based, and it is designed to be used in support groups, during case manager home visits, or at times when the family is experiencing a particular challenge or situation. Right Time videos are about 20 minutes in length and include:

- Stories from families exploring how the theme impacted them and how it related to their behavior
- Resource families talking about the importance of the topic and how best to parent
- Experts describing why this theme may be important and offering guidance.

Discussion guides help to facilitate an individual's reflection or group discussions after participants view the video, and an action plan helps the family consider what changes can be made and how to support those changes.

Staff Resources

Complex Trauma in Children and Adolescents:

- https://www.nctsn.org/sites/default/files/resources//complex_trauma_in_children_and_adolescents.pdf

Childhood Emotional Abuse and the Attachment System Across the Life Cycle: What Theory and Research Tell Us:

- https://www.tandfonline.com/doi/pdf/10.1080/10926770903475968?needAccess=true

Seven Core Issues in Adoption and Permanency:

- https://www.nacac.org/resource/seven-core-issues-in-adoption-and-permanency/
- https://www.childwelfare.gov/pubPDFs/f_transition.pdf

Characteristics of Successful Adoptive Families:

- https://www.michigan.gov/documents/mdhhs/Characteristics_of_Successful_Adoptive_Families_507720_7.pdf