



A TARGETed[®] Approach to Working with Traumatized Youth and Families

Program Manual for the Illinois PII Project
Illinois Department of Children and Family Services

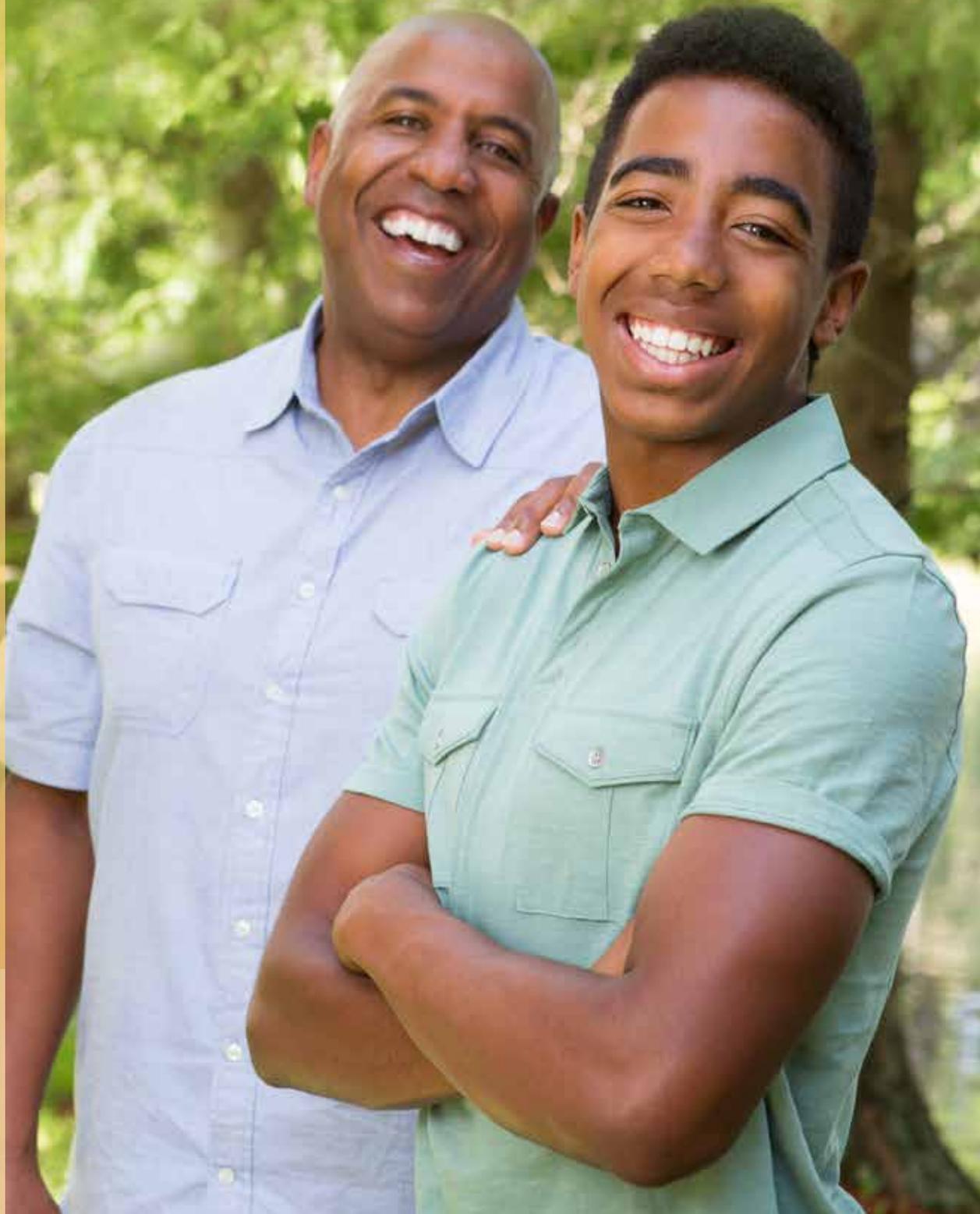


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INTRODUCTION

Background

The Permanency Innovations Initiative (PII) is a 5-year, \$100 million initiative of the Children's Bureau underway since 2010 that includes 6 Grantees,¹ each with an innovative intervention designed to help a specific subgroup of children leave foster care in less than 3 years. The project combines requirements for purposeful application of implementation science, rigorous evaluation, and coordinated dissemination of findings. PII aims to:

- Implement innovative intervention strategies, informed by relevant literature, to reduce long-term foster care (LTFC) stays and to improve child outcomes;
- Use an implementation science framework enhanced by child welfare expertise to guide technical assistance (TA) activities;
- Rigorously evaluate the validity of research-informed innovations and adapted evidence-supported interventions (ESIs)² in reducing LTFC; and
- Build an evidence base and disseminate findings to build knowledge in the child welfare field.

This integration of implementation science and program evaluation in a coordinated framework is intended to build or enhance the capacity of child welfare agencies to develop, implement, and evaluate research-informed innovations and adapted ESIs and

to provide evidence about program effectiveness. An overarching objective of PII is to increase the number of ESIs available to the child welfare community. To this end, Grantees follow a systematic approach (the PII Approach³) focusing on clearly operationalizing the infrastructure needed to support practitioners' implementation of the interventions as intended.

The PII Approach readies interventions for broad-scale use, which is more likely to be warranted and feasible when interventions have been well-operationalized with specified core components, and implementation teams have documented necessary infrastructures to support, sustain, and improve implementation integrity over time. The PII Approach provides a model for child welfare administrators and agency directors to add evidence to the body of knowledge about what works in child welfare. Its systematic approach offers a guide for child welfare stakeholders to identify existing interventions or to develop innovations to solve complex problems and evaluate them for effectiveness.

The federal government is supporting Grantees as they implement and evaluate their interventions through two offices within the Administration for Children and Families: the Children's Bureau and the Office of Planning, Research and Evaluation (OPRE). The Children's Bureau is providing training and technical assistance to Grantees to strengthen their use of best practices in implementation. OPRE is supporting rigorous within- and cross-site evaluations of Grantees' interventions.⁴ Both offices are working together to disseminate the lessons learned from PII.

1 The Grantees include Arizona Department of Economic Security; California Department of Social Services; Illinois Department of Children and Family Services; Los Angeles LGBT Center; University of Kansas; and Washoe County, Nevada Department of Social Services. For more information about Grantees' target populations and interventions, please visit <http://www.acf.hhs.gov/programs/cb/resource/pii-project-resources>.

2 Evidence-supported interventions are specific, well-defined policies, programs, and services that have shown the potential, through rigorous evaluation, to improve outcomes for children and families (Framework Workgroup, 2014).

3 More information about PII, PII Grantees, and the PII Approach can be found at the Children's Bureau website at <http://www.acf.hhs.gov/programs/cb/resource/pii-project-resources>.

4 For more information about the evaluation, see: <http://www.acf.hhs.gov/programs/opre/research/project/permanency-innovations-initiative-pii-evaluation>.

Purpose of This Manual

This program manual provides detailed information about the implementation process of the Illinois Department of Children and Family Services (IDCFS) Permanency Innovation Initiative, Illinois Trauma Focus Model for Reducing LTFC (Illinois PII Project). The purpose of the manual is to assist others in the field in replicating or adapting Trauma Affect Regulation: Guide for Education and Therapy (TARGET®) for their local use.

TARGET® was created by Advanced Trauma Solutions, Inc. (ATS) (referred to as the developer) and has empirical support for effectiveness with adolescents with complex trauma. To replicate TARGET®, ATS can be engaged via the following information:

TARGET®: TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY®

Advanced Trauma Solutions, Inc.
www.advancedtrauma.com

Judith Ford, President
 judy@advancedtrauma.com
 860-269-8663

Ford, J. D. (2015). An affective cognitive neuroscience-based approach to PTSD psychotherapy: The TARGET® model. *Journal of Cognitive Psychotherapy*, 29, 69-91.

Replicating or adapting ESIs with fidelity to the interventions builds evidence in child welfare and expands the range of intervention effectiveness to different target populations and organizational contexts. These efforts to build evidence serve several purposes, including preparing an intervention for evaluation, either during implementation or later depending on the organizational context in which an intervention is implemented; and building a base of replicable interventions that can serve the complex needs of diverse communities of children and families.

The intended audience for this program manual comprises potential implementers of the intervention, including child welfare administrators and staff, evaluators, and researchers. This document contains background information about the explorative stage of implementation and describes how the Illinois PII Project worked through processes related to:

- Organizational readiness for implementation
- Teaming and communication
- Practitioner recruitment, selection, and training
- Client recruitment and selection
- Operationalized intervention
- Coaching and fidelity assessment
- Using data for decision making and improvement
- Usability testing
- Program evaluation
- Sustainability

This manual describes how the Illinois PII Project implemented TARGET® while participating in a rigorous study. It should be noted that some decisions were made based on study requirements. This is noted throughout the document, along with recommendations based on the experience of the Illinois team, for future replication.

It also includes reflections, lessons learned, and other practical information based on the experience of the Illinois executive leadership and implementation team. The appendices include numerous program documents (**Appendices A, B, C, and D**), a glossary (**Appendix E**), the project theory of change (**Appendix F**), and sample presentations (**Appendix G**) used to engage stakeholders.

Project Background & TARGET® Overview

The Illinois PII Project was awarded to IDCFS. It involved implementation of an evidence-based trauma intervention, TARGET®, to assist youth and

families in developing greater internal capacities to mitigate stress responses. TARGET[®] uses a strength-based approach to education and therapy for youth, biological,⁵ and foster parents when they have been affected by trauma or experienced a high level of stress related to adverse experiences. TARGET[®] helps youth and adults understand and gain control of trauma-related extreme stress reactions that interfere with their ability to think clearly, make good decisions, and build healthy relationships.

TARGET[®] teaches a set of skills to help family members understand their reactions to stress and to increase control over emotional self-regulation and relational engagement. It has a strong psycho-educational component that teaches about the impact of trauma on cognitive, emotional, behavioral, and relational processes. Sessions throughout the intervention explain that the brain's stress response system (the alarm in the brain) can become stuck in survival mode after experiencing trauma and, therefore, have difficulty partnering with the brain's thinking and memory systems, especially at times of stress. TARGET[®] ultimately aims to teach clients how to better understand their own stress triggers so that they can regulate otherwise overwhelming feelings (or prevent them from becoming overwhelming) and make and achieve prosocial goals for themselves and their families.

The full TARGET[®] model consists of seven essential core skills. These are called the FREEDOM steps:

1. Focus – Pay attention to your body signals, clear your mind, and focus on one thought that reflects what you truly value.
2. Recognize Triggers – Know your stress triggers and teach your brain to distinguish between a real threat and a reminder.
3. Emotion Self-Check – Identify ALARM/Reactive Emotions (fear, anger, sadness) and balance them with MAIN Emotions (calmness and confidence).
4. Evaluate Thoughts – Learn to evaluate the ALARM thoughts and find within them the MAIN thoughts that represent what you believe in.
5. Define Goals – Restore hope by tapping into goals that express your true values and dreams rather than quick fixes.
6. Options – Regain personal control by making choices that reflect who you are and what you want most in your life.
7. Make a Contribution – Recognize how you make the world a better place when you are in control of your brain's stress ALARM.

The model can be delivered in individual sessions with youth, in a group format for youth, as an educational group or class (such as for parents), or as home-based family therapy with youth and their biological and/or foster parents. When delivered in the individual modality, the length of treatment is 12 sessions, with additional sessions as needed to apply and reinforce the core skills. It has been delivered with milieu support (in which youth attend groups and then direct care staff in detention centers or residential treatment provide ongoing support of the youth's use of TARGET[®] skills) and in an outpatient format (in which parents had little involvement in the intervention, and no milieu support was provided). In this project, the TARGET[®] 12-session intervention was applied with youth and the youth's biological parent (when reunification is being pursued). In addition, the youth's foster parent and any additional permanency resources (e.g., a relative who is considering subsidized guardianship) received therapy via the TARGET[®] model sufficiently to serve as a source of reinforcement and support for the youth. When possible, the preferred method was to introduce TARGET[®] to the youth and biological parent separately and then move to conjoint sessions, which include the youth, biological parent, and foster caregiver. When conjoint sessions occur, the total number of TARGET[®] sessions the youth and biological parent receive could exceed 12 sessions.

⁵ In this project, "biological parent" refers to the parent from whom the child was removed. This may include guardians, adoptive parents, or biological/birth parents.

Target Population

TARGET[®] is appropriate for youth who have a broad range of difficulties in symptoms and functioning. A major strength of TARGET[®] is that it is designed to address difficulties with emotional regulation and relational engagement that occur across a wide range of trauma-related and mental health issues. TARGET[®] does not require a diagnosis of post-traumatic stress disorder (PTSD) or a particular severity of traumatic stress symptoms, so youth are not screened based on trauma symptom severity.

The target population for the Illinois PII Project consisted of youth ages 11–16 placed in traditional, relative, and specialized foster homes throughout the state of Illinois. Further, upon reaching the 2-year anniversary of entering care, these youth were experiencing mental health symptoms and/or changed placements 2 or more times. This manual describes how these youth were identified to participate in the intervention and the associated study.

A screening process developed by Illinois with ATS' input ensures that youth are appropriate for the intervention. Screening criteria focus on the exclusion of youth for whom the intervention was expected to have no significant benefit (e.g., when a child has a no significant symptoms or functional impairment, untreated substance abuse, or significant developmental disabilities). *Section 4: Client Recruitment and Selection* details the complete screening criteria. Though the process and criteria may be slightly different depending on the goals of implementation, a screening process is suggested to make sure that youth are not only appropriate for TARGET[®], but would benefit from it.

The target population for the TARGET[®] intervention is not restricted geographically. TARGET[®] can be delivered in multiple formats (e.g., groups, milieu-based, family-based, individual therapy) with a high degree of fidelity by providing support for its adaptation for urban and rural settings, which may require different delivery methods.

Process to Identify the Target Population

Those considering use of TARGET[®] should identify the population in their system that would most benefit from treatment for trauma via a psychoeducational intervention. In Illinois, for example, the PII Project team worked with university partners and IDCFS to conduct quantitative data analyses, qualitative case reviews, and focus groups to identify the population in Illinois most at risk for LTFC. The findings provided six risk factors:

1. Age (over 9 years at entry into foster care)
2. Previous placement instability (3+ placements in the first 2 years)
3. Mental health issues, trauma symptoms, or risk behaviors
4. Termination of parental rights (if not completed by 2 years after entry)
5. Region (Cook County, which includes Chicago)
6. Placement type (placement in group home at any point)

The first three risk factors became the criteria for inclusion in the intervention because of their particularly strong links to long-term care. The final two risk factors were not used for inclusion because of restrictions it would have placed on the otherwise wide-reaching population, as discussed above.

Theory of Change

A theory of change maps out the rationale that connects the needs of the target population and the expected outcomes of the intervention. The goal of the Illinois PII Project was to increase rates of permanency for the identified target population by addressing the impact that trauma has on youth and their caregivers. An additional goal was teaching parents and caregivers to support youth in managing the emotional and behavioral effects of experiencing traumatic stress

reactions (e.g., anxiety, depression, anger, addictive behavior, sleep problems, conflicts in relationships). Improved rates of permanency were expected through higher rates of (1) reunification, for youth for whom reunification is still being pursued or (2) adoption and subsidized guardianship, for youth who do not have a goal of return home (by providing TARGET® to youth, foster parents, and prospective permanency resources). Analyses before implementation indicated just over half (56 percent) of youth meeting the screening criteria had reunification permanency goals.

The most salient barriers to permanency identified in this population include:

- Emotional and behavioral issues of the identified youth, frequently related to histories of complex trauma, such as abuse or family or community violence

- Lack of biological parent engagement and service completion required to achieve reunification
- Insufficient or ineffective services to address biological parents' underlying issues related to child welfare involvement
- Lack of support and training to foster parents to address the needs and behaviors of the children in their care

To address these barriers, the Illinois PII Project theory of change was premised on the assumptions laid out in **Figure 1**.

A full exposition of the theory of change for the Illinois PII Project can be found in **Appendix F**.

FIGURE 1: ASSUMPTIONS OF THE ILLINOIS PII PROJECT'S THEORY OF CHANGE

Youth

- Youth with histories of trauma and/or emotional and behavioral issues have difficulty regulating their emotions and behavior leading to difficulty in forming relationships.
- TARGET® will increase youths' skills in emotional and behavioral regulation and increase their capacity to manage stress and reduce behavior problems.
- Youth who are better able to regulate their emotions and behaviors will have increased ability to form relationships.
- Youth who are better able to regulate their emotions and behaviors will have a greater capacity to form relationships, which will lead to increased placement stability and greater likelihood of attaining permanency.

Biological Parents

- Biological parents' histories of trauma often lead to difficulty with emotional and behavioral self-regulation.
- Biological parents who learn skills that help to regulate their emotions and behavior will make more progress in completing required services for reunification and in resolving the issues that resulted in child welfare involvement.
- TARGET® will provide biological parents with increased skills in emotional and behavioral regulation, allowing them to better address their own needs and parent their children.
- Participation in TARGET® will, therefore, result in higher rates of reunification compared to families who have not participated in TARGET®.

Foster Parents

- Foster parents often feel unprepared to care for children with trauma-related and mental health symptoms.
- TARGET® will provide foster parents with a greater understanding of trauma-related and mental health symptoms and skills to assist the child in self-regulation of disruptive emotions and behaviors.
- An increase in foster parents' skills to assist youth with disruptive emotions and behaviors will result in decreased stress and greater placement stability.
- Increased placement stability will result in increased legal permanency through adoption and subsidized guardianship.

Through implementation of TARGET®, IDCFs aimed to increase capacity in both urban and rural areas to:

- Assist youth in regulating their emotions and behavior, resulting in an increased ability to form relationships and to maintain their placements
- Support biological parents in regulating their emotions and behavior, leading to gains in service completion, resolution of issues that resulted in child welfare involvement, and improved reunification rates
- Give foster parents a better understanding of the trauma experienced by youth and biological parents and train and support them and other potential permanency resources to assist youth in self-regulation, leading to increased placement stability and increased permanency.

Expected Short- and Long-Term Outcomes

TARGET® is expected to improve placement stability via alleviation of trauma-related and mental health symptoms in both the youth and their biological parents. It also provides caregivers with a common understanding of the youth's behavior and an increased capacity to prevent or respond to disruptive behaviors that might otherwise seem unmanageable. Decreases in youth and caregiver dysregulation and the caregiver's increased perception of capacity to effectively parent the youth are expected to strengthen the youth-caregiver relationship. While other parenting skills, such as behavior management, would also be likely to improve the caregiver's capacity to parent a child with behavioral and emotional issues, these interventions may be less effective in strengthening relationships for youth with trauma histories. The intent of this intervention is to address the effects of trauma that are likely to be inhibiting strong relationship development and, ultimately, achievement of permanency.

Proximal (short-term) outcomes identified by the Illinois PII Project team include:

- Increased rates of:
 - placement stability
 - biological parent's ability to regulate their own emotions and behaviors and to respond effectively to children's emotional and behavioral dysregulation
 - biological parent's service completion
 - biological parent's contact with the youth
- Decreased rates of:
 - biological parent's experience of trauma-related symptoms
 - youth's trauma-related and mental health symptoms
- Increased foster parent skills in responding to children's emotional and behavioral dysregulation
- Increased support for biological and foster parents
- Increased capacity of the youth to form and maintain relationships and regulate emotions and behaviors

Permanency is expected to improve through higher reunification, adoption, and subsidized guardianship rates. Reunification is expected to increase due to parents' increased abilities to self-regulate, increased completion of mandated services, and increased contact and connection with the youth through the TARGET® sessions. Completion of services and increased contact with the youth both indicate increased engagement, corresponding to a reduction of a key barrier to permanency identified in the theory of change. Additionally, the eventual inclusion of both biological and foster parents in sessions is expected to improve reunification rates by clarifying a commitment to the youth's permanency goal as reunification and by increasing foster parents' support of this goal as they see the biological parent working with the youth to learn TARGET® skills.

Primary distal (long-term) outcomes identified by the Illinois PII Project team are:

- Increased permanency rates
- Increase in timely permanency within 3 years of entry into substitute care
- Maintain rates of placement stability after legal permanence
- Maintain rates of repeat maltreatment following legal permanence

Involvement with TARGET[®] may affect additional outcomes. These include a change in permanency goals and an increase in perceptions of emotional permanence. When a youth participates in the intervention, the TARGET[®] therapist collaborates with the caseworker, discusses progress, and works collectively to support the youth and family. Through involvement with the TARGET[®] therapist, the caseworker or court may develop greater optimism about the possibility of the youth returning home and therefore adjust a goal. Additionally, TARGET[®] may affect a youth's perception of emotional permanence or the extent to which he or she has a sense of security based on positive relationships with adults. For example, work with the foster parent may strengthen the youth and foster parent relationship such that the foster parent is more likely to serve as a support to the youth into adulthood. Regardless of whether the foster parent becomes a legal source of permanency (via adoption or subsidized guardianship), the youth may be more likely to feel like he or she has a permanent source of support in his or her life, also known as relational or emotional permanence.

Although the published literature does not specify the extent of child welfare involvement among enrolled youth, the developer had used TARGET[®] extensively with child welfare-involved families. In Connecticut, where the intervention was most fully implemented, two-thirds of families receiving TARGET[®] through the juvenile justice system were previously or still actively child welfare involved. Within a clinic at

the University of Connecticut Health Center where TARGET[®] was created in a program funded primarily by Connecticut's child welfare agency, the developer estimates that about 90 percent of youth receiving TARGET[®] are or have been child welfare involved, with approximately 60 percent of youth currently placed in substitute care.

The developer prefers to use TARGET[®] in a family therapy model that initially engages youth and biological parents in separate courses of therapy. Foster parents participate in some of the youth's sessions, and when both youth and biological parents have learned some initial skills, conjoint sessions are held. The developer's goal is to include both biological and foster parents in sessions with youth believing that this increases the model's effectiveness. This is thought to be the case because, in addition to the youth's improvement in self-regulation skills, parents also have improved regulation skills, and the family has a common vocabulary to identify experiences, a better understanding of each other's triggers, and effective methods to de-escalate or prevent crises (Ford, 2015).

While TARGET[®] was not developed specifically to improve permanency outcomes, there is potential for it to increase collaboration between biological and foster parents and thereby to improve permanency outcomes. For example, foster parent mentoring of biological parents has been shown to be an effective intervention to improve reunification rates, with the literature identifying one program that found that parents participating in a foster parent mentoring program achieved reunification significantly more often (Marcenko, 2008, cited in Kemp, Marcenko, Hoagwood, & Vesneski, 2009). TARGET[®] engages biological and foster parents in the shared learning and application of skills for their own and their child's self-regulation, providing them with knowledge and skills that foster collaborative teamwork.

Strengthening relationships between foster and biological parents has also been linked to better outcomes in

key areas that can pose barriers to permanency, such as biological parent disengagement and inconsistent visiting with children. Linares, Montalto, Li, and Oza (2006) tested a parenting intervention with foster and biological parents to enhance parenting practices and co-parenting and to reduce children's behavior problems. Among families assigned to the intervention condition, parenting practices improved, and youth's behavior problems decreased. In another effort to improve relationships between youth, foster families, and biological families, staff were trained to coach families before, during, and after visits to reduce stress around visits. Participating biological parents had a high level of participation in visits and more frequent and positive contact with foster families (Gerring, Kemp, & Marcenko, 2008). Greater levels of inclusive practice also increased frequency of visits in another study (Leathers, 2002), and an increase in number of visits is associated with improved reunification rates (Leathers, 2002; Davis, Landsverk, Newton, & Ganger, 1996).

Although use of TARGET[®] to improve permanency had not been empirically tested, the developer's experience using the intervention in a family therapy model in their child clinic suggests that biological and foster parent joint participation in TARGET[®] often supported successful reunifications that would not have otherwise been possible (Ford & Saltzman, 2009). In this project, TARGET[®] was used to help youth, biological parents, and foster parents develop a common understanding of their stress responses. Youth and biological parents were expected to develop skills that help them emotionally regulate during conjoint meetings. It was expected that their participation in these sessions would enhance regulation and the ability to communicate with each other and ultimately lead to better permanency outcomes. The Illinois PII Project will study the extent of biological and foster parent engagement in TARGET[®], youth and biological parent affect regulation, service plan completion, and permanency outcomes to test this hypothesis.

Logic for Selecting TARGET[®]

Community and Institutional Values

In selecting an intervention, it is important to consider how it fits with the implementing agency's organizational values. TARGET[®] was selected as the evidence-based practice (EBP) for the Illinois PII Project because it strongly aligns with the community and institutional values of the child welfare practice community in Illinois. Since 2008, Illinois has focused on providing comprehensive training to child welfare staff in use of a family-centered, trauma-informed, and strengths-based practice model.

Foster parents also receive strengths-based training that includes content on how to recognize and address symptoms of trauma in their foster children prior to placement of a child in their home. However, despite the high level of commitment to providing strengths-based, trauma-focused services, few therapists had been trained in an evidence-based model to provide this type of treatment, creating a gap in the mental health services typically provided to youth and families. The selected intervention and its implementation statewide provide youth and their families with a mechanism to receive trauma-focused services. A key factor leading to the selection of TARGET[®] is the

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES MISSION STATEMENT

The mission of IDCFS is to:

- Protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them
- Provide for the well-being of children in our care
- Provide appropriate, permanent families as quickly as possible for those children who cannot safely return home
- Support early intervention and child abuse prevention activities
- Work in partnerships with communities to fulfill this mission

extent to which it is family-centered and strengths-based. The box below shows a more detailed list of values and goals that TARGET[®] fulfilled.

In most child welfare agencies, the individual youth is typically the primary recipient of clinical services. Because the ultimate goal of the Illinois PII Project is to improve rates of permanency for youth who receive TARGET[®] services, family participation in the service was given high priority whenever possible. Therapists receive training and ongoing supervision in engagement strategies and family therapy techniques. It is assumed that much of the training would offer new skills for many therapists, and this new skill set would allow therapists to better address both youth and parent mental health needs and thus improve permanency outcomes for youth.

TARGET[®] is also explicitly strengths based. For example, throughout the TARGET[®] manual for treatment of adolescents,⁶ therapists learn to identify and support the youth's use of TARGET[®] skills and to build upon the youth's adaptive responses to stress. Even the conceptualization of how youth have been affected by trauma is presented through a strengths-based lens. Rather than focus on deficits or symptoms, youth learn to use their personal strengths to understand and have better control over their stress reactions. Through this process, they are expected to gain a greater perception of self-efficacy.

ILLINOIS COMMUNITY AND INSTITUTIONAL VALUES MET BY THE SELECTION OF TARGET[®]

- Trauma informed
- Evidence based
- Family centered
- Highly relevant to mental health needs of many in the child welfare population
- Strengths based

High Degree of Relevance to Target Population's Needs

All youth in the Illinois PII Project experienced traumatic events, including maltreatment and parental separation. However, most had a range of trauma related symptoms without meeting criteria for PTSD. One of the strengths of TARGET[®] is that it is designed specifically to address complex trauma and difficulties with emotional regulation and relational engagement that occur across a wide range of trauma-related difficulties. Specific, discrete incidents of trauma are not required for its use. Practically, this means that a greater proportion of the identified population was expected to benefit from TARGET[®], and screening youth for specific diagnoses or types of traumatic histories is not necessary.

TARGET[®] addresses three key barriers to permanence for the identified population, including (1) children's need to improve emotional regulation and reduce symptom severity, particularly disruptive behaviors; (2) biological parents' skills in regulating their emotions so they are better able to complete services and address the underlying issues related to their involvement in the child welfare system; (3) foster parents' need for skills to help them understand and address the needs and disruptive behaviors of the children in their care with trauma histories.

TARGET[®] has a strong psychoeducational component that teaches a set of skills to help people understand the impact of stress and helps them become familiar with their own stress responses. It also teaches people how to regulate feelings and thoughts to prevent states of high distress or arousal. With these skills, TARGET[®] participants become better able to make and achieve goals for themselves. Many foster youth have had experiences that lead them to feel out of control, angry, depressed, detached, and helpless. Because TARGET[®] teaches them how to think more clearly and choose more adaptive behaviors, youth

6. ATS has developed multiple manuals designed to deliver TARGET[®] in varying settings with varying audiences. For information about other manuals, please contact ATS.

should be better able to regulate their emotions and address conflicting feelings. According to the theory of change, this ability to better understand their stress responses and to have greater control over their emotional reactions should support the development of more positive relationships.

TARGET® is also used with biological parents to assist them in understanding and addressing issues related to their own histories of trauma. The potential effectiveness of the intervention is supported by studies that find that integration of trauma-focused interventions in substance abuse treatment improves outcomes for adults with substance abuse issues (Frisman, Ford, Lin, Mallon, & Chang, 2008), which are frequently present for families with delayed reunification.

Foster parents are provided with the skills and support to assist youth in using TARGET® skills that will ultimately result in improved self-regulation for the youth. Many foster parents are receptive to this role because they are accustomed to learning about how to better care for children in their care through the requirement to attend regular trainings to maintain licensure.

1 ORGANIZATIONAL READINESS FOR IMPLEMENTATION

Background

Implementation of innovations often occurs in a complex organization. As a result, the organization must pay constant and ongoing attention to readiness. Attention to ongoing readiness means paying close attention throughout the implementation process to the entire organization, both the people and the overall structure, in which an innovation is being implemented. This can take multiple forms, e.g. administration of a readiness assessment before beginning implementation or targeted information gathering through meetings and outreach sessions. However the information gathering occurs, it should include ongoing exploration of how an organization is currently operating and how it should or could be operating to support the innovation more effectively. A readiness assessment could reveal that, in general, a certain innovation does not fit into the organization's current mission and vision, or that the organization needs to involve more partners. A targeted look could reveal that current hiring practices do not assess for the specific competencies needed for the innovation. Although assessment methods and results vary by organization and implementation stage, attention to ongoing readiness is crucial throughout the process.

Organizational Structures and Supports

Implementation of TARGET® is facilitated by focusing on the infusion of the intervention into an existing program focused on enhancing placement outcomes. The implementation mechanism ultimately chosen was the System of Care (SOC) program. It includes a network of providers focused on maintaining stability in relative or traditional foster care placements.

INTEGRATING A NEW INTERVENTION IN THE CONTEXT OF OTHER INITIATIVES AND PRIORITIES

IDCFS began its effort to provide family-centered, trauma-informed, and strengths-based services in 2008, and this effort continues today. This practice model has led to multiple initiatives affecting staff and foster parent training, reflecting ICDFS's commitment to this model of service. Because ICDFS has engaged in this work for several years, much of the groundwork for the implementation of TARGET® was already completed. Notably, in the multiple meetings with administrators, supervisors, and other agency staff that occurred, reactions to the selection of TARGET® were overwhelmingly positive. This positive reception is likely due to the high level of fit between the intervention and the system's priorities and the extent that TARGET® is perceived as potentially addressing the gap in clinical services that is apparent.

In Illinois, for example, two mechanisms for implementation were considered. The first was to use existing mental health providers who are employed by larger private child welfare agencies that maintain a clinical staff. These providers are not linked by any type of statewide structure, meaning they would need to be accessed through their agencies, which potentially have diverse practice orientations and attitudes about EBPs. Most focus on individual child treatment, and most serve youth in office settings. Additionally, data collected for the purposes of implementation planning indicated that many (approx. 30 percent) of the youth meeting eligibility criteria were currently receiving therapy services from one of these private agency providers.

These factors posed significant barriers to the successful implementation of TARGET® and to the extent

that the intervention could be evaluated in a rigorous design. Without an established organizational structure and common orientation to services and goals across the multiple clinical programs that will be involved, successful implementation would require a lengthy process, including building organizational support within each of the private agencies, assessing provider fit with the intervention, and multiple other activities. Ultimately, this had the potential to result in a low level of intervention use and fidelity, particularly given most therapists' orientation to individual office-based treatment and the lack of a centralized administration across the programs.

SOC, the second mechanism considered and defined in the box below, provided an ideal mechanism for implementation for the following reasons:

- Its strong organizational structure, including centralized leadership within IDCFS
- Consistency between the mode of intervention required for successful implementation of TARGET® and SOC services
- Staff capacity and openness to learning EBPs, as evidenced from a prior pilot study (Weiner, Schneider, & Lyons, 2009)

IDCFS SYSTEM OF CARE

SOC is a short-term (6 months) placement stabilization program. It covers the entire state, and any youth who are a ward of the state in traditional or family member foster homes are eligible for services. Services are provided in the home or community and include, but are not limited to:

- Therapy and counseling
- Legal and school advocacy
- Mentoring and tutoring

Use of the SOC program addressed many of the issues noted concerning private providers. Although SOC providers are also hired through individual agencies to provide services to families in a specific geographic region, agencies are required to have common elements in their training, and supervisors meet regularly with an IDCFS administrator. Training requirements include elements consistent with traditional SOC principles, such as understanding the family systemically and working with clients in community- or home-based settings. SOC providers were also accustomed to coordinating with other therapists, which was beneficial for implementing TARGET[®].

SOC providers had been engaged in prior work implementing EBPs, were familiar with the importance of model fidelity and documentation, and were enthusiastic about learning new EBPs that addressed their clients' needs.

Another key to success was the SOC program administrator's enthusiasm about working to improve therapeutic services. Administrators who work with their staff to support implementation of TARGET[®] should have a centralized leadership position that allows them to adapt workers' responsibilities to support the needs of the intervention. Regular, open communication between the administrator and the agencies in the field is also imperative to ensure an effective implementation.

Some of the lessons learned by the Illinois PII Project when working within the SOC program included:

- The providers' focus on the family as primary recipient of services was expected to be helpful, but for TARGET[®] youth, they had to practice in a mode that was much more constricted and were unable to offer the array of services they were used to offering.
- It was important to closely monitor and limit the use of other trauma-focused interventions with TARGET[®] youth in order to adequately test the effectiveness of those services rather than TARGET[®] plus other trauma-focused intervention. See *Section 7: Using Data for Decision Making and Improvement* for additional information on how this issue was monitored and addressed.

Developer Involvement in Intervention Readiness and Implementation

ATS, the developer of TARGET[®], is a key resource for those implementing the intervention. It has in-depth knowledge about the role of trauma in high-risk populations, has trained entire juvenile justice workforces in one state, and is working with child welfare-involved populations. ATS makes itself available for numerous conference calls and e-mail exchanges. In Illinois, it demonstrated a clear interest in working with IDCFS on the Illinois PII Project and became acquainted with both the goals of the project and the structure of the Illinois child welfare system. ATS participated in monthly consultation calls throughout the project, as well as weekly consultation calls during the first 3 months of rollout (the usability testing phase) to ensure effective delivery and support of the TARGET[®] intervention. The Illinois PII Project continues to collect feedback in order to address concerns about how the systems in place could best support the therapists in disseminating the intervention to families.

The developer is an integral part of data collection, fidelity monitoring, and performance assessment. ATS also administers satisfaction surveys at the end of each training session and every 3 months to the TARGET[®] consultation groups (quarterly surveys are collected by PII staff to ensure therapists'

confidentiality and honest feedback). Summary reports of these surveys inform the ongoing implementation and planning process.

ATS ASSESSMENT FOCUS GROUPS

In an effort to continue engaging providers in the study, ATS conducted focus groups with SOC providers to assess readiness for implementation of TARGET® and to address their goals and concerns about TARGET® and the required model of service delivery. ATS gathered information about their experiences using EBPs, their prior training in trauma work, and what they saw as potential catalysts and barriers to implementation. Two additional focus groups were held with birth families involved in the child welfare system and foster families. This information was compiled into a report and helped to inform the rollout of the training and quality assurance plan. This process also facilitated a working relationship between ATS and the selected providers.

2 TEAMING AND COMMUNICATION

IDCFS developed a strong organizational structure to support the Illinois PII Project. In the planning phase, the initiative was led by a steering committee, an executive committee, and three workgroups: population and evaluation, intervention design, and implementation. As the project progressed through implementation, a staff-composed Implementation Support Team (IST) was added. The IST in particular was imperative to making time-sensitive decisions with an implementation-science lens to ensure effective use of the intervention. Below is a detailed description of organizational structure and supports.

Teaming and Governance Structure

An effective teaming and governance structure is very important to the implementation of TARGET®. Especially with a large system like Illinois', communication across different parts of the system required well defined roles and expectations of each role. The teaming and governance structure for the Illinois PII Project is reflective of IDCFS. The Illinois child welfare system is state supervised and administered under a centralized management structure serving youth up to age 21. Case management responsibilities are largely privatized in Illinois with over 80 percent of case management responsibilities being provided by private child welfare agencies under purchase of service contracts with IDCFS. Foster care services are also provided through contracts with private child welfare agencies. Through this organizational framework, IDCFS is able to devote the collective resources of both the public agency and its partnerships with private child welfare agencies statewide to implement initiatives and projects uniformly throughout the state.

The teaming structure can be adjusted as needed. For example, the Illinois PII Project created smaller teams to be more agile in reacting to problems and questions or to address new phases of the project (e.g., design, implementation, and sustainability). Larger teams or those with a “high-level” view, such as the steering and executive committees, were collapsed or moved to less frequent meetings as the focus changed, and the study moved from implementation into sustainability. In some cases, team members whose groups were collapsed got folded into previously existing groups, and, in other cases, they were kept informed about project progress through the various dissemination efforts undertaken by the Illinois PII Project team.

PII Committees

The committee structure for the Illinois PII Project was organized under the Child Welfare Advisory Committee (CWAC). Overlapping membership on each PII committee ensured communication of expectations,

roles, and deliverables. Each of the committees was advisory to IDCFS, composed of diverse membership, and provided invaluable expertise and direction to the project. Figure 2 displays the committees’ structure. In addition, more detailed information is available in the attached Terms of Reference for each committee in **Appendix H**.

Illinois Child Welfare Advisory Committee (CWAC): The Illinois PII Project is governed by CWAC. CWAC was established to provide a forum for collaboration between public and private child welfare agencies in Illinois, with an explicit purpose of advising IDCFS on “programmatic and budgetary matters related to the provision of purchase of child welfare services” (Illinois Administrative Code 428.50).

CWAC comprises 25 members appointed by the Director of IDCFS and is co-chaired by the Director and a private child welfare agency executive. The sub-committees and workgroups, representing public and

FIGURE 2: ILLINOIS PII PROJECT GOVERNANCE STRUCTURE



private sectors, are tasked with child welfare policy development and large-scale system improvement.

PII Steering Committee: The PII Steering Committee provided a platform for collaborative leadership and vision for the project. The Steering Committee was composed of 23 members and included a broad representation of internal and external stakeholders. Membership was purposefully structured to include IDCFS, private agencies, the courts, university partners, and a national policy organization. The committee met quarterly and formed an executive committee and three workgroups. As the project progressed, the Steering Committee was collapsed. This occurred because once implementation began, there was less of a need for broad program-level and larger system-level decisions and more of a need for detailed implementation work and decisions.

PII Executive Committee: The PII Executive Committee was formed to provide more agile and timely decision-making support on behalf of the PII Steering Committee. The Executive Committee shared common co-chairs with the PII Steering Committee; its membership was composed of the chairs of the PII workgroups and additional child welfare experts. The task of the committee was to ensure cohesiveness and integration across the whole of the project. The PII Executive Committee initially convened every other week before moving to a semiannual schedule. This committee had the active participation of the federal partners, TA providers, and evaluators involved in the PII project.

PII Population and Evaluation Workgroup: The primary responsibilities of the PII Population and Evaluation Workgroup included specification of the target population and guidance for the evaluation. The workgroup was chaired by the Evaluation Liaison and was composed of researchers from the various university partners involved in planning the evaluation. The workgroup acted as an ongoing source for data analysis, decision support, implementation planning

SUGGESTED OUTCOMES FOR TRACKING AND REPORTING

- Client-level mental health and wellness measures
- Service/intervention utilization rates
- Service/intervention completion rates
- Client and therapist satisfaction

Outcomes should be specific to the goal of the intervention, whether permanency, safety, prevention of criminal re-offending, or other goals of the program implementing TARGET®.

and monitoring, and coordination of Illinois' participation in the cross-site and site-level evaluations. The chair of the PII Population and Evaluation Workgroup served on the PII Executive and Steering Committees. In a situation where a rigorous evaluation is not part of the TARGET® intervention, this committee could be responsible for identifying, tracking, and reporting on measurable outcomes.

PII Intervention Design Workgroup: The primary responsibilities of the PII Intervention Design Workgroup included review of available EBPs matched to the needs and barriers of the identified population, formulation of a theory of change, due diligence evaluating select interventions and developers, selection of a recommended intervention, and development of the Intervention Template. The workgroup was chaired by the Principle Investigator. The workgroup remained available as necessary to support initial implementation and evaluation of the selected intervention. As implementation was solidified after usability testing, the workgroup was dissolved. The chair of the PII Intervention Design Workgroup served on the PII Executive and Steering Committees.

PII Statewide Implementation Workgroup: The PII Statewide Implementation Workgroup was composed of executive- and program management-level public and private child welfare leaders, university

partners, and representatives from the Population and Evaluation Workgroup and the Intervention Design Workgroup. The PII Implementation Workgroup worked collaboratively to provide direction for the operational planning and initial and ongoing implementation of the Illinois PII Project. The co-chairs of the PII Implementation Workgroup served on the PII Executive and Steering Committees. In addition, TA consultants routinely participated in these meetings.

PII Implementation Support Team (IST): The IST was chaired by the SOC Administrator and composed of the Project Director, Evaluation Liaison, Deputy Director of Clinical Practice, representatives from the university partners, and the Research and Project Assistants. Representatives of the developer periodically participated with the team. The IST met weekly to review enrollment, training completion, fidelity, and implementation data across the project to ensure consistent, high-fidelity implementation of the initiative.

The Project and Research Assistants provided direct coordination, support, and communications with involved agencies for the project. As described below in the communications plan, they had regular contact with agencies, identified barriers, and reviewed performance data with their assigned agencies on an ongoing basis to promote procedural compliance and project fidelity. Assistants' activities were reviewed regularly with the full IST to provide oversight of implementation and consultation when implementation issues arose.

During usability testing, the IST developed a detailed schema of case movement. As a result, PII staff members were able to anticipate significant case milestones and the subtasks necessary for successful implementation. This group was also focused on sustainability planning, moving to a biweekly and then monthly schedule as the project reached the end of evaluation and moved towards sustainability after the grant period. The most important attribute of the IST was its flexibility in roles. The team was built to

respond to whatever implementation questions arose, both during implementation and when preparing for sustainability. In order to ensure this flexibility is used most effectively, the goal(s) of the IST should be continually and openly discussed so that each team member can contribute most effectively.

Communication Plan and Strategies

This section describes the processes, procedures, and strategies for maintaining efficient and effective communication with the various internal and external partners for the project.

Internal Communication: The formal teaming and governance structure for the implementation of TARGET® includes active communication linkages across committees, workgroups, and teams. These linkages are supported through shared memberships across committees and other groups as detailed above. Communication linkages are also created through the production and dissemination of summary notes of meetings. The Project Director and Coordinator work closely with group chairpersons, attend all committee meetings, report information and key issues across groups, and serve as the primary linkage to external groups. These activities support efficient and effective communication within the formal teaming and governance structure for the project.

Evaluation Liaison Feedback: Information collected about the number of TARGET® therapists, families completing TARGET®, placement outcomes, and measures of functioning are used in planning efforts throughout the project. In Illinois, the Implementation Workgroup members received monthly updates from the Evaluation Liaison based on available data. In addition, ongoing performance measurement data were shared through the IST. Adjustments to the program to enhance intervention uptake were discussed as needed. Of particular importance for IDCFS were adjustments in engagement as the project progressed.

Evaluation Team Feedback: The Evaluation Team is responsible for analyzing key output data and all proximal outcome data. In Illinois, this was completed at the end of a 6-month initial evaluation phase (formative evaluation) and again (along with the distal outcomes) at the end of the project evaluation phase. The team shared the formative evaluation findings with the Illinois PII project committees and workgroups once they became available. This information can be used to assess whether the intervention was yielding the expected results. In Illinois, the project showed favorable results and moved into the summative evaluation phase.

Information Sharing With External Providers for Project Implementation

Information sharing is important because both initial implementation and sustainability require buy-in from a wide range of parties outside the immediate team. The complex composition of the Illinois child welfare system, for example, required additional communication strategies to successfully engage the general child welfare community. The primary audience for these strategies included public and private agency child welfare professionals, foster caregivers, and the courts. The strategy for reciprocal communications with the child welfare community included tailored written communications, peer communication, and in-person presentations. Three core presentations describing the PII Project were developed and adapted for various audiences. Guidance from the PII Implementation Workgroup suggested that in-person communication is especially important.

Foster caregiver and court personnel buy-in was also important to the Illinois PII Project, both in implementation and sustainability. These groups were reached most efficiently via existing structures: newsletters, meetings, and committees that combine large groups of stakeholders. To use those avenues, PII staff presented and discussed the project in person or on the phone, published updates on the project, and shared

“success stories” to show anecdotal evidence for the benefits of TARGET®. Early interaction with the Illinois courts showed that though they were very excited about TARGET® and its possible benefits, they were not as interested until they could start using it. Moving forward, ensuring that the audience is receiving information with tangible value ensures better buy-in.

The extent to which one engages and communicates with agency administrators about implementation greatly affects the level of supervisory, caseworker, and therapist buy-in. In Illinois, for example, program administrators were informed about the intervention through presentations to standing committees and IDCFS publications: provider committee meetings, Specialized Foster Care, CWAC Infrastructure, Child Care Association of Illinois regular meetings, supervisory forums, the IDCFS newsletter *Fostering Illinois*, Illinois Adoption Advisory Council, Statewide Foster Care Advisory Council, Youth Advisory Council, IDCFS supervisor meetings, and IDCFS regional staff meetings. Samples of presentations can be found in **Appendix G**.

It is also important to build awareness of TARGET’s® fit into the current service model. Explaining how implementation of TARGET® is accomplished (e.g., how workers collaborate with existing therapists, training time of SOC workers, what the research entails) and, in the case of Illinois, what the research component entails, a timeline for implementation activities, and the directors’ and supervisors’ roles in supporting implementation is important to gaining buy-in. The ultimate goal of sharing information is to address questions and concerns while mobilizing interest in the initiative and identifying champions.

Feedback From the Field

In an effort to ensure a continuous feedback loop between frontline staff, administrators, TARGET® developer, and others involved in the Illinois PII Project, stakeholders should maintain close communication throughout the project as detailed above. The Project

and Research Assistants play a critical role in ensuring that issues that arose in the field are effectively communicated and addressed by the IST, ATS, or the larger system. In addition, they serve as conduits for feedback to the field on the progress of the project and project outcomes. Implementation challenges and the best practices that resulted from working out those challenges are communicated via check-in calls.

Case management issues, such as engagement, involvement of different family members, and finding space to meet with clients, were brought to the IST for both clinical and research discussion and decision making.

3 PRACTITIONER RECRUITMENT, SELECTION, AND TRAINING

Staff Recruitment and Selection

Selection Strategy

The following guidelines ensure that selected therapists have the required characteristics to successfully deliver the TARGET[®] intervention:

- A Master's degree or 3 years in the field is preferred. In Illinois, some exceptions were made in cases where the therapist was able to demonstrate a strong ability to engage with clients and had interest in learning an EBP for the treatment of trauma and the desire to implement TARGET[®] with a family system in the home.
- Geographic location, to ensure complete coverage of the state
- Experience (or willingness) to work in collaboration with the foster parent,
- Open to working with the birth parent
- Knowledge about or exposure to Evidence Based Practices (EBPs)
- Commitment
- Familiarity with in-home services

The SOC clinical staff provided an excellent pool of potential TARGET[®] therapists, but some were more or less suited for delivering the intervention than others. Identifying differences and providing in-depth information to coaches and trainers before initial training of therapists helped tailor training and coaching to the strengths and weaknesses of therapists.

Nomination Process

To aid in the selection of cohorts to train, PII staff used geomapping. The maps indicated the number of historically eligible youth surrounding each SOC agency. Based on locations that had the greatest number of potential PII families, the SOC supervisor was contacted to nominate one or more of its staff to become a TARGET[®] therapist. (See *Section 4: Client Recruitment and Selection* for a more detailed explanation of geomapping.)

Though SOC agencies administrators had been involved in planning, therapist supervisors were not necessarily included in that process. For that reason, to begin the study, the Project Assistant invited the SOC supervisors to a webinar and included the following informational documents prior to asking for a nomination:

- PII Project Summary – A high-level overview of the study, its design, and the evaluation so supervisors could understand the larger picture of their therapists' involvement.
- PII Project Summary for TARGET[®] Therapist – An FAQ-style document explaining what participation in PII as a therapist would mean. It detailed training requirements, ongoing supervision, and a brief explanation of the client population so the therapists could make an informed decision about committing to the project.
- Supervision Guidelines for Supervisors document – This document presented a breakdown of the supervision responsibilities of PII Staff, ATS, and agency supervisors given that supervisors were not trained in TARGET[®].

PII staff also sent the SOC supervisor a standardized nomination form to return by a given deadline. Supervisors could nominate up to two therapists from their agency; however, the second candidate was only interviewed if the first was not selected. If two therapists from the same agency were needed, the agency nominated three staff members.

Some agencies, especially those in rural areas of the state, were too small to accommodate staff being used for any activities other than typical services. In this case, a therapist was hired for the direct purpose of serving as a TARGET[®] therapist and was subsequently nominated.

Interview Process

Once the TARGET[®] therapist was nominated, the PII Project Assistant sent the therapist an email with a project summary and a request for an interview. In addition to learning about the therapist, the interview was an opportunity to provide information to the therapist about the project. This included an overview of PII, TARGET[®], and the research study components and a review of the proximal and distal outcomes of the study. The purpose of providing such in-depth information was to ensure that the therapist understood what his or her role would be and the commitment it required.

Staff typically conducted these interviews in pairs in order to discuss the therapist's responses before sharing impressions or concerns with the implementation team. A TARGET[®] Therapist Interview Template (see the Section 3 supporting documents in **Appendix A**) was created to ensure a standardized interview approach. A standard was set for the score a therapist could receive and still be considered for the project; in addition, a low score on any interview section warranted further review with the implementation team. Therapists did not need to demonstrate proficiency in all categories, but a basic level of skill, interest, and openness to learning were important.

It was not uncommon for therapists to have limited knowledge about or exposure to EBPs. Participation in the project was expected to facilitate their understanding of EBPs and to improve clinical skills. While therapists were not required to have prior experience including birth parents and foster parents in services, they had to demonstrate willingness to work towards including the birth parent and foster parent in services.

Most SOC therapists were accustomed to collaboration with the foster parent, but collaboration with the birth parent was not as common. The interview served to ensure that the therapists were open to working with the birth parent. Therapists also needed to understand the importance of collaboration with caseworkers and other service providers. They had to demonstrate familiarity with the child welfare system and an openness and willingness to do the outreach required by the PII Team.

This collaboration was a key to improving outcomes for the youth, family communication, and permanency outcomes, according to the theory of change.

As part of the PII Project, IDCFS completed an Implementation Drivers Assessment, which assesses the implementation supports currently in place from the perspective of various project stakeholders. The goal was to use the results to develop a plan for improving the existing supports. For example, as a result of the assessment, a case scenario was added to the interview process. It provided more information to PII staff, enabling a more accurate view of the therapist's abilities and, hopefully, a better fit between the position and the candidate.

The therapist interview process proved to be accurate in identifying therapists who were not a good fit for the

project. All therapists who moved through the training process but were ultimately not retained had been “red flagged” at some point in the process. Those red flags included a lack of familiarity with in-home services, low interest in learning an EBP or in trauma-informed practice, and no experience or interest in learning to interact with biological parents.

Training

The manualized training developed by ATS guides the therapist training. It includes the administration of satisfaction surveys at the end of the initial training, biweekly coaching calls between ATS and therapists after training, feedback from the videotaped sessions sent from the therapist to ATS, quarterly satisfaction surveys with therapists throughout their first year, and booster training sessions. The purpose of these activities is to ensure that the model was being delivered with fidelity, that TARGET[®] therapists have a means for voicing implementation concerns or barriers while providing services, and that a feedback loop exists for TARGET[®] therapists, developer, and those responsible for the administration of the project to be in close communication.

Training for Delivery

The TARGET[®] training and coaching model provided by ATS is very strong. In the Substance Abuse and Mental Health Services Agency (SAMHSA) registry of evidence-based programs and practices, the training, coaching, and quality assurance completed by the

Throughout the project, ATS was also active in identifying therapists that did not fit well with the project and TARGET[®]. TARGET[®] is an EBP with a set sequence of steps, so it is important that these steps are done in the proper order. Specifically, some therapists showed ongoing struggles with the sequence of implementing TARGET[®]. This difficulty was initially identified in training, and ATS worked with therapists in subsequent coaching sessions to address it. In some cases, however, ATS ultimately had to inform PII Project staff that the therapist was not delivering the TARGET[®] model proficiently despite extensive efforts by ATS to enhance the therapist's skills by providing specific feedback and coaching.

developer received the highest scores possible.⁷ ATS training provided all the elements that are fundamental to successful training of providers in new practices, including the following:

- An initial intensive training (Level One training) followed by an expectation to immediately begin using the new practices
- Follow-up with ongoing coaching and supervision with daily availability for consultation, as needed
- Use of video monitoring with validated fidelity monitoring
- Regular feedback to providers to support and correct practices, as needed, with a defined level of expertise required to be considered an intervention provider
- Follow-up training (boosters) to reinforce use, correct drift from fidelity, and provide more advanced skills

Further Intervention Development for Training

The ATS protocols for training, ongoing supervision, and fidelity monitoring can be adapted. For example, the Illinois PII Project requested that certain elements be emphasized in its training to more closely fit the context in which TARGET[®] was going to be provided. First, we asked that ATS provide a framework explaining how learning TARGET[®] skills can assist in placement stabilization and permanency. This oriented TARGET[®] therapists to the goal of improving permanency outcomes. Furthermore, for clinicians who had not been trained in therapeutic models of working with multiple family members (such as youth, biological parent, and foster parent), training needed to address some of the core practices of family therapy, as identified by the developer. As a practitioner of family therapy and supervisor and trainer of other family therapists for 25 years, Judith Ford and the team of trainers at ATS were well qualified to provide

this overview, and the trainers agreed to incorporate elements of family therapy training into the training and ongoing coaching.

Therapists also had the role of presenting TARGET[®] concepts to the youth's case manager, and possibly the youth's existing therapist if the youth was receiving psychotherapy. Although case managers received an initial introduction to the PII Project and TARGET[®] from PII staff during a training webinar (discussed in detail in the next section), the TARGET[®] therapist needed to collaborate effectively with the existing therapist to ease the transition to and/or add the model. ATS developed this guidance and integrated it into the practice manual used in the provider training.

We also asked the ATS trainers to include a discussion of the role of videotaping as few existing SOC therapists used videotaping as part of their clinical practice. Some clinicians hesitate to tape themselves delivering therapy or have clients who resist being video recorded. ATS had addressed these issues in other locales implementing TARGET[®], and it addressed these issues in training for Illinois. ATS reinforced that the recordings were used to support the therapist's correct use of the model via effective clinical feedback, with each recording erased immediately after it is viewed and rated. This process allows for feedback that could greatly improve a therapist's ability to work with youth and families in general, in addition to teaching the specific evidence-based trauma intervention. Because the tapes were essential to the fidelity monitoring process, the ATS trainers were accustomed to and prepared to discuss this process with any clinicians who had concerns.

The ATS team was very flexible about addressing our concerns and incorporating requests into the training. Although ATS had a core set of skills to transmit, it adapted the training based on the initiative's needs and staff feedback during the assessment phase.

⁷ <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=258>

The main intention of ATS was to teach TARGET® in a way that was most relevant for the therapists. Our interactions with ATS indicated that they were able to address potential concerns and make adaptations as needed so training was effective for our initiative. To provide the processes through which these adaptations can be made, ATS communicated with IDCFS regularly.

Initial Training

The initial, or Level 1, training lasts 4.5 days and provides an overview of the following topics:

- Impact of traumatic stress on the brain, social and emotional development, and ability to regulate affect
- Neurobiology of stress and coping
- Use of the manual to provide TARGET®

As written by ATS, “This workshop will redefine the nature and dynamics of psychological trauma and explain how trauma causes post-traumatic stress by changing the brain and body’s stress response systems.” Trainers use a range of learning techniques, including role plays, dyadic learning, and group discussions, in addition to formal informational sessions. Training techniques provide therapists with detailed scripts for presenting TARGET® concepts and skills seamlessly in therapeutic interactions with clients and with coaching and guided practice to enable them to integrate the therapeutic techniques into their clinical work.

TARGET® training was an additional opportunity to ensure therapist fit with the program. After training, PII staff debriefed with ATS trainers to discuss any potential problems. Topics to consider included therapists already flagged during the interview process, pre- and post-test scores during training, and engagement and level of participation during training.

It may be appropriate to supplement the ATS training on the TARGET® model. In Illinois, for example, PII staff provided an overview of the research study and the implementation and evaluation components. PII staff returned on the last day to review the PII therapist standard operating procedures and to provide training in the database used for TARGET® evaluation. PII staff assembled a PowerPoint and training materials for all therapists and staff. The training materials covered:

- An overview of the Illinois PII Project
- Basic implementation and therapist standard operating procedures
- Training in the data system used (REDCap)
- Protective factors and case studies
- Evaluation principles

These materials formed the basis of ongoing training and supervision in the PII protocol. They provided therapists both a broader understanding of where they fit in the project and a detailed set of instructions on day-to-day responsibilities like data entry.

ATS uses pre- and post-training scores to ensure the appropriate level of information uptake and skill building. This process also serves to provide a starting point for supervision of therapists before a session even takes place. If a particular skill or concept is not completely grasped by a newly trained therapist, it can be reviewed and discussed on group and individual calls.

In the rare case that a therapist was found not to fit with the project, PII staff worked with the agency supervisor to counsel the therapist out of the project. When deciding not to maintain a therapist on the project, the geographical necessity of replacing that therapist was assessed on a case-by-case basis.

Training Webinar

An overview of TARGET® should be delivered to foster care case managers who had a youth on their case-load identified as eligible for the intervention and their

RETAINING AND RELEASING STAFF

ATS was one source of information when deciding to release a therapist from the project. The therapist's fidelity to data entry was also taken into account. Near the end of the project, one therapist, who was regularly well behind in data entry for the project, was released due to concerns about the accuracy of the data being entered. Throughout the process, agency supervisors, PII staff, and ATS were in contact to create and implement a corrective action plan.

supervisors. In Illinois, the training webinar provided an overview of the PII Project and TARGET[®] services before the youth was enrolled. This webinar allows for the use of consistent language and support among all involved with the youth, including caseworkers, supervisors, program staff, and others involved in services for the youth. Webinars generally lasted 40–60 minutes with a full explanation of the study goals, population, intervention, and the case manager's role. By interacting with the case managers in smaller groups, project staff could build a relationship that improved the chances of engagement and cooperation later in implementation.

One strategy for engagement in the webinars is to give continuing education units (CEUs). Because CEUs are required for licensure in most states, it is believed that this strategy improves attendance at the webinars. It is also useful to streamline the process of signing up for the webinar.

To prepare the caseworker for the webinar, staff should send a personalized email with the name of the youth involved in TARGET[®] to the caseworker and supervisor. This, along with monitoring of registration and reminder emails and phone calls, can improve attendance. Caseworkers are given a brief explanation of the project in the invitation email, with the goal of showing them how the youth fits into the study.

Caseworker participation in the webinar is important because it provides baseline knowledge about TARGET[®]. This was also an opportunity for the Illinois PII Project to have caseworkers complete the PII Eligibility Screening Form (detailed in Section 4), a necessary tool to enroll a youth in the project.

If a caseworker is not able to complete a webinar, a brief one-on-one overview via phone can ensure that they have enough information to screen potential clients. If supervisors or administrators miss the webinar, a copy of the PowerPoint presentation and related information can be shared. The ability of supervisors and administrators to understand the project is important in the event that caseworkers are unavailable or unresponsive to requests for assistance from therapists or other project staff at various stages of the study.

Webinars typically required only one trainer, but having a backup was helpful. Because the webinar schedule was very compact, illness or vacation had the potential to delay the project timeline.

Booster Session

After completing the initial training, participation in group consultation and individual coaching with TARGET[®] fidelity monitors is provided to the therapists. After approximately 12 months, therapists can participate in booster sessions that provided TARGET[®] skills integration training. The focus of this training is on fuller understanding and integration of key concepts and practical skills application of the FREEDOM steps (discussed earlier in the introduction).

Participants are given the opportunity to work on structuring TARGET[®] groups and using the FREEDOM steps fluidly to help clients process stressful experiences and build resilience. After this first booster training, all boosters are held and designed based on responses to therapist surveys. One topic of note

TABLE 1: TARGET® TRAININGS CONDUCTED BY ATS

Begin Date	Training Component	Description
Start of Training	Level 1 Introductory TARGET® Training	3 days totaling 24 hours
Ongoing from the completion of Level 1 Training	Consultation calls	1-hour, biweekly calls for a group of approximately 10 therapists
Ongoing from the completion of Level 1 Training	Video fidelity monitoring	Monthly review of therapist tapes providing feedback of random sample of sessions and additional written feedback
12 months after completion of Level 1 Training	Booster Skills Integration Training (booster session)	3 days, totaling 24 hours, of booster training

was addressing secondary trauma and self-care for therapists. Although TARGET® does not require a trauma narrative, knowledge of their clients' trauma experiences was common for most therapists. To support their ongoing self-care, booster trainings offered skills and tips on this topic.

Table 1 provides a summary of the training and coaching of therapists conducted by ATS.

Training Certification Program

To support an organization's capacity to disseminate and sustain the model, ATS offers a trainer certificate program. Becoming a credentialed ATS trainer prepares the trainer to facilitate large and small group TARGET® trainings, act as a consultant to staff who are learning TARGET®, and work within an agency that has a fully executed contract with ATS. The trainers for Illinois were selected based on experience as clinicians and previous training experience. It was also important that the trainers were committed to a long-term relationship with IDCFS and ATS. When the "trainer training" is complete, the trainer is then eligible to train other therapists. The initial 4-day training for Illinois was held in Connecticut and taught the following content:

- Understanding dissemination and implementation of TARGET® as a group or individual modality, as a milieu model, and in home-based settings

- Communicating TARGET® concepts and teaching skills creatively and with fidelity
- Conducting consultation groups, reviewing and rating session tapes, and providing feedback on fidelity
- Documenting implementation activities and outcomes.

Once prospective TARGET® trainers completed the initial training for certification, they are given support, guidance, and feedback on their fidelity to the model as they began training therapists. This period of direct feedback and training in fidelity monitoring in Illinois lasted for approximately 1 year, during which the trainers assisted in initial trainings, reviewed videos, and co-facilitated group and individual calls with therapists. **Table 2** summarizes the TARGET® training for the certification program.

Staff Turnover

Although estimates suggest unusually high rates of turnover within the child welfare system (23- 60 percent) (Cyphers, 2001; Drake & Yadama, 1996), research shows that a number of factors can help improve staff retention, including training in and use of EBPs (Aarons, Fettes, Sommerfield, & Palinkas, 2012; Curry, McCarragher, & Dellman-Jenkins, 2005) and supervisory support and guidance. Because the selection process focused on staff able to commit to long-term

TABLE 2: TARGET TRAINER TRAINING CERTIFICATION PROGRAM

Year	Training Component	Description
Year 1	Initial Training	4 days totaling 32 hours
Year 1	Direct Feedback 1	Review and evaluation of practice tapes with Master Trainer, 3 hours per quarter per trainee in quarters 2, 3, & 4
Year 1	Video/teleconferencing 1	1 hour twice monthly implementation consultation
Year 1	Fidelity Monitoring 1	Expert review by trainer of 12 hours of practice and/or training tapes plus 3 hours written feedback per trainee
Year 2	Second Training	2 days totaling 16 hours
Year 2	Direct Feedback 2	Review and evaluation of practice tapes with Master Trainer, 2 hours per quarter per trainee in quarters 2, 3, & 4
Year 2	Video/ teleconferencing 2	1 hour twice monthly implementation consultation
Year 2	Fidelity monitoring 2	Expert review by trainer of 12 hours of practice and/or training tapes plus 3 hours written feedback per trainee

involvement with the project and an intensive learning process, lower than average staff turnover is expected. It is also anticipated that training in TARGET® will add to work satisfaction, as it helps therapists' personal and professional development, potentially reducing job turnover. However, this was not the experience of the Illinois PII Project as described in the following text box.

Replacement Therapist Training

When a TARGET® therapist leaves the position and needs to be replaced, the same staff selection protocols were used as for the original hiring. ATS provides a condensed version of TARGET® training (3 rather than 5 days). ATS developed this revised training to ensure it provided the same level of skill building as the longer training.

STAFF HIRING AND TURNOVER MITIGATION

A total of 60 therapists were expected to be trained, but later data analysis showed a lower need; thus no more than 28 therapists were active at any point in the study. This reduction in expected population occurred mainly because the population identified had a larger portion of ineligible youth than was expected. A total of 39 therapists were trained, 22 of which left the project. As new therapists were trained beyond the first three cohorts, they were placed in one of the existing cohorts based on the number of therapists in each.

The project ended up with a turnover rate in the range found in previous literature, which was higher than expected. Although it did not affect turnover, the reasons to expect a lower rate were still true. Satisfaction surveys and exit interviews confirmed that therapists had higher job satisfaction, low "burnout", and, in some cases, stayed in their positions longer due to PII and TARGET® before moving on for better professional opportunities. Procedures for mitigating and reacting to staff turnover are addressed below.

Case Transition

When a therapist notifies staff that he or she is leaving the project, an assessment of his or her current case status and geographical options for reassignment to another therapist is conducted. A conference call is held with the outgoing therapist, the therapist taking over the case, and relevant staff to discuss the case transfer(s). In Illinois, a Notification of Enrollment Form is sent to the new therapist, who is put in touch with the caseworker. The outgoing therapist could help significantly by making every attempt possible to introduce the new therapist to the caseworker and the family prior to departure. Data on case transfers was also kept, including to whom the case was transferred and the date of transfer.

Therapist Exit Interview

The knowledge, experience, and insights of outgoing therapists should be valued and used to refine protocols and practices. In Illinois, PII staff made every attempt to conduct an exit interview with all outgoing therapists. Knowledge gained was used to better serve youth and families enrolled in the PII study, as well as families who may receive TARGET[®] services in the future. The interview could be conducted on paper via the Therapist Exit Interview Template (see the Section 3 supporting documents in **Appendix A**) or via phone with the PII Project Assistant.

Results from all exit interviews conducted showed high satisfaction with TARGET[®] and PII. The most common reasons for leaving the agency were better career opportunities and conflicts with the SOC agency unrelated to PII supervision. Some therapists expressed difficulty in balancing their SOC and PII caseloads, but indicated that PII was often a reason for their staying longer than they would have otherwise.

4 CLIENT RECRUITMENT AND SELECTION

Who Will Receive the Intervention

TARGET[®] is meant to be delivered to adolescents (and, in some cases, the adults supporting them) who have experienced single- or multiple-episode and complex trauma. It is important to take into consideration the engagement of youth and multiple caregivers and the use of the model concurrently with youth and biological parents. (More information on engagement practices is included in *Section 5: Operationalized Intervention*.)

Youth and their biological parents are the primary clients in the intervention, but foster parent participation in the youths' sessions is encouraged. Foster parent involvement supports the youths' use of the intervention and provides the primary caregivers with a common vocabulary and shared goals focused on the youths' self-regulation and permanency attainment. In the instance that a youth has a goal of reunification with a legal guardian or adoptive parent, he or she is encouraged to attend TARGET[®]. **Table 3** below describes who received TARGET[®] services in Illinois.

If there is a termination of parental rights (TPR) or if the permanency goal is not reunification, TARGET[®] should not be pursued with the biological parent. If there is not a TPR, and the permanency goal is reunification, the therapist should discuss the involvement of the biological parent with the youth and caseworker to make a joint determination.

The Illinois PII Project found that the decision about whether to include biological parents in the intervention was not always clear. Involvement of biological parents in the TARGET[®] therapy was pursued for

TABLE 3: TARGET® PARTICIPATION AS DETERMINED BY PERMANENCY GOAL

Permanency Goal	Participants
Reunification	Youth and their biological parents are the primary recipients of TARGET®. Foster parents are also included in some sessions and provided the overview so that they can be supportive of the intervention.
Adoption or Guardianship	Youth are the primary recipients, receiving all TARGET® components. Foster parents and other placement resources are also included and provided the overview so that they can be supportive of the intervention whenever possible.
Independence	Youth are the primary recipients, receiving all TARGET® components. Foster parents and other placement resources are also included and provided the overview so that they can be supportive of the intervention whenever possible.

all cases where reunification was a viable option. Assessing the viability of reunification involved consideration of:

- The youth's current permanency goal from the administrative data
- The youth's preference for reunification
- The caseworker's opinion on the viability of reunification

In situations in which the youth and case manager had different assessments of the likelihood of reunification (e.g., the case manager reports that the goal should be changed, but the youth is interested in reunification), services were provided to the biological parent whenever possible. However, if any party believed that engaging the biological parent could be detrimental to the youth or biological parent, services with the biological parent were not pursued.

Ultimately it was decided that unless provided a reason by the caseworker (e.g., an impending court date), the legal permanency goal would inform the inclusion of the biological parent. If there was a return home goal that was not expected to be changed by an upcoming hearing, the parent would be offered the opportunity to participate in TARGET®.

A benefit of TARGET® is that the initial stages of the intervention provide the option to begin the youth and biological parents on separate courses of TARGET® sessions. Once initial skills are learned, conjoint sessions allow the learning and practicing of additional skills together. That option is one way to slowly integrate the biological parent if it is not immediately clear they are appropriate for the intervention.

In cases where the foster parent is involved, he or she received training in the intervention sufficient to serve as a source of reinforcement and support for the youth. The developer indicated that foster parent training at its clinic typically occurred through the foster parent's participation in the youth's TARGET® sessions, so that model was used to train foster parents in Illinois.

As noted above, the reason to include potential permanency resources and foster parents is to provide them with an understanding of the youth's stress responses, how TARGET® skills are used to regulate these responses, and how to support use of TARGET®. The common vocabulary, understanding of the effects of trauma and how the brain works, and knowledge of TARGET® skills assist the caregiver or potential permanency resource in understanding how to best support the youth in his or her home. It is also expected that this knowledge could assist the caregiver in regulating his or her own emotional responses and increase

the caregiver’s capacity to effectively respond to the youth’s emotions and behaviors. **Figure 3** provides a visual representation of participation in the intervention depending on return home goal.

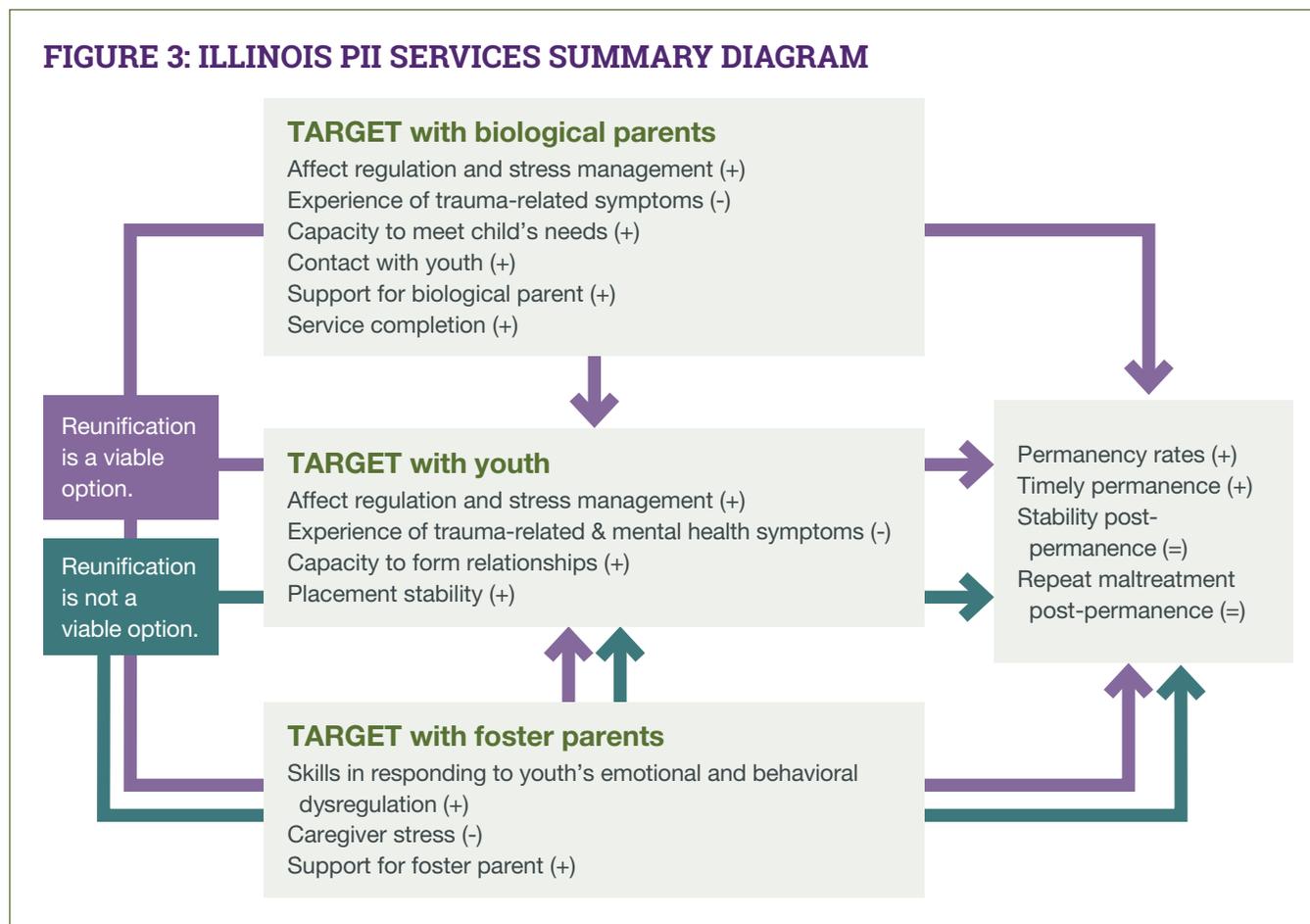
As depicted in **Figure 3**, there are three pathways for the TARGET® intervention. The purple box at the far left highlights the steps that occurred prior to assignment to the intervention group (explained in more detail below). After determination of eligibility, consent, and enrollment, the youth’s caseworker determines if reunification is a viable option. When reunification is viable, a three-pronged service delivery system occurs, with the youth, biological and foster parents involved (depicted by the purple lines). When reunification is not a viable option, or when a youth’s permanency goal changes from reunification to

adoption or guardianship, services are two pronged, with the youth and foster parent involved (depicted by the teal lines). When a biological parent is engaged in TARGET® services, and the permanency goal changes from reunification to adoption or guardianship, the biological parent could continue to receive TARGET® services if they chose to do so, and it was not counter-indicated. In Illinois, this was determined on a case-by-case basis.

Eligibility Screening Process

Youth may be eligible for TARGET® if they meet all initial requirements for age, time in care and moves, or existing mental health symptoms. In Illinois, as part of the rigorous evaluation, a multi-step eligibility process was established to enroll youth and families in the

FIGURE 3: ILLINOIS PII SERVICES SUMMARY DIAGRAM

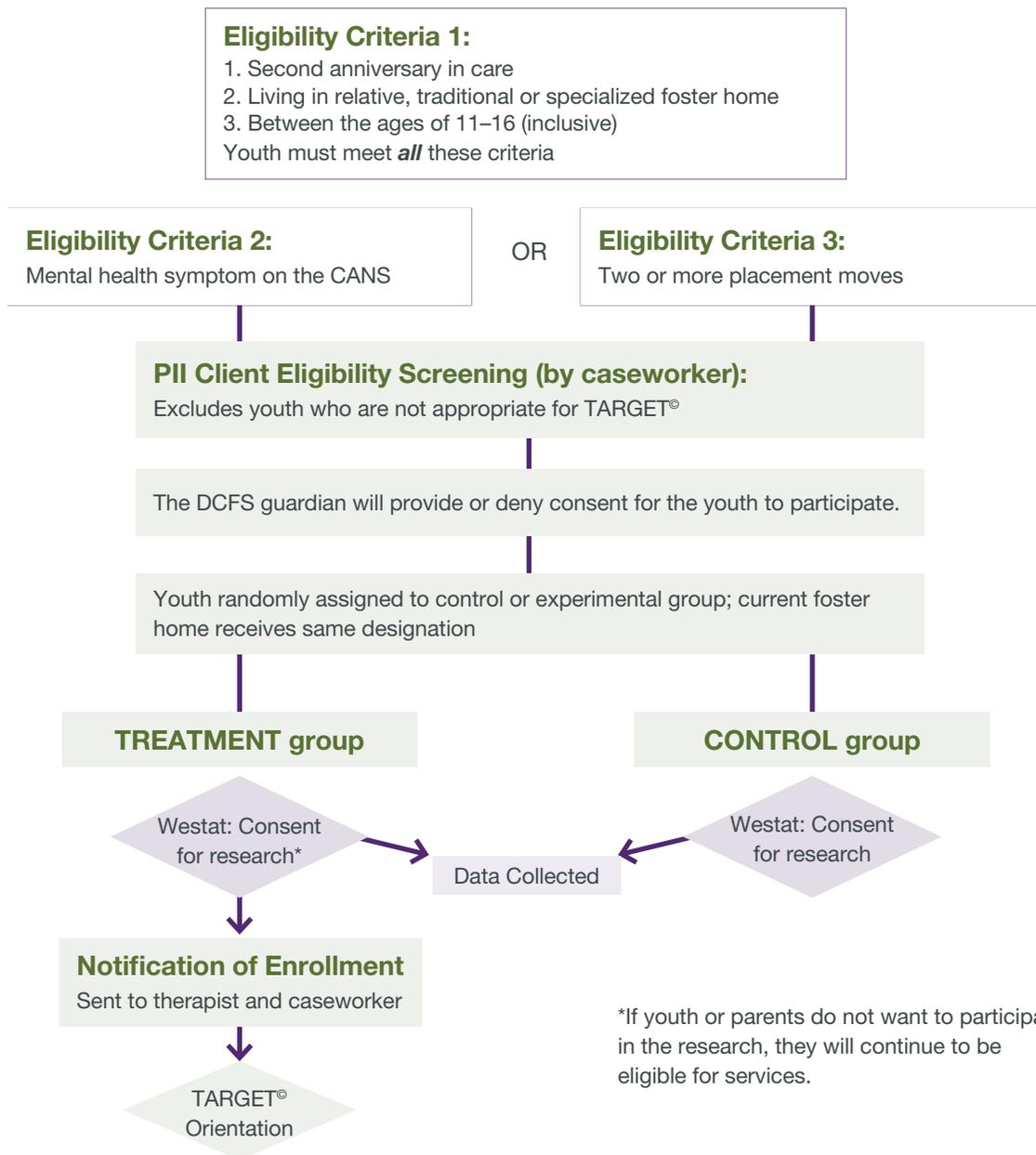


study and to ensure that the youth and family would benefit from the intervention. The purposes of eligibility screening were to not just identify youth who met the age and time-in-care criteria identified by early, data-based investigation, but to identify youth who had a need for the intervention and could potentially benefit (in addition to excluding youth for whom the

intervention could be contra-indicated). **Figure 4** below demonstrates the eligibility screening process.

For all youth who met the age, placement, and time-in-care criteria (Criteria 1), project staff used administrative data to determine if the youth met either the mental health (Criteria 2) or placement move (Criteria 3) criteria.

FIGURE 4: ELIGIBILITY SCREENING



The administrative data included the most recent Child and Adolescent Needs and Strengths (CANS) was used to indicate the presence of one or more mental health symptoms. If the youth had a mental health symptom (defined as an actionable score in trauma-related or mental health symptoms on the CANS), he or she moved to the next eligibility check. If a CANS had not been completed in the last 6 months, PII project staff requested that the case worker complete a new CANS. The state requires CANS be updated every 6 months; any records older than that are deemed too outdated to accurately determine eligibility based on mental health symptoms. The administrative data also included information on placement moves. If the youth has at least two placement changes, he or she proceeded to the second level of screening.

If neither the CANS nor move criteria were met, the youth was ineligible and noted as such in the PII administrative data. If the youth met the eligibility requirements of age and time in care and had experienced one move, the PII Project Assistant requested that his or her CANS be re-scored to further assess eligibility under the CANS criterion. This process was implemented to account for any changes since the data were compiled even when the CANS had been completed within the 6-month timeframe.

ATS uses a number of measures to assess whether TARGET® would be appropriate for a youth. Measures should have the capacity to capture not just behavioral problems, but the underlying trauma and the affective responses to it that create problem behavior. The CANS was already in use in Illinois and had a long history of use, so data were readily available.

Eligibility Screening With Caseworker

When a youth was determined eligible for the study based on administrative data, the caseworker was contacted for a training webinar to learn more about

the study. After completing the training webinar, foster care caseworkers completed an Eligibility Screening Form for potentially eligible youth. The form was used to exclude youth for whom the intervention could be contra-indicated. It was also useful to gather more case information, such as expected changes to the permanency goal that were not yet official, existing therapists, and comments from the caseworker about the youth's fit for the project.

Screening criteria focus on the causes for the exclusion of youth. Youth are screened for substance abuse and dependence, suicidal ideation (within the last 24 hours), and IQ. The developer of TARGET® indicates that a certain level of functioning is required for youth to understand and thus benefit from the intervention, so a minimum IQ of 70 was established in Illinois. In cases where the caseworker cannot locate the IQ of the youth, the caseworker's opinion can be used to determine if the youth functioned at a high enough developmental level to understand the material.

Some youth had experienced the requisite amount of placement changes, but had no mental health symptoms reported on the CANS. A portion of these youth had a high level of functioning and good self-regulation skills, such that providing TARGET® would offer no significant benefit. This was especially likely in what was termed "policy moves"; those moves made because a more preferable placement was available even if there were no problems in the current placement. It is suspected that though these youth were eligible, they declined participating in the intervention at a higher rate, lowering the overall project engagement rate.

More detailed information about the permanency goal of the youth was collected to inform who would be invited to participate in the study. If a goal of

reunification was indicated, the caseworker also noted if the return home goal was expected to change within the next 6 months. Biological parents were offered an opportunity to participate in TARGET[®] unless their rights had been officially terminated, or there was a safety concern expressed by the caseworker, as noted above. In Illinois, parents also had an opportunity to participate in the research study data-collection process. The caseworker was asked to contact PII staff when the goal officially changed.

Youth in residential treatment centers (RTC) and group homes were excluded in our population due to anticipated implementation barriers that exceed the potential benefits for the relatively small population in RTCs (approximately 20 percent of the population meeting criteria) and group homes (approximately 6 percent). Specifically, the highly developed and structured milieu treatment models characteristic of RTCs complicated the successful integration of the proposed TARGET[®] intervention. The resulting necessity for separate methods and infrastructure to accomplish installation in RTCs had the potential to detract from the capacity to successfully implement with the primary population in foster homes. Similarly, youth in group homes do not have a primary caregiver to include in the intervention. Developing and implementing a process to identify a staff member from each youth's group home could again detract from the capacity to successfully implement the intervention in foster homes. It should be noted that at the point of step-down from an RTC or a group home to a foster home, youth became eligible for the study if they still met eligibility criteria.

Finally, if the youth is receiving therapy, the caseworker indicates who is providing the therapy. The caseworker, current therapist, TARGET[®] therapist, and staff decide together if the provision of TARGET[®] is appropriate for the youth. Youth may participate in addition to their current therapy, long-term therapy could be put on hold while completing the 12 sessions, or TARGET[®] can be delayed in the event current therapy was coming to a close.

Geomapping Youth and Therapists

Case dynamics as the study progressed altered case assignment in key ways. Active caseload (both PII and non-PII cases) and ability level of therapists influenced assignment. Those more experienced with TARGET[®] could be assigned more cases and more complex cases. In Illinois, case assignment was affected by geographical location of therapists. In order to most efficiently and accurately assign cases, PII staff used geomapping (the transformation of addresses to coordinates for mapping) when deciding which therapist would receive each case as it moved through the eligibility and consent process.

After eligible youth were identified and added to the evaluation database, each youth is mapped in ArcGIS. The agency location for each therapist, as well as his or her home zip code, should also be mapped, as discussed in the textbox below. The therapist or agency was identified for assignment based on the location of the youth and, later in the project, by caseload. If siblings lived in separate homes, the nearest therapist to all siblings was identified. An attempt was made to balance the caseload between therapists, especially in areas served by multiple therapists (e.g., the Chicago area, East St. Louis, and Rockford).

If a youth moved prior to case assignment, he or she was remapped, and, if necessary, a new therapist was identified. If a youth moved following case assignment, changes to the therapist assignment were decided on

USE OF GEOMAPPING IN STAFFING AND CASE ASSIGNMENT

Geomapping provided important capacity information to the project staff. Initial estimates of eligible youth proved to be high, and geomapping offered data-driven guidance about how many therapists would be needed and where they should be located.

Every time a youth was identified for possible receipt of TARGET® services, the youth's foster home location was geocoded, and a file was generated. This allowed project staff to see the dispersion of youth across the state for staffing, both in preparation for trainings and during case assignment.

Therapists' home and work locations were also held for mapping. Home addresses were included because many therapists lived far away from their agency addresses and closer to a client than another agency. This meant they were the closest available therapist, despite what the agency addresses suggested.

Because the enrollment process could take up to 3 months, geocoding allowed PII staff to estimate where youth would be assigned well in advance. This was useful for agency supervisory staff and PII staff when planning caseloads.

a case by case basis; decisions depended mainly on how far the youth moved and how many TARGET® sessions had been completed and on a new nearest therapist's caseload.

Time Study

During a 6-month period, a time study was conducted with the goals of determining both the speed at which a case moves through the entire administrative process and opportunities and strategies to decrease

When a child moved, the new foster parent was contacted by the SOC worker or other therapist and introduced to the model. Regardless of whether the biological parent was also participating in TARGET®, the foster parent was included as soon as possible in order to support stress management outside of therapy. In cases where a biological or foster parent was too busy or not interested in talking with the therapist, the youth still received individual TARGET® services.

that total time. Cases were tracked and measured for time between steps from when Eligibility Screening Forms were sent to caseworkers through the successful completion of the TARGET® orientation with assigned families. Main areas that were found to need improvement included:

- Outreach to caseworkers for the return of Eligibility Screening Forms
- Return of signed consent forms from the IDCFS Guardian's Office
- Data collection and associated activities by the federal evaluators

As a result of the findings, more intensive efforts were made to retrieve Eligibility Screening Forms from caseworkers immediately after the webinar. In asking for a 24-hour turnaround, the project was still fresh in the caseworker's mind. To speed the consent process with the Guardian's office, a single contact was established to handle all PII consents. This provided PII staff with a single person to contact and to hold accountable for the movement of consents. Finally, to improve data collection, a series of structured communication

systems between PII staff in Illinois and the federal evaluators were established to speed the recognition of problems at various points in the project.

Further details on TARGET's® evidence of effectiveness in both adolescents and adults can be found in the Section 4 supporting documents in **Appendix B**.

5 OPERATIONALIZED INTERVENTION

Level of Program Development Work and Explanation

TARGET® includes manuals, training materials, and other teaching tools used to engage clients and to assist with both group and individual treatment modalities. The FREEDOM steps, group activities, and other materials are written in simple language that was implementation ready. They provide detailed instruction, scripts, and activities that engaged both youth and adults.

Materials are available for adult and adolescent treatment in both individual and group modalities. In the SAMHSA registry of evidence-based programs and practices, the developer materials are identified as “well organized, clearly written, and comprehensive,” and the training, coaching, and quality assurance received the highest scores possible.

Despite being nearly a direct replication, in Illinois there was still some development work by ATS required prior to implementation to more closely align with the Illinois-specific context in which TARGET® would be delivered. The core skills of this intervention were used in a way similar to other TARGET® interventions, but three areas were identified for further development.

First, the intervention was provided as a home-based intervention in this initiative. The developer was already involved in using TARGET® in clients' homes and identified some areas that needed further specification to further facilitate its in-home use. For example, in a home-based model, family members may be in the middle of a conflict when the therapist arrives. In this case, the therapist could use TARGET® skills to address the situation prior to moving to the session's expected content. The developer adapted

the individual practice manual to create a home-based intervention model that addresses how to adapt training for these types of issues. This manual retains all the core components of the TARGET[®] intervention, so it was not expected to vary in its effectiveness if the components continued to be delivered with fidelity.

The second area of development was youth and parent engagement. The developer incorporated evidence-based engagement guidance into the practice manual. Although empirically based strategies to increase biological parent engagement in child welfare services are not well developed, the added strategies were based on the developer's clinical experience working with foster children and their parents. The developer reviewed literature on evidence-based engagement of biological parents in services to assess the extent that strategies suggested by this literature were included in the TARGET[®] practice manual and training. The revised practice manual and training curriculum were assessed during a pilot phase to determine whether there was a need for other engagement strategies.

Two additional documents were also created to help improve engagement and to help SOC supervisors and therapists understand more about their roles in the project. One document, titled "What is PII? What is TARGET[®]?" was a short explanation of both the PII Project as a whole and the intervention that the therapist could provide to the caseworker or family to increase their knowledge and buy-in of the project. The other was a set of guidelines for SOC supervisors so they were able to supervise the case (including engagement issues) while a TARGET[®] coach worked on the provision of TARGET[®].

The additions to the practice manual and training were consistent with engagement resources found on the Child Welfare Information Gateway, the National Resource Center for Permanency and Family

Connections, and the National Child Traumatic Stress Network websites (see References), as well as empirically based strategies developed to engage urban families in child mental health services. To support initial engagement of parents in the intervention, strategies found to increase attendance in initial and second therapy sessions were also incorporated (McKay & Bannon, 2004).

Kemp et al's framework (2009) for parent engagement in child welfare was also used to help guide the development of additional sections in the practice manual. Key practices that facilitate engagement include:

- Early, responsive, and structured outreach
- Practical help
- Parent empowerment and education
- Supportive relationships with peers, foster parents, and workers
- Collaboration and partnership
- Inclusive, family-centered organizational cultures.

TARGET[®]'s focus on providing practical self-regulation strategies in everyday language and in enhancement of communication between caregivers and youth by giving them a common vocabulary is consistent with these engagement practices.

The third and final area that was further developed involved use of the intervention with youth, foster parents, and biological parents with a goal of improving permanency rates. Specific examples relating to permanency were added to the TARGET[®] manual. Illinois and ATS spent time making more significant modifications to the permanency language, but ultimately decided that adding it to the model conflicted with the theory of change that suggested TARGET[®], in its original form, could affect permanency. This occurred because TARGET's[®] empirical support was for the version without permanency language.

Engaging Families in TARGET[®]

Below are additional strategies for therapists to increase the engagement rate of families in TARGET[®].

Collaboration with Caseworkers

The buy-in of the caseworker is essential for effective TARGET[®] delivery. Therapists contact the caseworker to re-introduce the intervention (see the Section 5 supporting documents in **Appendix C**). Therapists can also provide information about TARGET[®], including the general skills that it provides and why it was important for the youth to participate. Caseworkers are essential to family engagement because they are a familiar and trusted source of information.

The TARGET[®] Orientation

A timeline and protocol for TARGET[®] therapists when contacting caseworkers and families is useful because it provides outreach strategies that decreased the time to first contact and reliance on the staff.

In Illinois, as part of the protocol, a TARGET[®] orientation with the family was scheduled, which included the therapist and caseworker. The meeting would ideally take place within 10 days of receiving the Notification of Enrollment. It was preferred that the caseworker go with the therapist, but if he or she could not commit to a timely visit, the therapist consulted with the caseworker about the possibility of scheduling the visit without him or her.

It was found that therapists had a much better chance of engaging the family in the intervention if the collaboration and unified effort with the caseworker was seen by the family. If the therapists had difficulty setting up appointments or contacting the caseworkers, they were encouraged to contact PII staff for assistance.

At the initial visit, the therapist explains the TARGET[®] intervention to both the family and the caseworker and provides them with a short handout that explains TARGET[®]. The therapist also uses the orientation to set up a weekly meeting time with the family if the family agrees to participate. When the family agrees to participate, the therapist and caseworker set up a monthly phone call to discuss case progress. Before the phone call, a progress report is sent to the caseworker and staff (see the Section 5 supporting documents in **Appendix C**).

In cases with a return home goal, the therapist calls the birth parent to offer TARGET[®] services instead of making a home visit to do so. In Illinois, the rate of engagement for biological parents was lower than that of foster parents. This may be in part because they did not receive a home visit from the therapists to explain the intervention (and study) more fully.

The initial visit with the birth parent and the caseworker should occur at a location that is convenient to the birth parent. It is important that both the caseworker and birth parent understood the goals of TARGET[®]. Each birth parent is offered services in a way that is most helpful to that family. In Illinois, for example, some birth parents had a relationship with the foster parents. If all therapy members (youth, birth parent, and foster parent) were open to starting the therapy together and could agree upon a location, the family could begin to learn about TARGET[®] together. In other cases, the TARGET[®] therapist offered individual services to the birth parent separate from the foster caregiver and child. This decision should be made based on the relevant clinical and case dynamic information available to the therapist and be informed by the family members.

The ultimate goal is to move into conjoint sessions after rapport is established with the separate parties. Once families meet in conjoint sessions and establish the groundwork for using TARGET[®] skills, they are better able to discuss the strengths and opportunities

MEETING WITH THE FAMILIES

To improve both foster and biological parent engagement in the intervention and to minimize barriers related to travel for families, a majority of the meetings occurred either in the foster or biological parents' homes. Initial sessions with youth occurred in the foster home to improve attendance and to facilitate foster parent involvement. When youth met with their biological parents or conjointly with both foster parents and biological parents, the therapists helped the families sort out logistics, such as where services should occur. In addition to either the biological or foster parents' homes, some visits occurred in a community location outside the home or the agency. These logistics were determined on a case-by-case basis and took into consideration geographic and travel barriers.

Adaptations to the training materials focused on providing TARGET® in a home-based setting and addressed some of the complications that could occur when providing services in the home, such as difficulty finding a private space or uninterrupted time. Because SOC providers were accustomed to delivering services in community and home-based settings, this group was a resource to the initiative and was prepared for some of the challenges encountered when doing work directly in the home. As discussed above, the training and materials incorporate strategies for engagement, as well as ways to work with biological and foster parents together in a way that minimizes tension between family members that could undermine engagement.

in the relationship. Regardless of case dynamics, the goal is for the therapist to meet with the birth parent weekly and go through the TARGET® sessions as he or she would with the youth or foster parent.

Progress Reports

Successful caseworker/therapist collaboration is key to the success of carrying out the intervention and of trying to affect permanency outcomes. After the initial meeting at the family's home, the therapist should set a time to follow up with the caseworker. It is strongly encouraged that the therapist and caseworker be in touch during the first few weeks. This allows the caseworker to know how engagement efforts are going. The therapist should call the caseworker and notify appropriate staff if he or she has specific concerns about engagement. Any problem that could have wider application to the project was brought to IST for dissemination to others on the project.

To continue the dialogue, the TARGET® therapists should submit a progress report each month (see the

Section 5 Supporting Documents in **Appendix C**). He or she can also follow up with the caseworker over the phone to discuss the report and to answer questions. Sessions with the birth parent are included on the same report as the youth and foster parent. The use of this progress report by PII staff is detailed in *Section 7: Using Data for Decision Making and Improvement*.

Impact of Video Recording on Engagement

ATS requires video recording. The Illinois PII Project clients had varied responses to the presence of the video camera. No clients during the project declined services due to the presence of the camera, but a number were initially wary. ATS, having required videotaping since the creation of TARGET®, provides training for therapists on how to present the camera and explain its purpose when beginning to engage the family in treatment.

6 COACHING AND FIDELITY ASSESSMENT

As a strict manualized approach, TARGET® requires ongoing coaching and fidelity monitoring to ensure the intervention is delivered with fidelity. Therapists are rated on their fidelity to the content and structure of each session and on their ability to engage clients; those ratings inform the ongoing coaching by ATS. This process begins immediately after training in the form of group and individual coaching calls, as well as the booster trainings.

Monitoring, Consultation, and Supervision

ATS provides biweekly fidelity monitoring, supervision, and feedback to the therapists after the initial training. Clinicians record all sessions and upload them onto a secure website for the developer on a monthly basis. The videos are reviewed for fidelity to the model and used for coaching in individual and group conference calls. Clinicians also receive written feedback on a monthly basis in the form of fidelity reports. ATS is typically available to therapists when more immediate consultation is needed. Throughout the implementation of TARGET® in Illinois, ATS proved very responsive to emails and phone calls.

Video Recording

Secure transmission of digital recordings of TARGET® sessions is required to coach therapists and to ensure that they provide the intervention with a high degree of fidelity. Each therapist has a digital recorder for the exclusive use of recording sessions. Therapists tape every session and upload their videos to ATS secure website. Technological support on how to record and upload the videos is provided by ATS. Recordings

are made by the therapist, immediately transmitted through an encrypted process to ATS, and rated by ATS. The therapists are asked to wait to delete the video until they receive a confirmation email from ATS, usually within 24 hours. The ratings and narrative written feedback are sent to the therapist and to a contact on the implementation team to ensure the continued monitoring of therapists.

Fidelity Monitoring

In Illinois, ATS randomly selected therapist videos to score and provided numerical ratings and written feedback to the therapists. ATS aimed to provide a fidelity monitoring report within 2 weeks of submission, but was often able to complete the review much more quickly. ATS also followed up with a monthly individual consultation call, in addition to the biweekly group supervision (both detailed below). The therapist's supervisor at the agency received a quarterly summary of the therapist's fidelity reports for supervisory purposes.

Each therapist with an active case received feedback on a minimum of one video per month in which he or she submitted a video. If a therapist did not have a case assigned, individual fidelity calls still took place, focusing on practicing TARGET® skills rather than on fidelity from video submissions.

Addressing Problem Indicators: When ATS identified a more serious competency problem (e.g., boundary violation, critical attitude toward client, failure to acknowledge potential trauma disclosure) while reviewing a session tape, it contacted the PII team. The team determined what feedback had been shared with the therapist and identified a plan for follow-up with the therapist based on steps already taken. The PII team was also responsible for informing the therapist's supervisor of concerns and next steps. ATS assumed primary responsibility in reviewing the video and areas of concern with the therapist and provided detailed coaching and feedback on the areas needing improvement.

Consultation Calls With ATS: TARGET® therapists met biweekly for 1 hour with ATS in their cohort to check in about case progress, receive support, and obtain ATS protocols for the project. The group call provided the trainer with the opportunity to help resolve challenges and to teach specific TARGET® concepts or activities that may not have been fully understood in the initial training. Issues identified via video-fidelity review and those brought up by therapists themselves were topics on the call. The group, especially later in the project when it contained both experienced and inexperienced therapists, offered a collaborative learning environment for everything from client engagement to ideas for celebrating clients graduating from the intervention.

These calls were mandatory. If therapists were not able to attend, they notified ATS in advance. Therapists unable to attend their cohort's consultation call were able to join a different cohort's call, provided that the therapists communicated their absence and scheduled the makeup with ATS. If there were any days that a consultation call did not take place as normally scheduled, e.g., a holiday, ATS was responsible for offering a make-up consultation call at the end of the month.

Guidelines for Supervisors: Supervisors with TARGET®-trained staff were encouraged to talk with their staff about the clients that they were working with. Because of the ongoing study, TARGET® therapists were not to share TARGET®-specific skills or training materials with their supervisor. They could talk about engagement, mental health diagnoses, or anything else about the family. In accordance with the evaluation portion of the PII Project, the SOC supervisors were intentionally not trained in the TARGET® intervention.

7 USING DATA FOR DECISION MAKING AND IMPROVEMENT

Decision Support Data Systems

A decision support data system (DSDS) ensures data are used when questions around implementation or outcomes are being answered. To provide the ongoing feedback required for adequate implementation in the Illinois PII Project, a DSDS was developed and used throughout the project. These processes were refined in the initial stage of the initiative, and a comprehensive plan was developed to address the need for decision support in the summative stage. ATS provided direction for some of the processes, while others were established and directed by IDCFS. The systems included the following:

- Submission of session information to ATS and feedback from ATS: This was one of the main data sources for decision making. Written and verbal feedback were provided for each therapist on a continuing basis in the form of fidelity reports and consultation calls. Feedback was also made available to project staff, especially when therapists were struggling. This information was used, as previously noted, for staffing and case assignment decisions.
- Ongoing data collection: Throughout the project, staffing needs and trainings should be tracked. These data can be used to assess client progress and the outcomes of individual therapists and agencies. Data on staffing, client eligibility, engagement, and outcomes are also tracked both for ongoing implementation and evaluation.

ATS provides summary information on its work with the TARGET[®] therapists, including regular reports on fidelity levels for groups and individuals and on issues that needed to be addressed. In the Illinois PII Project, the Evaluation Liaison, the IST, and the Implementation Workgroup regularly monitored fidelity and outcomes related to the initiative via the Evaluation Liaison. PII staff shared these results with the TARGET[®] therapists to improve delivery and evaluation processes.

Therapist fidelity ratings from ATS were an excellent source of information about performance for individual providers, ATS, and the implementation team. Ratings included a quantitative measure assessing fidelity to the model, with a rating of 80 percent or higher considered adequate. A qualitative assessment, including client and therapist engagement and degree of empathy expressed by the therapist, was also provided. ATS' ratings were shared with the Project Director, who facilitated ongoing monitoring of fidelity performance in conjunction with the Evaluation Liaison and Implementation Workgroup. Though ATS completed most coaching and thus used the fidelity scores most directly, PII leadership used the scores when a pattern of poor scores necessitated the release of a therapist from the project.

Therapist Assessments

To assess each TARGET[®] therapist through client outcomes, ATS provides training and requires ongoing use of client outcome measures (the Abbreviated Dysregulation Inventory [ADI] and CANS). In Illinois, all TARGET[®] therapists were already trained in use of the CANS. ATS provided training in use of the ADI so therapists and the project were able to use both measures to assess client change. At the 6-week point, the therapist re-administered the ADI to assess progress and to plan for the areas to be addressed in the remaining sessions. At 12 weeks, the measures were administered again by the therapist to assess whether areas requiring additional work still remained.

Internal Implementation Tracking Report

Throughout the eligibility screening and implementation processes, data about the client and his or her status in the project (presence of siblings, current therapist, session of TARGET[®], etc.) should be recorded in REDCap. From this information, an ongoing report can be created to share with the Implementation Workgroup, IST, evaluators, TA providers, and other interested parties as a way to easily report project status. Fields addressing ineligibility reasons, case assignment, and youth TARGET[®] involvement can also be made available. This information can be used to identify trends in each of these areas, plan for staffing, and prepare for sustainability.

Therapist Progress Reports

Therapists should submit monthly progress reports with information about how many sessions the youth had completed or missed in the previous month, the therapist's rating of youth and caregiver engagement level, and any notes about concerns or plans moving forward.

Before check-in phone calls with the therapists, the reports should be reviewed and cross-checked with information provided in the evaluation database to ensure all completed TARGET[®] sessions were accurately captured. Any concerns about data accuracy (e.g., missing, incomplete, or inaccurately recorded

One therapist was having trouble meeting with the client due to the amount of people and noise in the house. After a number of attempts to meet in a quieter space of the home, PII staff suggested meeting either in the library or at the client's school. Though the intervention for PII was to be delivered in the home, because the foster parent was not participating, it was decided that an effective therapeutic environment was more important than being in the home.

sessions) should be addressed during the call. PII staff also noted engagement problems or other concerns and discussed them with the therapist on the group call.

Regular Reports From the Evaluation Liaison

The evaluation database was used to collect a number of process measures and outputs. The Evaluation Liaison provided updates to the Implementation Workgroup on an ongoing basis about outputs such as:

- Number of therapists using TARGET®
- Number of children or parents receiving TARGET® services
- Sessions per family
- Engagement rate
- Evaluation interview completion rate

The data were used to identify geographic areas, agencies, or individuals who may have needed more support in implementing TARGET®. As noted above, case decisions could vary according to a number of different factors. The IST used the information from the Evaluation Liaison to inform those decisions. The clinical expertise of a number of workgroup members was also informed by the information when making decisions about case transfers and progress.

Data Entry

Data entry throughout the project should be completed by both the therapists and project staff. It should be monitored, and corrective action must be taken when needed to ensure that therapists complete all necessary data entry. Throughout the Illinois PII Project, delays in entering data about client sessions were common. A standard protocol for contacting the therapist, supervisor, and SOC Administrator would have assisted in improving data entry fidelity and timeliness.

REDCap: The REDCap (Research Electronic Data Capture) web-based application was used to store information on the eligibility, contact information, and services received by PII participants, as well as their caregivers and any involved birth parents. The PII REDCap database stored information on the therapists involved in PII, their training, and all of their PII-related activities. In addition, the PII Research Assistant used REDCap to generate reports for other PII Project Staff and the federal evaluators. Two groups of individuals entered information into PII's REDCap database, PII project staff (Research and Project Assistants) and TARGET® therapists.

For all cases, initial placement and contact information for all TARGET® youth, caregivers, and birth parents should be entered into the system based on administrative data. All fields gathered throughout the eligibility screening process (webinar training dates, screening form sent and received, guardian consent, etc.) and updated contact information based on new information from caseworkers and placement moves were also entered. It was also the responsibility of project staff to document all instances in which a safety issue is identified for the youth, birth parent, or caregiver and the steps taken to address the safety issue.

TARGET® therapists are responsible for documenting their PII-related activities and TARGET® supervision in the project database. These Included TARGET®-related activities completed for each individual case, such as:

- Initial contacts with the caseworker, youth, and family
- TARGET® orientation activities
- TARGET® therapy sessions

- Case collaboration activities (Clinical Intervention for Placement Preservation [CIPP] meetings, child & family team meetings, Administrative Case Reviews [ACRs], court activities, Individualized Education Program meetings, and case staffings)
- Case consultation with ATS
- All documentation (paper or REDCap)

For all activities, therapists should record the date the activity took place and the amount of time the activity took in minutes. For TARGET[®] orientations and therapy sessions, therapists should also document attendees and where the activity took place. (See the Section 7 supporting documents in **Appendix D.**)

Other Sources of Quality Assurance and Support

Numerous other sources of quality assurance and support for PII staff exist, as described below.

Table 4 summarizes the activity, involved parties, timeframes, and resulting data or other output for the decision-making tools specific to the therapists and clients.

Administrative Support for Therapists

As an additional tool for successful TARGET[®] implementation, the therapists used administrative support. There is a protocol for working with case-workers and therapists, but there were frequently items that require administrative staff to reach out and “advocate” for the therapist. In the Illinois PII Project, staff also provided quarterly updates to supervisors who were available for typical supervisory practice outside of the provision of TARGET[®].

Check-In Calls With Staff

TARGET[®] therapists were required to participate in check-in calls, which should begin weekly after the TARGET[®] training and gradually shift to biweekly and then monthly as therapists become more familiar with the protocols.

Check-in calls consist of information on protocols and processes, data entry, case assignment projections, and updates from each therapist on the progress of the cases. Topics also include foster parent and birth parent engagement, caseworker collaboration, and administrative requirements. This is a time for therapists to seek feedback on handling case situations and to ask for support staff when needed. In Illinois, the frequency of check-in calls decreased after a discussion between PII staff and therapists about their level of competency and need for ongoing support. (See the Section 7 supporting document in **Appendix D.**)

Quarterly PII Reports

In the Illinois PII Project, therapists and their supervisors were provided with quarterly reports from the PII staff on the same schedule as the ATS quarterly reports. These covered the therapists’ attendance at the check-in calls with PII staff, their adherence to data entry and protocols, and their case assignment and status. The reports were followed up by a call between the therapists’ supervisors, ATS, and PII staff. These reports and calls served as a way to keep the supervisors informed of their employees’ participation in PII without needing to know all information related to TARGET[®].

Communication and coordination with therapists and supervisors when new youth entered the intervention were necessary. Prospective tracking of clients allowed the SOC supervisors to plan caseloads effectively, to ensure both adequate therapeutic capacity and that control group youth were not assigned to TARGET[®]-trained SOC therapists. The goal was to have enough therapists trained in TARGET[®] so that as youth enter the sample, they could begin receiving services in a timely manner. There was minimal wait time based on caseload and only in the urban areas.

Therapist Satisfaction Surveys

PII staff administered satisfaction surveys to the therapists, which were required and created by ATS. Surveys covered ATS' consultation and training; the de-identified results were then submitted to ATS. Questions included the therapists' perspective of knowledge uptake by clients and their experience implementing TARGET[®] with ATS' supervision. Results identified trends in implementation and coaching so that ATS could improve the ongoing coaching and fidelity in the project. (See the Section 7 supporting document in **Appendix D.**)

Feedback From Participants

As part of its manualized training and feedback system, ATS has protocols to administer satisfaction surveys for TARGET[®] participants. In the Illinois PII Project, this included satisfaction surveys for youth and their biological and foster parents, which were

administered at the completion the intervention. (See Section 7 supporting documents in **Appendix D.**)

At the final TARGET[®] session, therapists gave their clients the Client Satisfaction Survey. The survey was filled out individually by each youth, foster parent, and birth parent that "graduates". The therapist lets the clients know that they did not have to put their names or the therapist's name on the survey. The therapists also instructed the clients to place the completed form into an addressed envelope that the client sealed. This protocol ensured that there was not any pressure felt by the client, as the therapist would not see the satisfaction scores. After the session, the therapist mailed the envelope for the client. Having the therapist mail the survey was found to increase response rates. The project staff received and processed the satisfaction surveys and entered their receipt into an evaluation database.

The project would have benefited from the inclusion of an "exit survey" for youth and caregivers that started but did not complete all TARGET[®] sessions. Such a survey would identify for evaluation purposes if there was a particular characteristic of youth or caregivers that made them less likely to participate. It would have enabled PII staff and TARGET[®] coaches to identify patterns and to coach and assist therapists more effectively, individually and collectively.

TABLE 4: CONTINUOUS QUALITY ASSURANCE

Quality of Training, Coaching, and Monitoring of Fidelity

Activities	Responsible Parties	Timeframes	Output
Satisfaction survey for therapist-training	ATS, therapist	End of training	Summary report to evaluators and the Implementation Workgroup
Biweekly calls	ATS, therapist	For 1 year after initial training	Summary report to evaluators and the Implementation Workgroup
Feedback from videotaped sessions	ATS	For 1 year after initial training	Summary report to evaluators and the Implementation Workgroup
Satisfaction survey for therapists-coaching	ATS, therapist	Quarterly	Summary report to evaluators and the Implementation Workgroup
Booster training	ATS	1 year after initial training	Summary report to evaluators and the Implementation Workgroup

Feedback From Participants

Activities	Responsible Parties	Timeframes	Output
Satisfaction survey for biological parents	ATS	Every 6 sessions	Summary report to evaluators and the Implementation Workgroup
Satisfaction survey for foster parents	ATS	Every 6 sessions	Summary report to evaluators and the Implementation Workgroup
Satisfaction survey for youth	ATS	Every 6 sessions	Summary report to evaluators and the Implementation Workgroup

8 USABILITY TESTING

Background

Before full implementation, a “rapid-cycle improvement process” can be used to test key implementation and evaluation processes. This process, known as usability testing, uses a small population to observe movement through the project and alter implementation as issues arise. The aim is to discover unforeseen problems before a large population makes the project less “agile” in making changes. Evaluation is also considered during usability, and the evaluation plan can change to reflect items discovered during testing.

Illinois developed a specific and detailed plan for usability testing. Testing was completed with 42 cases at 8 SOC agencies during a 3-month period. Ultimately, 8 control cases and 14 treatment cases were assigned. Two to three therapists were selected from each of the four IDCFS administrative regions to ensure a broad cross-section of geographic representation. Each therapist served one to two clients during usability testing.

Usability testing was organized around key components of the intervention, implementation supports, and data collection. The primary objectives for usability testing were to stabilize the intervention and to resolve systemic problems with implementation.

Staffing, including the availability of qualified therapists across the state and the management of caseload size, were important aspects of usability testing. Case movement through the eligibility and consent process was also of particular interest, as were the engagement rates of youth and caregivers. Usability testing provided information that continued to influence implementation through the conclusion of the study.

Major Findings of Usability Testing in the Illinois PII Project

The most important finding of the usability phase was a reduction in hiring expectations. Initial estimates of the number of therapists necessary to carry out the study were higher than needed. The overestimate was in part because a higher proportion of youth was found ineligible than expected. The highest number of active therapists at any point in time was 28, less than half of the 60 expected. Related to staffing needs, workload management showed therapists were able to handle the balancing of caseloads between the PII Project and SOC. Moving forward, PII administrative staff initiated conversations with therapist supervisors if it was indicated that SOC caseloads became too heavy to successfully deliver TARGET®.

Another change from usability testing was more detailed definitions for the eligibility criteria. Age requirements, legal status, methodology to count placement moves, and use of the CANS data were all refined so that the data pulls used to identify possible youth could be more accurate and comprehensive. This led to the use of a wait list to ensure all information was up to date and accurate.

Surveys completed by therapists at the end of the usability testing phase indicated that the initial training and ongoing support for TARGET® and the Illinois PII Project were helpful. There were mixed, though generally positive, results regarding engagement and case progression. PII staff responded by creating materials to share with families and caseworkers that offered more information about TARGET® and the PII Project.

9 SUSTAINABILITY

SOC Program

While the path to sustaining TARGET[®] within any organization will vary, there are a few key factors that are broadly applicable. Illinois was supported early on by (1) creating a strong implementation infrastructure, (2) creating or sustaining all needed data support systems, and (3) ensuring that mechanisms for fiscal support were established during the initiative. The following describes the approach to successfully sustaining TARGET[®] in Illinois.

Long-term integration of the intervention was led by the SOC program. With the inclusion of TARGET[®] and the adolescent population it is meant for, the SOC program added a group it had not traditionally engaged (traditionally, 70 percent of youth in the program were under the age of 11). As a placement stabilization program, SOC saw fewer older youth because they were being moved to higher levels of care instead of referred for placement stabilization. Due to the change in population and services, as well as an attempt to meet nationwide definitions of “systems of care”, the SOC program was renamed Intensive Placement Stabilization (IPS) services.

SOC/IPS was an ideal program to provide TARGET[®] after the project ended for many of the same reasons it was chosen for the Illinois PII Project. It had centralized leadership and experience with the model. It also provided an ideal design for infrastructure development needed to support TARGET[®]'s use after the initiative. All materials developed for the PII Project to select staff, provide information to agencies and providers, coordinate services, and implement the intervention also directed the creation of materials, processes, and infrastructure for SOC/IPS.

TARGET[®] Trainer Sustainability

Training of TARGET[®] trainers occurred during the course of the initiative to decrease cost long term. Implementation was a significant investment due to the intensity and quality of the services, so preparing a group of experienced IDCFS trainers to in turn train therapists, monitor fidelity, and coach was imperative to making the intervention cost effective.

Having access to a group of trainers who are certified to train others in the TARGET[®] model was key to Illinois' ability to integrate the intervention into the SOC/IPS program and will be key to ensuring Illinois will continue to be able to offer TARGET[®] in the future.

Particular care was taken in the selection of trainers in the TARGET[®] model to be sure that those selected could make a long-term commitment to their role. Fortunately, ATS' certification of trainers was a comprehensive process that attended to not only the trainers' fidelity to the model in their own practice, but also to the fidelity of their training to the ATS training model. This was essential, as it ensured that drift from the model does not occur when subsequent generations of TARGET[®] providers are trained.

Long-Term Sustainability and Outcomes Measurement

While the SOC/IPS program was expected to continue as the primary provider and administrator of the TARGET[®] intervention, training of therapists employed through specialized foster care contracts would enhance the saturation of the model throughout the IDCFS system.

Approximately one-third of eligible youth for the PII Project were placed in specialized foster care, so

these therapists represent a clinical resource for a significant proportion of the identified population. These therapists were employed through many of the same agencies as those with IPS programs, but may have different direct supervisors, which could affect their practice orientations. It is expected that TARGET[®] will be well received by these providers, but given the less centralized administration of these services, less is known about how services are currently provided. This strategy will develop as sustainability continues into the future.

The cost of TARGET[®] and its relationship to specialized foster care was important to justifying its sustainability. By engaging with youth in specialized foster care, it has the potential to prevent youth from going to higher levels of care (“stepping up”) and may increase the chance of them dropping to lower levels of care (“stepping down”). The cost of specialized and other high-intensity placements, as compared to traditional and home of relative placements, is substantial enough that even small-scale success in using TARGET[®] to prevent youth from stepping up in placement intensity would have a neutral or positive cost-benefit ratio.

TARGET[®] was also well suited for continued use in Illinois as it is potentially a Medicaid-billable service. Its high level of structure and the plan to implement it using primarily master’s-level providers also support reimbursement through Medicaid. Moving into Medicaid-approved case notes is an ongoing process in Illinois that will be very compatible with the expanded use of TARGET[®].

Building capacity for continued data support systems was also a key to sustained use of the intervention. To provide data support after the evaluation component of the project ended, the capacity to collect data needed for decision support at the therapist and program level was developed. Each TARGET[®] therapist was trained in the use of CANS prior to receiving training, as this was required by IDCFS. This capacity, as well as the use of a trauma-focused measure, such as the ADI, was integrated into the assessment and intervention process that each therapist was trained to use. In addition, all staff performance measures that were developed during the course of the project were available. As the administrators for the program were mainly currently employed IDCFS staff, their capacity to integrate TARGET[®] administration into their positions remained after the initiative ended.

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APPENDIX

Appendix A: Section 3 Supporting Documents

Document 1: *THERAPIST INTERVIEW TEMPLATE*

Name: _____ Date: _____

Phone Number: _____ Email: _____

Agency: _____ Interviewer: _____

Thank you for taking the time to complete a brief interview with us! It should take about 15 minutes of your time. As you know, the Permanency Innovations Initiative (PII) is a federally funded project that has the goal of improving permanency for youth at risk of long term foster care. In Illinois, we will be training therapists to do TARGET[®], a trauma affect-regulation therapy. TARGET[®] is an evidence-based practice and requires training and ongoing supervision from the model developers, as well as a fidelity monitoring process, which involves videotaping yourself doing TARGET[®] therapy and getting feedback about your use of the intervention. Youth in the study sample, as well as their parents, will receive TARGET[®]. When a youth has a return home goal, we will engage his or her birth parent in services. Foster parents will be seen as a permanency resource and/or a source of support for using TARGET[®] skills.

You have been nominated by your supervisor as a good candidate for becoming a TARGET[®] therapist. The first training will be held the week of November 18th in Lisle. If you complete the training, fidelity monitoring, and group supervision process, you will become a certified TARGET[®] therapist within a year. This is a 19-month research study. We are looking for therapists who are interested in making a commitment to become a certified TARGET[®] therapist.

The following questions will help us clarify your interest and availability to commit to this intensive learning process and are also an opportunity for you to voice any questions or concerns you may have. First, we have a brief screening questionnaire, and then we'll ask you five follow up questions.

INTERVIEW SCREEN

- 1) Level of Education
 - a) Bachelors
 - b) Masters
 - c) Other. Please Specify _____

- 2) Licensure _____

- 3) Years of Experience in the Field _____

Please select your ability to do each of the following.

4) Attend a 5-day initial training in Lisle, IL. In addition to TARGET [®] , this training will also include an overview of PII, the evaluation plan, data collection in the REDCap system, and documentation of therapy sessions.	YES	NO
5) Deliver TARGET [®] in conjoint sessions with biological parents, foster parents, and youth.	YES	NO
6) Videotape yourself providing TARGET [®] , and submit the video to ATS within two business days.	YES	NO
7) Willing to allow videotaping during training	YES	NO
8) Utilize an online data management system to enter information about therapy sessions and other services provided in conjunction with TARGET [®] . Enter data into REDCap after each session.	YES	NO
9) Participate in a 2-day follow-up training after using TARGET [®] for a year. Location TBD.	YES	NO

6) Tell us about your experience working in conjunction with caseworkers. How important do you think it is to coordinate services with caseworkers? Have you ever had to coordinate services with another therapist on a case? How was that experience?

7) Do you have any questions for us? Do you have any concerns about this commitment?

FINAL SCORING

Candidate Name: _____

1) Was this candidate ruled out based on his or her educational or work experience?

Yes ____ No ____

Below are some criteria to help determine a score for this therapist’s competencies asked about in questions 1-4. Choose the response that most closely resembles this candidate. He or she does need to meet all the criteria in a section in order for you to choose the response.

2) Commitment or Interest in Learning an EBP ____

Score	Explanation
3- Meets or Exceeds Criteria	Regularly uses EBPs or understands their usefulness, or demonstrates high level of interest in learning an EBP.
2- Has some relevant or related experience	Has been trained to use an EBP but no longer uses it; slightly interested in learning and EBP; does not quite understand why an EBP would be helpful.
1- Did not demonstrate ability in this area	Does not appear to be interested in learning an EBP.

3) Ability to work with foster parents ____

Score	Explanation
3- Meets or Exceeds Criteria	Sites examples of effective engagement and treatment with foster parents, or has a good understanding of the challenges that foster parents have to work with.
2- Has some relevant or related experience	Has worked with foster parents, but has had difficulty engaging them; does not have much experience working with foster parents, but is open and interested.
1- Did not demonstrate ability in this area	Seems to have challenges engaging and collaborating with foster parents or does not like working with foster parents.

4) Interest in working with biological parents ____

Score	Explanation
3- Meets or Exceeds Criteria	Has previous experience working with bio parents and feels that he or she has a good ability to engage biological parents, or demonstrates openness and interest in working with biological parents.
2- Has some relevant or related experience	Has previous experience working with bio parents and appears to be hesitant to do so. Seems tenuous about working with bio parents.
1- Did not demonstrate ability in this area	Has never worked with biological parents and/or expresses dislike of or hesitation about working with them.

5) Process of communication with case manager or existing therapist ____

Score	Explanation
3- Meets or Exceeds Criteria	Understands the importance of case coordination and has been able to engage caseworkers and/or therapists with success
2- Has some relevant or related experience	Routinely does case coordination but finds it challenging to maintain contact with the case manager.
1- Did not demonstrate ability in this area	Thinks that case managers do not need to know about TARGET [®] and will not spend time coordinating with the case manager.

6) Additional Comments:

7) Will we contact this therapist about participating in the upcoming training?

Yes ____ No ____

8) If he or she is not able to attend the upcoming training, will we keep him or her in the pool for future trainings?

Yes ____ No ____

Document 2:
THERAPIST EXIT INTERVIEW

Therapist Name: _____ Today's Date: _____
PII Agency: _____ Project End Date: _____

Thank you for taking the time to complete a brief exit interview. We have greatly enjoyed working with you on the PII project and wish you well in all of your future endeavors. The knowledge, experience, and insights you hold are greatly valued and can help us continue to refine our protocols and practices in order to better serve youth and families enrolled in the PII study, as well as future families who may receive TARGET[®] services. Please be honest in your feedback.

EXIT INTERVIEW QUESTIONS

- 1) Tell us about what you liked and what you found challenging about learning and implementing an evidence-based model.

- 2) ATS has a fidelity monitoring and quality assurance process that aims to assess the degree of integrity with which the TARGET[®] model is being implemented and to support staff in their growth as TARGET[®] therapists. Please take a moment to share any thoughts you have about the fidelity monitoring and quality assurance processes:

- 3) As a federal research study, the PII evaluation requires a number of administrative tasks in addition to delivering the treatment intervention. Please take a moment to share any thoughts you have about providing services within the context of the PII research study.

- 4) Effectively implementing an evidence-based model requires the commitment of many stakeholders, including the purveyor of the model (ATS), the agency funding and operating the program (PII/IDCFS), and the agencies that host the trainees (your agency). Please take a moment to provide any feedback (strengths and areas of improvement) you have with regards to each of these entities:
 - a. Advanced Trauma Solutions(ATS):
 - i. Strengths:

 - ii. Areas of improvement:

 - b. PII Administrative Staff
 - i. Strengths:

 - ii. Areas of improvement:

- c. Your Agency:
- i. Strengths:
 - ii. Areas of improvement:
- 5) Please take a moment to provide any feedback (strengths and areas of improvement) you have with regards to collaborating with caseworkers and supervisors.
- i. Strengths:
 - ii. Areas of improvement:
- 6) If you feel comfortable sharing, could you please briefly describe why you are leaving the PII project? Is there anything the PII staff, ATS, or your agency could have done differently that would have affected your decision?
- 7) Did your actual experiences with the PII project and TARGET[®] facilitation match the expectations you had coming into the project? How so?
- 8) Are there any additional comments, insights, or feedback you'd like to share?

May we contact you in the future if opportunities to provide TARGET[®] services in Illinois outside of the research context become available? If so, please provide your personal contact information where we may reach you:

- Email: _____
- Phone Number: _____

Thank you for your time!

Please remember, you cannot use TARGET[®] with any other clients in any other practice in Illinois during the remainder of the study (September 2015). If you would like to use TARGET[®] in practice after September 2015, you will have to contract independently with ATS for fidelity monitoring or work with the IL TARGET[®] Trainers through our sustainability plan. Please feel free to reach out to any PII team member if interested. Thank you!

Appendix B: Section 4 Supporting Documents

Evidence of Effectiveness with Adolescents and Adults

Adolescents

There is evidence to support the use of TARGET[®] with juveniles in detention facilities (Ford & Hawke, 2012) and with delinquent girls diagnosed with full or partial Post Traumatic Stress Disorder (PTSD) (Ford, Steinberg, Hawke, Levine, & Zhang, 2012). These studies support its use to improve emotional self-regulation and trauma-related and mental health symptoms among youth (key proximal outcomes in the Illinois PII Project). Studies conducted in detention facilities provide the most compelling evidence for the potential for TARGET[®] to reduce difficulties with emotional self-regulation and the behavioral consequences of these difficulties. In two evaluation studies, one in Connecticut (Ford & Hawke, 2012) and one in Ohio (Marrow, Knudsen, Olafson, & Becker, 2012), youth who received TARGET[®] had fewer disruptive behaviors requiring seclusion and physical response by facility staff.

Ford and Hawke found that each session of TARGET[®] that a youth received in the first 14 days of detention stay was associated with a reduction in disciplinary incidents and 71.6 fewer minutes of disciplinary seclusion ($p < .001$). Risk of post-detention recidivism was not associated with TARGET[®], suggesting that the short duration of exposure to TARGET[®] was effective in helping youth regulate their emotional responses and subsequent disruptive behaviors while in an environment providing support of their use of TARGET[®], but that these skills may not have been established strongly enough to be sustained in the community. While not identified in the published article, in discussion with Ford and Ford, they reported that over 60 percent of the girls in this study had current or previous child welfare involvement, with some currently placed in foster care.

Marrow, et al. outcomes indicated that youth who received TARGET[®] made less than a fourth of the number of menacing threats than those in units without TARGET[®]; those in units without TARGET[®] also experienced physical restraint five times more frequently. Although this study did not include long term follow up to determine whether TARGET[®] improved outcomes after release from the unit, the benefits of TARGET[®] were observed over at least a six month period while youth were detained.

An additional study examined the effects of TARGET[®] in a randomized controlled study with 59 delinquent girls age 13 to 17 years old who were diagnosed with full or partial PTSD (Ford, et al.,

2012). TARGET[®] was provided in up to 12 sessions, with girls receiving an average of 7 sessions. TARGET[®] was associated with significantly reduced severity of PTSD Criteria B (intrusive re-experiencing symptoms) compared to an enhanced treatment as usual (ETAU) and a relatively greater reduction in overall PTSD symptoms and affect regulation.

These findings indicate that TARGET[®] had more positive outcomes than treatment as usual for several key proximal outcomes of the PII study. TARGET[®] decreased symptom severity and, in locked facilities that provide a milieu-based support for the use of TARGET[®], improved youths' ability to regulate emotional reactions that lead to behavioral incidents requiring intrusive disciplinary actions, such as restraint and seclusion.

Adults

TARGET[®] has also been tested with adults in community settings with low-income, minority mothers of young children, showing a reduction in trauma symptoms and enhanced emotional regulation and positive coping (Ford, Steinberg, & Zhang, 2011) and in outpatient clinics, showing a reduction in PTSD, depression, anxiety, and substance abuse (Frisman et al., 2008).

In a study with a diverse group of low-income, minority mothers (Ford, Steinberg, & Zhang, 2011), a randomized clinical trial compared TARGET[®] with present centered therapy (PCT) and a waitlist (WL) control condition. The mothers all had PTSD and past exposure to victimization, were ages 18- 45, and were the primary caregiver of a child 5years old or younger. Participants were enrolled at health clinics, family service centers, community centers, and residential treatment centers in the Hartford, Connecticut area.

TARGET[®] recipients reported lower levels of trauma memory intrusiveness than PCT or the WL condition. TARGET[®] participants also reported more improvement in trauma-related beliefs about themselves than PCT, and WL was superior in enhancing emotional regulation and positive coping. By the follow up period, TARGET[®] was associated with equivalent and possibly greater sustained reductions in depressive symptoms.

The second study tested TARGET[®] in a randomized trial with adults with co-occurring substance abuse and traumatic stress disorders. Counselors in three outpatient clinics attended a 3-hour course on trauma-sensitive care and a 2-day TARGET[®] training. Participants randomized to TARGET[®] received 8-9

weeks of manualized TARGET[®] treatment in gender specific groups. Participants who were in the usual treatment control group received trauma-sensitive care in the same number of sessions. Results suggested that participants from both groups generally improved on all primary outcomes (post-traumatic stress, anxiety, depression, and substance abuse over 12 months) except self-efficacy. Over time, the TARGET[®] group did not decline with respect to self-efficacy, unlike the trauma-sensitive usual care (TSU) comparison condition, which declined significantly.

There were ethnic and gender differences in response to TARGET[®]. White participants were found to improve more on the Post-Traumatic Cognitions Inventory (PTCI), which measures negative cognitions about self, negative cognitions about the world, and self-blame. Additionally, fewer non-White men reported relapses in TSU than in TARGET[®].

These studies provide support for the potential for TARGET[®] to improve parents' emotional regulation, trauma-related symptoms, and self-efficacy. According to the SAMHSA registry of evidence-based practices, external reviewers who independently evaluated the quality of research in 2007 using 6 criteria (reliability of measures, validity of measures, intervention fidelity, missing data and attrition, potential confounding variables, and appropriateness of analysis) rated TARGET[®] outcomes as follows on a scale from 0-4, with 4 being the highest rating given. The results are in **Table 1** below. TARGET[®] ratings were generally high.

Table 1: SAMHSA Registry of Evidence-Based Practices Rating of TARGET[®] Outcomes

Outcomes	Rating
Severity of PTSD symptoms	3.3
PTSD diagnosis	3.3
Negative beliefs related to PTSD and attitudes toward PTSD symptoms	3.3
Severity of anxiety and depression symptoms	3.3
Self-efficacy related to sobriety	2.8
Emotional regulation	3.3
Health related functioning	3.3

References

- Ford, J., & Hawke, J. (2012). Trauma affect regulation psychoeducation group and milieu intervention outcomes in juvenile detention facilities. *Journal of Aggression, Maltreatment, & Trauma*, 4(21), 365-384.
- Ford, J., Steinberg, K. L., Hawke, J., Levine, J., & Zhang, W. (2012). Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child & Adolescent Psychology*, 41(1), 27-37.
- Ford, J. D., Steinberg, K. L., & Zhang, W. (2011). A randomized clinical trial comparing affect regulation and social problem-solving psychotherapies for mothers with victimization-related PTSD. *Behavior Therapy*, 42(4), 560-578.
- Marrow, M., Knudsen, K., Olafson, E., & Becker, S. (2012). Pilot of a trauma-focused intervention in a juvenile justice setting. *Journal of Child and Adolescent Trauma*, 5.

Appendix C: Section 5 Supporting Documents

Document 1: Protocol for Caseworker and Foster Family Outreach

I. Setting up Initial Phone Call With Caseworker

Once you get the Notification of Enrollment, attempt to contact the caseworker (call and email) within 1 business day.

If no response from the caseworker, try again within 24 hours

If no response by day 2, try again with 24 hours

If after another 24 hours (on day 3) there is still no response from the caseworker, contact the caseworker's supervisor.

If no response from supervisor by day 5, contact PII Staff (Jen or Jane). Jen or Jane will contact the Administrator within 24 hours.

If no response from Administrator within 2 days, Larry or Mark will contact the Executive Director.

Repeat this process if the caseworker does not respond to any other messages.

(10 work days total)

II. Setting Up the Initial Visit With the Family

Once you have the initial phone call with caseworker, ask the caseworker if you can go out to see the family within a week. If the caseworker says he or she will set it up and get back to you, and you have not heard from him or her within 2 days, call the caseworker back and check in on the status. Ideally, we would like the caseworker to do the initial visit with you, so be persistent about trying to set up a time with the family and caseworker.

If the caseworker is not responding or is unavailable for visit after 10 business days, ask the caseworker if you can go out to the home without him or her. If you go without the caseworker, the caseworker must notify the family first that you are coming.

Once you do reach the family, if it says that it does not want to receive TARGET[®] the first time you meet with it, talk about TARGET[®], and give it a week to think about it. If the family says no again, then you're done.

If family does the initial visit and is okay with you setting up TARGET[®] Session #1, set it up as soon as possible. Ask the family if this time could potentially work on a weekly basis.

If you have trouble setting up the initial visit, the family re-schedules Session #1, or is difficult to schedule Session #1 with (cancellation, no shows), let the caseworker know immediately and ask him or her about tips for engaging the family. Continue to call the family 2 times per week; send a letter the second week. Try calling again for another 2 weeks, and then after 30 days send, a letter that you won't call any more unless you hear from the family. (We will provide this letter.)

Document 2:

What is PII?

PII stands for Permanency Innovation Initiative.

PII is a federal grant that Illinois was one of six grantees to win. PII is intended to address barriers to permanency in foster care through a research study. The state of Illinois identified a population of youth experiencing the greatest barriers to permanency and chose an evidence-based practice therapy (TARGET[®]) intended to help the youth, family, and foster caregivers understand the impact of trauma. Illinois' ultimate goal is to improve permanency outcomes for all youth involved in the study.

What is TARGET[®] (Trauma Affect Regulation Guide for Education and Therapy)?

TARGET[®] helps youth and adults to understand and gain control over stress. The goal in TARGET[®] is to help people recognize their personal strengths in order to be highly mindful in making good decisions and building healthy relationships. Throughout TARGET[®], we place a special focus on developing a safe learning environment for you and your family so that you are able to develop an understanding of how stress impacts you while also developing the skills to increase your personal control when feeling stressed.

TARGET[®] explains the difference between “normal stress” and “extreme stress” and “normal stress reactions” and “extreme stress reactions” and how to self-regulate in these situations.

TARGET[®] is a 12 - 20 session program that can span over several weeks. We prefer to work with both the youth, as well as the other adults in the family involved in the youth's life, especially those people who play an important role in the youth's permanency plan.

Our work together is important, and I am really looking forward to working with you over the next few weeks.

**Document 3:
Monthly Progress Report for Caseworkers**

The purpose of the progress report is to detail the strengths and progress of TARGET[®] clients and to increase collaboration between the TARGET[®] therapist and caseworker. Once this report is sent, it should be followed up with a telephone call by the TARGET[®] therapist to discuss client progress so the caseworker and therapist can be mutually supportive to the client and family.

Today's Date: _____ **Period of Report:** _____ **Therapist Name:** _____

1) CLIENT INFORMATION

Youth name: _____ **DOB:** _____ **CYSIS ID:** _____ **Youth Study ID:** _____

2) TARGET[®] THERAPIST INFORMATION

Name: _____

Agency: _____

Phone: _____

3) CASEWORKER INFORMATION

Name: _____

Agency: _____

Phone: _____

4) TARGET[®] THERAPY SESSIONS DATE AND CONTENT

Date: _____ **Session Covered:** _____

Dates of Missed Sessions: _____

5) LEVEL OF ENGAGEMENT

Please rate the family's level of engagement on a scale from 1 to 5, 5 being extremely engaged and 1 meaning not engaged at all. Describe why you chose that response.

Additional notes about birth parent/foster parent collaboration: _____

6) PLANS FOR SERVICES

Any concerns the therapist has at this time about the case: _____

Plans for therapist to address these concerns: _____

Describe other plans for case progress: _____

Appendix D: Section 7 Supporting Documents

Document 1: PII Data Entry on REDCap

- (1) Once you are logged into the site, select the "My Projects" tab at the top of the screen, and click on "PII Outputs and Evaluation."
- (2) On the left-hand side of the screen under "Data Collection," you will see the "Youth Data Entry Form 1" and "Therapist Data Entry Form 1" listed. These are the two data entry screens that you will be using to enter information about your cases. All sections that you will complete have (TARGET[®] Therapist) listed after the section's subheading. You can skip over any section labeled (PII Project Staff).
- (3) The **"Youth Data Entry Form 1"** is where you will log all TARGET[®]-related activities you complete on your case.
 - (a) First, search for your case based on name or CYCIS ID, or select your case ID from the dropdown list of partial responses. Scroll down to the section labeled "Case Participation (TARGET[®] Therapist)."
 - (i) Here, you will enter information about your initial contacts with the caseworker, youth, and family.
 - (ii) If the youth you are working with has already received an evidence-based clinical intervention for trauma, document that information in this section as well.
 - (b) Next, scroll to the "Youth Intervention Information (TARGET[®] Therapist)" section. The first 15 fields are dedicated to "Outreach Activities." Here, log any calls, emails, or letters you send (or voicemails you receive) to youth, parents, caregivers, caseworkers, PII staff, or case collaboration contacts as you schedule TARGET[®] sessions or engage in other case coordination activities.
 - (c) The next 45 fields are dedicated to all other activities involving your TARGET[®] treatment. Here, log information on your TARGET[®] orientation activities, TARGET[®] therapy sessions, case collaboration activities, case consultation (with ATS), and all documentation (paper or REDCap). For all activities, document the date it took place, and the amount of time the activity took in minutes.
 - (i) For TARGET[®] orientations, you will also be logging orientation attendees, as well as where the orientation took place
 - (ii) For TARGET[®] therapy sessions, you will be logging session attendees, where the session took place, as well as the TARGET[®] session content (broken down by week in the TARGET[®] manual). If you find yourself covering more than 1 week's worth of content in a session, select the week that represents the majority of content covered that day.

(iii) For case collaboration activities, log information on any CIPP meetings, Child & Family Team Meetings, ACRs, Court activities, IEP meetings, and Case staffings that you attend.

(d) At the bottom of this screen, log the treatment completion date, as well as ADI dates and scores for your TARGET[®] youth, as these become available.

(4) The “**Therapist Data Entry Form 1**” is where you will enter information about yourself, as well information about your contact with ATS.

(a) Complete all fields in the “Therapist Demographics Information” section about yourself, except for “Therapist ID.”

(b) In the “Session Videotapes” section, you will be logging the dates of when you sent your TARGET[®] therapy videotapes to ATS, when the tapes are destroyed, as well as dates of fidelity and supervision calls with ATS.

Data entry tips for REDCap:

- Dates must be entered in the format of 01/07/2013 or 1/7/2013 in order to be valid.
- Do not navigate away from the REDCap page while you are entering data until you have saved the record! Through some unfortunate REDCap glitch, navigating away from the page (including toggling between different application windows on a Mac) will erase your work. Work is only saved on the screen after you have hit the “save record” button on the bottom of the screen.
- Please do not edit or erase any of the youth, bio parent, or caregiver information already entered by PII Project Staff for your case. If any of the information you see is incorrect, please contact PII Project Staff.

**Document 2:
Therapist Check-In Call Agenda**

Cohort 1 Call

PII Staff Attendance:

Therapist Attendance:

Absent:

Agenda Recap:

- Attendance
- Updates
- Questions
- Case Checks (see questions below)
- Review of Outreach Needed

Questions to Ask for Updates:

What session are you on?

Is the caregiver involved?

If there's a return home goal is the bio parent involved?

How is the communication with the CW, do you need any support from PII staff?

Existing Case Updates:

PII STAFF ACTION

Document 3: Consultation Evaluation Form

Agency Name: _____ Consultant’s Name: _____ Date: _____

5 = Excellent 4 = Above Average 3 = Average 2 = Below Average 1 = Poor

As a result of participating in a consultation group, you are able to:

1	Teach clients how extreme Stress/Trauma affects the brain’s alarm system.	5	4	3	2	1	n/a
2	Teach clients how to use the seven FREEDOM Skills to effectively manage their Extreme Stress Reactions?	5	4	3	2	1	n/a
3	Serve as the facilitator for TARGET family sessions	5	4	3	2	1	n/a
4	Understand how each session should be conducted	5	4	3	2	1	n/a

Please tell us what you think about TARGET:

5	Consultation group has helped me to think about ways to use TARGET in the home	5	4	3	2	1	n/a
6	Consultation group has helped me to use TARGET in a culturally competent and individualized way with clients.	5	4	3	2	1	n/a
7	I would recommend the TARGET program to other agencies.	5	4	3	2	1	n/a
8	The consultation group has been a good source of dialogue with my co-workers and of peer support.	5	4	3	2	1	n/a
9	The TARGET consultant was a good teacher and facilitator (organized, explained things clearly, made group interesting, and informative, helped each member achieve her/his goals).	5	4	3	2	1	n/a
10	Consultation has improved my ability to facilitate TARGET groups/sessions	5	4	3	2	1	n/a
11	I have found the TARGET concepts and materials useful in my groups or case management work with a variety of clients.	5	4	3	2	1	n/a
12	I have found the TARGET skills helpful personally.	5	4	3	2	1	n/a
13	There is enough support from my agency and supervisors to enable me to benefit from working with the TARGET program.	5	4	3	2	1	n/a
14	I would recommend TARGET to my colleagues.	5	4	3	2	1	n/a
15	How many TARGET consultations (both group and individual) have you attended?	1-3	4-9	10-19	20+		

What changes would you suggest for this program? Please describe ...

Thank You

Document 4:
**Instructions for Administering Family
Satisfaction Survey**
Consumer Feedback for TARGET[®]

Purpose: Creating a Collaborative Approach to Family Treatment

In TARGET[®], we seek consumer feedback for several reasons:

- To actively engage families by sending a message that this is a team effort and we value their thoughts and opinions
- To align the treatment more closely with family expectations
- To improve the quality of the treatment and the delivery of services by understanding specifically what works for families and what doesn't
- To identify clinical staff who exceed family expectations

The purpose of the **Family Satisfaction Survey** is also to allow each member of the family who has participated in TARGET[®] the opportunity to make a contribution to the ongoing development of TARGET[®] by providing direct feedback to Advanced Trauma Solutions, Inc. and the Department of Children and Family Services on his or her experience with the model and the assigned TARGET[®] therapist. The survey is given at the end of the last meeting with the family; however, the therapist should encourage informal feedback as part of each session. This is an important part of demonstrating to the family that we respect them and value their insight.

Delivering the survey in the home

First, it is important to inform the members of the family that you will be bringing a survey to the next session. You should tell the participants that the survey is designed to solicit feedback from them about what they have learned and to help gauge their level of satisfaction with the model. Notifying the family ahead of time gives each person the time to think about his or her experience with TARGET[®] ahead of time. If requested, you may provide the members of the family with a survey to look over prior to it being administered at the next session.

It is also important to be sensitive to that fact that some people may not be able to read or write. In these situations, it will be important for you make alternative arrangements to ensure he or she has the same opportunity to provide feedback as the other family members. For these individuals, you may offer to have someone other than yourself call to administer the assessment over the phone. You may also have a family member help by reading the questions aloud and writing each answer as it is dictated. Do what is most comfortable for the client and reinforce how important the feedback is to the program.

Tips for Administration

- Explain the purpose of the survey
- Emphasize that each family member's feedback is important
- Be sure to inform the participants that the surveys are confidential
- Once the surveys are completed, ask the family members to put them in a pre-addressed, stamped envelope that can be mailed directly from their home.
- The surveys will be sent to the PII Staff.

Sample Script

***By this time, you should know if you will need to adjust the process for individuals who do not read or write. Special arrangements should be made before this session to ensure each individual's feedback is received.*

As we discussed last session, I am going to give you a survey today that gives you an opportunity to comment on our work together with TARGET[®].

We do this because my colleagues and I value our work with families and are always striving to understand what we are doing really well and where we need to improve. We also want to know if our work together has given you any more knowledge or skills in understanding and dealing with stress.

The survey should not take too long; however, I want to encourage you to take whatever time you need to answer each question thoughtfully. As you can see, the questions have a 1 to 5 rating scale, 5 being that you *strongly agree* and one being that you *strongly disagree* with the statement.

Be sure to answer each question. I am happy to help you if you have any trouble with a word or if you need clarification about what a particular question is asking. With that said, this is your opportunity to safely and securely provide feedback so I will not be seeing how you score each item or what you write.

When you are finished with the survey, I want you to put it in this envelope and seal it. You can then just drop it in your mailbox so it can be sent to the people who developed TARGET[®].

If you want to make additional comments, please feel free to use the space at the bottom or on the back of the sheet to do so. Your feedback is really important and will help us in our work with future families.

Thank you for your time and for giving us your feedback.

Document 5:
Client Satisfaction Survey

(adapted from the Southeastern Mental Health Authority Group Evaluation Form)

Agency or Program Where You Participated in TARGET[©]:

Participant ID:

TARGET[©] Group Leader, Counselor, or Case Manager:

Today's Date:[©]

How many TARGET[©] Sessions have you attended in all? ___Group Sessions ___Individual Sessions

As a result of what you've learned in TARGET[©], are you able to:		strongly agree → strongly disagree <i>please circle one number for each question</i>				
1.	Understand how stress affects the brain's alarm system?	5	4	3	2	1
2.	Use the seven FREEDOM Skills to manage stress reactions?	5	4	3	2	1
3.	Use the SOS skills to help you focus in stressful situations?	5	4	3	2	1
4.	Use the Stress and Control scales to do a self-check?	5	4	3	2	1
5.	See how experiences in your life fit together with the Lifeline?	5	4	3	2	1

Please tell us what you think about TARGET[©]. Do you think:		strongly agree → strongly disagree <i>please circle one number for each question</i>				
1.	TARGET [©] has helped me to understand stress in a new way.	5	4	3	2	1
2.	TARGET [©] therapists/teachers were organized, explained things clearly, made sessions interesting, and gave me good feedback.	5	4	3	2	1
3.	I learned a lot from the TARGET [©] activities and handouts.	5	4	3	2	1
4.	TARGET [©] provided enough time for me to practice FREEDOM skills with helpful feedback from therapist(s) and [if applicable] group members.	5	4	3	2	1
5.	Using the FREEDOM skills helps me feel better about myself, get along better in my relationships, and achieve my goals.	5	4	3	2	1
6.	The number of TARGET [©] sessions was just right, not too many sessions and not too few sessions.	5	4	3	2	1
7.	Compared to when I began TARGET [©] , I am able to cope a lot better if I feel really upset.	5	4	3	2	1
8.	Compared to when I began TARGET [©] , I am handling stressful life experiences more effectively.	5	4	3	2	1
9.	I am satisfied with TARGET [©] .	5	4	3	2	1
10.	I would recommend TARGET [©] to other people.	5	4	3	2	1

Would you make any changes to TARGET[®]? YES NO

Please describe any changes you think would improve TARGET[®]:

Appendix E: Glossary

Abbreviated Dysregulation Inventory (ADI) – 30-item self-report measure designed to assess 3 aspects of dysregulation (emotional/affective, behavioral, and cognitive) in adolescents

Advanced Trauma Solutions, Inc. (ATS) – Developer of the TARGET[®] model

ArcGIS – A geographic information system (GIS) used to create maps and compile geographic data

Biological Parent – Birth parent or family from which the study youth was removed from by IDCFS

Booster Training – Yearly trainings following the initial TARGET[®] training used to improve skills and to prevent model drift in therapists

Caseworker – Case manager position filled either by IDCFS or contracted employees. The caseworker is the family's main contact for IDCFS and services associated with the child.

Casework Supervisor – Team leader of caseworkers at individual contracted agency or IDCFS office

Child and Adolescent Needs and Strengths (CANS) - An information integration tool that supports service planning and decision making throughout the life of a case

Evaluation Liaison – The primary Illinois PII Project team member responsible for working with the federal evaluation team to develop an evaluation plan before study implementation, make in-study adjustments with evaluation in mind, and carry out the evaluation at the end of data collection

Geomapping – The use of an address or other information to map a location

Illinois Department of Children and Family Services (IDCFS) – The main child welfare system in the State of Illinois, comprising state and private entities that provide services to families in contact with child protective services.

Implementation Drivers (Assessment) – A review completed by members of the PII Project staff to determine the presence of various implementation supports

Implementation Science - The study of methods to promote the integration of research findings and evidence into healthcare policy and practice¹

Permanency – The goal of working with biological parents, relatives, or new adoptive parents, who will permanently bring the youth into their home

Project Assistant – Main PII team member acting as the point of contact for therapists, caseworkers, and families involved in the study

Research Assistant – Responsible for the REDCap database and geomapping of therapists and youth

Research Electronic Data Capture (REDCap) – Internet-based software for designing clinical research databases

¹ Fogarty International Center. (May 2013). *Frequently asked questions about implementation science*. Retrieved from: <http://www.fic.nih.gov/News/Events/implementation-science/Pages/faqs.aspx>

Reunification – Permanency by reuniting with the family from which the youth was removed

System of Care (SOC) – A series of private agencies covering all of Illinois that implemented TARGET[®] during the PII project. SOC is known for flexibility of services that are community-based and family-centered.

TARGET[®] Therapist – Therapist selected from the SOC program for training in TARGET[®]. After training from ATS, therapists deliver the intervention and record all interactions with the youth and family.

Termination of Parental Rights (TPR) – Legal disposition which ends a caregiver’s (usually biological parent) parental rights over a child

Therapist Supervisor – Clinical and administrative supervisor over the TARGET[®] therapist at each SOC agency

Trauma Affect Regulation: Guide for Education and Therapy (TARGET[®]) – A trauma-informed psychoeducation that uses a strength-based approach to education and therapy for youth and biological and foster parents when they have been affected by trauma or experience a high level of stress related to adverse experiences

Usability Testing – The process of testing an intervention (or other operation) with real users to observe and reconcile any problems encountered

Westat – Lead federal evaluators of the PII study in Illinois

Appendix F: Theory of Change

Theory of Change Statement

Our target population consists of youth ages 11-16 who are placed in traditional, relative, and specialized foster homes and group homes throughout the State of Illinois who, upon reaching the 2-year anniversary of entering care, are experiencing mental health symptoms and/or have had at least 1 placement change.

The most salient barriers to permanency identified in this population are (1) emotional-behavioral issues of the target children, frequently related to histories of complex trauma; (2) lack of biological parent engagement and service completion required to achieve reunification; (3) insufficient or ineffective services to address biological parents' underlying issues related to child welfare involvement; and (4) lack of support and training to foster parents to address the needs and behaviors of the children in their care.

The goal of the Illinois Permanency Innovations Initiative (Illinois PII Project) is to increase rates of permanency for the target population. Improved rates of permanency are expected through higher rates of (1) reunification for youth for whom reunification is still being pursued (by providing TARGET[®] to youth, biological parent, guardians, and foster parent or group home staff) or (2) adoption and subsidized guardianship for youth who do not have a goal of return home (by providing TARGET[®] to youth, foster parents, group home staff, and prospective permanency resources).¹

To address the most salient barriers to permanency, our theory of change is premised on the following 11 assumptions:

1. Youth with histories of trauma and/or emotional-behavioral issues have difficulty regulating their emotions and behavior leading to difficulty in forming relationships.
2. TARGET[®] will increase youths' skills in emotional and behavioral regulation and increase their capacity to manage stress and reduce behavior problems.
3. Youth who are better able to regulate their emotions and behavior will have increased ability to form relationships.
4. Greater capacity to form relationships will lead to increased placement stability and greater likelihood of attaining permanency.

¹ Increased rates of adoption and subsidized guardianship are not expected for youth for whom reunification is still being pursued (defined as no termination of parental rights and case manager assessment that reunification is the primary permanency goal). This is because in cases in which reunification is being pursued, it is not realistic for adoptions or subsidized guardianship to occur within a year given the time required to terminate parental rights if it is determined that reunification is unrealistic during the course of the intervention.

5. Foster parents often feel unprepared to care for children with trauma-related and mental health symptoms. TARGET[®] will provide foster parents with a greater understanding of these issues and skills to assist the child in self-regulation of disruptive emotions and behaviors.
6. An increase in foster parents' skills to assist youth with disruptive emotions and behaviors will result in decreased stress and greater placement stability.
7. Increased placement stability will result in increased legal permanency through adoption and subsidized guardianship.
8. Biological parents' histories of trauma often lead to difficulty with emotional and behavioral regulation in biological parents as well.
9. Parents who learn skills to regulate their emotions and behavior will make more progress in completing required services for reunification and in resolving the issues that resulted in child welfare involvement.
10. TARGET[®] will provide biological parents with increased skills in emotional and behavioral regulation allowing them to better address their own needs and parent their children thus resulting in higher rates of reunification.

Proximal outcomes

Our proximal outcomes include the following:

1. An increase in youths' ability to regulate their emotions and behavior and form relationships with caregivers
2. A reduction in youth trauma-related and mental health symptoms
3. An increase in biological parents' abilities to regulate their own emotions and behaviors and a decrease in their trauma-related symptoms
4. Greater parent service completion and contact with the youth
5. An increase in foster parents' skills in responding to children's emotional and behavioral dysregulation
6. Increased placement stability

TARGET[®] is expected to improve placement stability because it will alleviate trauma-related and mental health symptoms in both the youth and their parents, provide a common understanding of the youth's behavior, and provide caregivers with an increased capacity to prevent or respond to disruptive behaviors that might otherwise seem unmanageable. The youth and parents' decrease in symptoms and the caregivers' increased perception of capacity to effectively parent the youth are expected to strengthen the youth-caregiver relationship. While other parenting skills, such as behavior management, would also be likely to improve the caregivers' capacity to parent a child with behavioral-emotional issues, these interventions may be less effective in strengthening relationships for youth with trauma histories. The intent of this intervention is to address the effects of trauma that are likely to be inhibiting strong relationship development and, ultimately, permanency attainment.

Distal outcomes

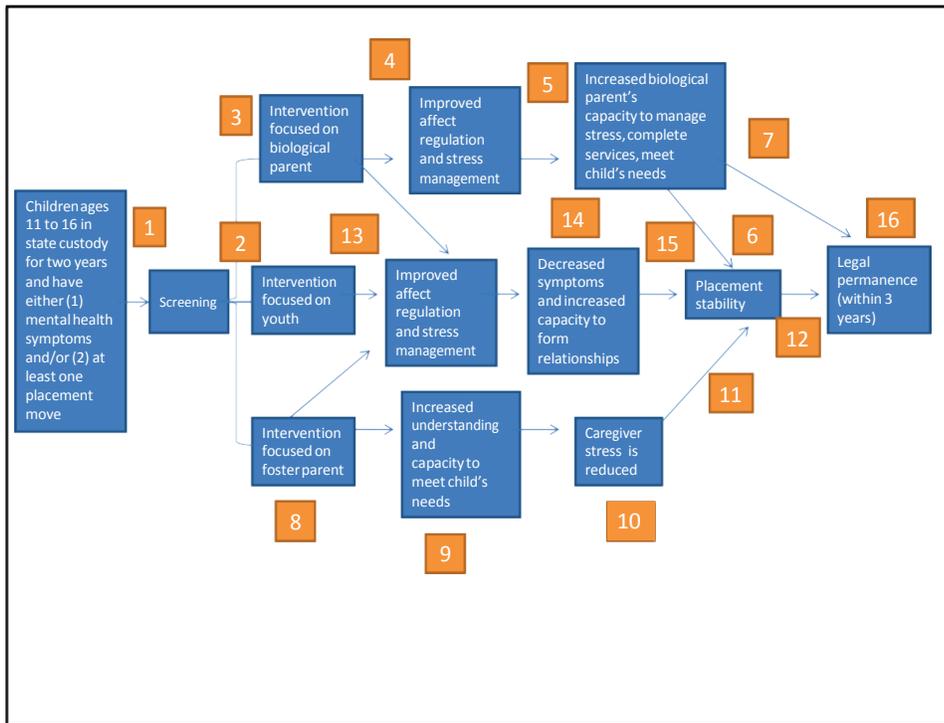
Our primary distal outcome is an increase in permanency rates and timely permanency within 3 years of entry into substitute care through increased reunification, adoption, and subsidized guardianship. We also expect relatively greater placement stability post-permanency and low rates of repeat maltreatment incidents post-permanency.

Permanency is expected to be improved through higher reunification, adoption, and subsidized guardianship rates. Reunification is expected to be increased due to parents' increased abilities to self-regulate, increased completion of mandated services, and increased contact and connection with the youth through the TARGET[®] sessions. Completion of services and increased contact with the youth both indicate increased engagement, corresponding to a reduction of a key barrier to permanency identified in the theory of change. Additionally, the inclusion of both biological and foster parents in these sessions is expected to improve reunification rates by clarifying a commitment to the youth's permanency goal as reunification and increasing foster parents' support of this goal as they see the biological parent working with the youth to learn TARGET[®] skills. Although use of TARGET[®] to improve permanency has not been empirically studied, the developer's experience using TARGET[®] in a family therapy model in its child clinic suggests that biological and foster parent joint participation in TARGET[®] often supported successful reunifications that would not have otherwise been possible (Personal communication with Julian and Judith Ford, April 2012).

Conceptualization of Problem and Intervention Diagram: Underlying Assumptions

The Illinois PII Project seeks to use an evidence-based trauma intervention to address some of the key identified barriers. **Figure 1** is a depiction of our conceptualization of the leading causes of long-term foster care (LTFC) and potential mechanisms through which TARGET[®] will increase legal permanence. Recipients of TARGET[®] include the youth, his or her biological family, and/or his or her foster family.

Youth will often receive TARGET[®] in individual sessions with a therapist, but the preferred model will include engagement of family members in a family therapy model. TARGET[®] will reduce trauma and stress responses and strengthen family connections. An increased capacity to form relationships will increase the likelihood of permanency.

Figure 1: Intervention Conceptualization

1

Children entering care experience high rates of complex trauma and additional stressors. The experience of trauma often results in difficulties with self-regulation. This dysregulation results in trauma-related behavioral or emotional issues. These difficulties are associated with a reduced capacity to form relationships and an increased risk of placement disruption and LTFC.

2

It is hypothesized that children in the target population would benefit from an intervention (TARGET[®]) which teaches them how to regulate their emotions and manage their stress responses. These skills will lead to improvement in behaviors that impede relationship development.

3

In addition, biological parents often have complex issues or histories of trauma that result in difficulty managing their emotions and stress.

4

Receipt of the TARGET[®] intervention will help biological parents address trauma-related issues by increasing their ability to regulate emotions and manage stress.

5

The increased capacity to manage stress and regulate emotions will also help the biological parent make better decisions, complete services, form stronger relationships with their children, and better meet their children's needs.

6

Increased capacity of the biological parents to meet their children's needs leads to increased placement stability.

7

Increased capacity of biological parents to manage stress, complete services, and meet the needs of the children will result in improved reunification rates.

8

If biological parents are not a viable option for reunification, then the intervention will focus on the foster parent pathway with the goal to increase legal permanency through adoption or subsidized guardianship. TARGET[®] will serve as a way to help the foster parent support the youth's FREEDOM skills in the home, as well as teach the foster parent stress management and emotional regulation skills.

9

Foster caregivers will have greater understanding of the children's behavior and increased capacity to respond to the needs of the children in their homes, which will lead to improved relationships and foster child integration into the home.

10

The increased capacity of the foster caregivers to address the children's needs, as well as improved self-regulation skills, will also reduce the foster parents' parental stress.

11

A reduction in caregiver stress will result in a greater willingness on the part of the caregivers to maintain the children in their home, and placements will be more stable.

12

Placement stability will lead to improved rates of adoption or subsidized guardianship with foster caregivers.

13

Improved affect regulation and stress management will help youth cope with the consequences of the challenging and often traumatic situations they have experienced in their lives so they have the skills to form relationships and longstanding ties to a family.

14

A decrease in trauma-related and other mental health symptoms and an increase in caregiver capacity to meet the youth's needs will lead to improved relationships with caregivers.

15

Improved relationships with caregivers will lead to improvements in placement stability.

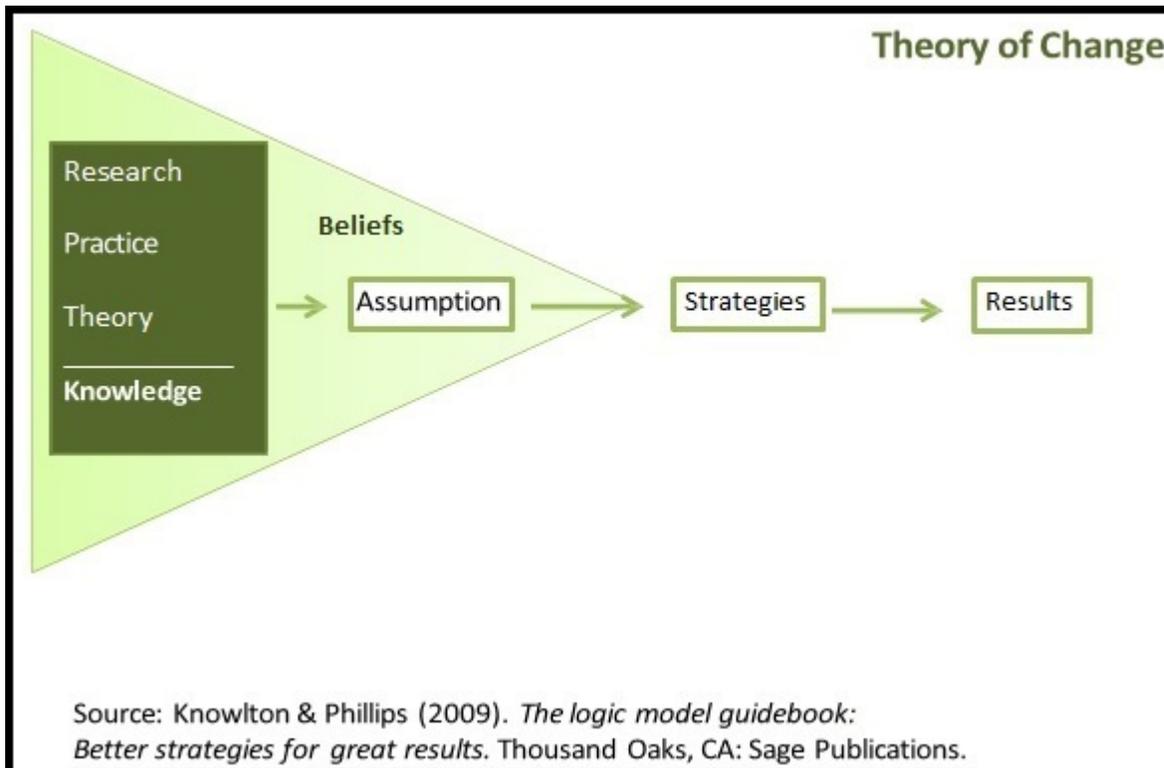
16

Improvements in parental capacity to manage stress, meet the child's needs, and complete services and greater placement stability will lead to improved permanency outcomes.

Developing a Theory of Change

The theory of change of the Illinois PII Project is grounded in the research conducted in Illinois and about Illinois' target population for the grant, those children most at risk of LTFC. The desired long-term, or distal, outcome for this initiative is to decrease the number of children in LTFC by increasing permanency rates and timely permanency (within 3 years of entry into substitute care through reunification, adoption, or guardianship). In addition, we expect to see an increase in placement stability post-permanency and low rates of repeat maltreatment post-permanency.

The theory of change links the distal outcomes to the knowledge, beliefs, and assumptions about effective means to achieve these outcomes. In this document we begin with a summary of the knowledge about this population, based on specific research done regarding the target population for this study, and an additional literature review on barriers to permanency for this population. In this summary, we focus on the barriers to permanencies that have been identified in the research, in practice, and in theory (the knowledge base for these barriers). Next, we identify the assumptions implicit in this knowledge base to understand the assumptions related to the causes of this population's difficulties in achieving permanency. As depicted in **Figure 2**, these are the initial steps needed to move forward to the selection of a strategy to address the identified barriers that will ultimately achieve the intended results.

Figure 2: Theory of Change

Knowledge: What Are the Barriers to Timely Permanency?

In this section, we briefly summarize the results of our analysis and the identified barriers to permanency. These analyses consisted of analysis of administrative data, conducted by researchers within Illinois and by Westat, and qualitative analysis. The qualitative analysis consisted of a review of 29 case files and 4 focus group interviews, 2 with child welfare caseworkers and 2 with supervisors.

Lack of family engagement. A strength identified in the qualitative analysis was that most caseworkers made an effort to identify individuals who had a meaningful relationship with the child. However, many of these people were not actively involved with the child: 24 percent of individuals were actively involved; 55 percent were partially involved; and 23 percent were not currently involved in the child's life.

The qualitative review also suggested a lack of efforts to engage persons close to the child and lack of consideration of these individuals as permanency resources for the child. These individuals included relatives and others (including former foster parents) who had significant relationships with the child. It was noted that engaging fathers was particularly challenging. The focus group respondents suggested that caseworkers need more time to effectively engage fathers. Some barriers to engaging family members in general were identified: lack of a trusting relationship, conflicting loyalty on the foster parents' side if they are interested in adopting the child, and some foster parents who believe the biological parents may be "too far gone" by the time they become involved with the Illinois

Department of Children and Family Services (IDCFS). The focus group respondents acknowledged that much of the work that needs to happen for a case to attain permanence revolves around the foster parent – biological parent interaction. When foster parents have a negative view of the biological parent, this potentially interferes with permanency attainment. The focus groups suggest, and case file records support, the lack of time available for caseworkers to engage in such activities for children and youth while in state custody.

Addressing the lack of family engagement is important due to the potential for family members to provide permanent placements and also because relationships with caring adults are essential to healthy adolescent development (Avery, 2010; Frey, Ruchkin, Martin, & Schwab-Stone, 2009). Foster care alumni report that enduring relationships are essential to the development of supportive relationships, and research supports that these enduring connections are linked to positive outcomes in adulthood (Samuels & Pryce, 2008). Some researchers refer to these connections as a form of social capital, the set of connections and support systems that adults employ to increase a child or youth's ability to be successful in life (Coleman, 1990).

Findings from the Illinois qualitative review are consistent with research that suggests that most caseworkers have difficulty engaging persons close to the child as permanency sources. Also, training lacks emphasis on nurturing biological family ties while youth are in care. Efforts to support family connections in youth, such as those made by the National Institute for Permanency and Family Connectedness, demonstrate that when staff is trained and supported to connect children with families, children's permanency outcomes improve. Findings from an evaluation of the California Permanency for Youth Project showed that 74 percent of children age 11 and above (n=293) who received these enhanced permanency services in 2006 achieved permanency by 2008 and that children had better sibling connectedness. Additionally, even when children did not achieve permanency, they were more connected to biological family members (Stuart Foundation, 2008). Unfortunately this study did not report findings from a comparison group.

Father involvement in a child's life has clear benefits, including improved cognitive ability, educational achievement, psychological well-being, social confidence, and financial stability. Smithgall et al. (2009) found that children were more likely to be reunified when both parents were interviewed as part of the integrated assessment than when only one or neither parent was interviewed. The presence of a father can also be protective against maltreatment (Rosenberg & Wilcox, 2006; Dubowitz et al., 2001). However, research suggests that father involvement in child welfare services is significantly lower than mothers' and that caseworkers tend to make greater effort to work with mothers than with fathers (Franck, 2001; O'Donnell, 1999). One qualitative study with caseworkers (O'Donnell, Johnson, D'Aunno, & Thornton, 2005) suggested that some caseworkers held negative beliefs or stereotypes about fathers and that there was a need for professional development of staff on understanding issues related to fathers and how best to engage them. Malm, Murray, and Green (2006) found that caseworkers that were trained in father involvement were more likely than workers without training to report having located fathers of children in the sample. Furthermore, authors recommended that paternal searches occur at the start of the case

and that workers receive support and training to identify, locate, involve, and engage fathers in the case.

Family members' participation in family group decision making (FGDM) or family team meetings when a child comes into care can also improve child permanency. One study of families who participated in FGDM found increased rates of permanency compared to the control group (Sheets, Wittenstrom, Fong, James, & Tecci, 2009). Families participating in FGDM also had higher satisfaction rates, felt more empowered, and had lower levels of child behavior issues.

It is hypothesized that without these efforts to engage family members through effective interventions or strategies, youth are at risk of LTFC, eventually emancipating from the foster care system without supportive relationships and at risk for poorer adult outcomes.

Insufficient or ineffective services. Caseworkers and supervisors also reported that additional resources are needed to respond to the complex factors that contribute to family challenges, such as trauma and unhealthy behaviors and decision making that passed from one generation to the next, and to an inability to manage a home and household resources. They thought that the caseworkers did not have the resources they need to effectively help families. While the reviewers found high rates of caseworkers connecting youth and families to services, there was no evidence that the provided services addressed the targeted issue. It was suggested in the focus groups that higher quality services and those that were more culturally responsive would be helpful. One example provided in the focus groups was that some therapists work with youth via Skype, which participants thought was impersonal, making it difficult to establish a rapport; it was also reported that the youth prefer in-person therapy. Unfortunately, specific recommendations for enhanced service development (e.g., caseworker training, clinical support) to improve service quality were not made.

Case reviews coded service needs providing an indication of caseworkers' perceptions of families' service needs. The most frequent identified service needs (identified for more than one-fourth of the sampled cases) included individual counseling or therapy, home visiting, family counseling or therapy, substance abuse treatment, psychiatric assessment or evaluation, child academic instruction, group counseling or therapy, medication management, and recreational activities. In the focus groups, it was reported that judges are more interested in program completion than in program effectiveness. Finally, caseworkers reported that service needs are frequently identified based on available services and not necessarily on the kinds of supports and services they believe would really help a family overcome its challenges.

In addition to the finding that services provided did not appear to resolve the underlying youth and family challenges, there was mention that the services provided were not consistent with IDCFS' trauma-informed practice model. Of the sampled cases in which child/youth trauma experiences were explicitly identified (83 percent), there was an explicit system response to the trauma experience(s) in approximately 50 percent of those cases. Typical system responses included individual, group, and/or family counseling or therapy; resources to reduce levels of anger, as well as resources to reduce acting out and sexually inappropriate

behaviors; opportunities for increased visits with relatives; and recreational services. Reviewers indicated that many of the supportive services and other resources aimed at redirecting or shifting child and youth behaviors followed a mental/behavioral health treatment model in which behaviors were seen and responded to in isolation and not in relationship to the underlying traumatic experiences that may have shaped those behaviors.

Research related to insufficient or ineffective services typically explored specific types of services, while the findings from the qualitative review were more general. However, a national study (Bellamy, Gopalan, & Traube, 2010), which used NSCAW data to examine outpatient therapeutic outcomes for a subsample of 439 children in LTFC, suggested that youth do not show improvements in internalizing or externalizing behaviors as a result of receiving outpatient mental health services. The authors concluded that lack of improvement could have been due to the type of services that they received and that lack of dissemination of evidence-based practices throughout the child welfare system could negatively affect therapeutic outcomes. For example, although the use of evidence-based interventions that include parent participation is associated with more positive child behavioral outcomes than usual services (Landsverk, Burns, Stambaugh, & Reutz, 2009; Weisz, Jensen-Doss, & Hawley, 2006), these interventions are underused in child welfare and school settings (Horwitz, Chamberlain, Landsverk, & Mullican, 2010). To further understand what is provided in therapy with foster children, Cantos and Gries (2010) conducted a descriptive study with 138 children at 4 different offices of a New York child welfare agency. Therapists described their treatment modalities as eclectic and used practices such as interpersonal/social skills, relationship-based non-directive, cognitive-behavioral, and information processing.

Two-thirds of children improved within 6 months of therapy. One-third did not improve. These children were mostly children with a high level of aggression at initial assessment. They also found that about a third of foster parents participated in services and suggested that it might be important for foster parents to be more involved in therapy to address the needs of the children who did not improve (Cantos & Gries, 2010).

Services to biological parents have also been described as insufficient as typically provided. For example, Barth et al (2005) reviewed the literature on parent training for biological parents and recommended that parent trainings be tailored to the specific needs of the family, addressing the unique needs of each family and the specific developmental needs of each child. Furthermore, they suggest that there may be a mismatch between assessments, services provided, and the individual needs of the families participating in the service.

Given the evidence that many children and their families have unmet service needs due to a lack of effective services, it is hypothesized that ineffective services may impede the progress of both parents and children in effectively treating issues that potentially inhibit permanency.

Trauma and child behavioral-emotional issues. Several child emotional and behavior issues were identified in the qualitative and quantitative analysis. These issues may be symptoms of having experienced trauma or other characteristics or adverse experiences that increase stress or impair functioning, such as conflict in the foster home, inconsistency

in parental visiting or feelings after visits, foster parents' parenting style, and genetic factors increasing risk for mental health issues. From the qualitative review, the most common emotional and behavioral issues included anger control, grief, difficulties in social functioning, adjustment to trauma, attention or concentration issues, impulsivity, depression, and oppositional behavior. The typical system response to these issues was individual, group, or family counseling or therapy. The quantitative analysis found that mental health symptoms (as defined on the Child and Adolescent Needs and Strengths or CANS) were predictive of LTFC and that placement instability was associated with a decrease in strengths over time.

Research has shown that traumatic experiences at an early age involving abuse, neglect, family violence, and/or traumatic loss may result in major impairments across several areas of functioning that can last through adolescence and into adulthood (Cook et al., 2005). Exposure to chronic and repeated interpersonal trauma, or complex trauma, may result in problems modulating emotions and behaviors, impulsivity, problems with attention, difficulties with social functioning, and impairment of one's ability to form consistent relationships with others (Cook et al., 2005; Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Schore, 2001).

Studies within the Illinois child welfare population suggest that youth with complex trauma histories (including multiple and chronic/repeated traumas by caregivers) exhibited more traumatic stress and mental health symptoms, risk behaviors, and life-functioning difficulties and fewer strengths compared to youth with single-type or non-chronic traumas. In all of these domains, youth with complex trauma had higher levels of need and a broader range of difficulties. In addition, these complexly traumatized youth were significantly more likely to have placement disruptions or interruptions compared to other youth (Kisiel, Fehrenbach, Small, & Lyons, 2009).

The factors that were most predictive of placement disruptions for youth with complex trauma included problems with risk behaviors and life functioning; therefore, the combination of a complex trauma history with risk behaviors and/or functional impairment was linked with a greater likelihood of placement disruption overall. Similarly, in a follow-up study, Kisiel, Fehrenbach, McClelland, Burkman, & Griffin (2009) found that youth exposed to both violent (e.g., sexual abuse, physical abuse, domestic violence) and nonviolent (e.g., neglect, emotional abuse) interpersonal traumas together were over 20 percent more likely to have placement disruptions in the 2 years following entry into care compared to other youth.

In another study within Illinois child welfare, Griffin, Martinovich, Gawron, and Lyons (2009) found that the degree of overlap between trauma and mental health symptoms is high and that the presence of trauma symptoms increases the likelihood of other mental health symptoms (IRR=1.74). Another study by Griffin et al. (2009) found a relationship between trauma and increased likelihood of risk behaviors as measured by the CANS. Notably, findings indicated that protective factors, such as educational opportunities, mentors and supportive relationships, and talents can weaken the relationship between trauma and risk behaviors and that these strengths had a moderating effect as the number of traumatic experiences increased. These findings are consistent with the notion that interventions enhancing strengths could potentially protect children from dangerous behaviors, as well as

buffer the harmful impact of trauma. In addition, some trauma interventions with children increase child strengths and protective factors more than other trauma treatments. Careful consideration of which intervention to use with a child could affect the type of outcomes associated with treatment (Personal communication, Cassandra Kisiel, February 15, 2012).

Problems with attachment and emotional or behavioral dysregulation that can occur in response to trauma can lead to disruptions in foster care settings. One study found significant associations among problems with attachment, behavioral difficulties, and placement instability in foster care (Strijker, Knorth & Knot-Dickscheit, 2008). Difficulties with externalizing problems, in particular, can be overwhelming for caregivers to handle and have repeatedly been shown to be associated with placement disruptions and instability (Fisher, Stoolmiller, Mannering, Takahashi, & Chamberlain, 2011; Hurlburt, Chamberlain, DeGarmo, Zhang, & Price, 2010; Leathers, 2006; UC-Davis, 2008).

Consistent with these findings, the qualitative analysis done for this project found a relationship between LTFC and externalizing behavior problems such as anger control, danger to others, and oppositionality. It is worth noting that not all behaviors are caused by trauma, and children in care may have emotional-behavioral issues unrelated to trauma. Regardless of whether the behaviors are related to trauma, they have important implications for permanency.

Based on these findings, it is hypothesized that mental health symptoms, such as emotional and behavioral dysregulation and attachment disorders, affect permanency outcomes through their effects on the caregiver-child relationship and the increased stress of parenting a child with these issues. For many foster youth, trauma is likely to play a key role in the etiology of these mental health issues. The child's behaviors cause stress for the caregiver and make it difficult for the child and caregiver to develop a strong relationship, which, in turn, increases the likelihood of placement instability and decreases chances for permanency.

Biological parent issues. In the qualitative review, substance use/abuse was the most identified barrier for biological parents, followed by depression and anger control. Similar to the findings on child behavior issues, the typical system response to these issues was individual or group counseling or therapy. In the focus groups, caseworkers expressed concern that families need more time and more thoughtful consideration of services in order to effectively resolve some of their underlying issues.

In particular, trauma may also play a role in the substance abuse and emotional issues mentioned in the focus groups, which affects the biological parent's ability to regain custody of his or her children. There is no evidence explicitly linking unaddressed biological parent trauma to longer stays in foster care, but studies focused on women with co-occurring mental health and substance abuse disorders suggest that trauma may be an etiological factor associated with co-occurring disorders. Over 50 percent of women with a mental health problem have co-occurring substance abuse, and co-occurring conditions are often associated with trauma histories (Fallot & Harris, 2004).

Several studies have also shown that substance abuse treatment that addresses both trauma and parenting needs are more effective in addressing substance abuse than substance abuse treatment alone and can improve participation in services (Amaro, Chernoff, Brown, Arevalo, & Gatz, 2007; Niccols et al., 2010; Stromwell et al., 2007). Engagement in services, in turn, is a strong predictor of reunification and children whose parents enter treatment faster spend less time in care (Green, Rockhill & Furrer, 2007). Although there have not yet been studies directly testing the effect of trauma-focused services on reunification rates, these studies suggest that integration of trauma treatments in substance abuse treatments and possibly other services for biological parents might result in more effective treatment and ultimately higher rates of reunification.

Results from other studies suggest that a lack of support and assistance for birth parents might make it difficult for birth parents to engage in services and, therefore, be a barrier to permanency. For example, the Parent Partner (PP) Program aims to improve placement stability and permanency outcomes by connecting birth parents with parents who recently reunified with their children. These parent partners provide social support and assistance to birth parents navigating the child welfare system. Anthony, Berrick, Cohen, and Wilder (2009) compared 236 birth mothers who participated in the PP program with 55 birth mothers served before the program was established. Approximately 60 percent of children with parent mentors reunified with their families within 12 months of removal, compared to 26 percent of birth parents receiving services before the PP program was established.

These findings suggest that effective engagement, adequate identification of biological parents' needs, provision of effective treatment, and social support and assistance may increase the likelihood of reunification.

Lack of foster parent training and support. The qualitative review found a lack of attention to the needs of foster parents and a lack of support to foster parents who may be struggling with issues related to parenting and other stressors in their lives. Findings from a study that conducted focus groups with urban foster parents in Cook County also indicate that foster parents often feel unsupported by child welfare staff (Spielfogel, Leathers, Christian, & McMeel, 2011). Foster parents said that they would benefit from training in how to address children's problematic behaviors, and they also wanted their agency to work more collaboratively. They wanted to be provided with relevant information about the child and updated about visits with biological families and case proceedings. Foster parent felt they would be better able to manage children's behaviors in their homes with a greater range of parenting strategies and more complete information. Foster parents reported that feelings of alienation from agency staff could lead to decreased motivation to foster and, therefore, made it more likely for their placement to disrupt.

There were no cases in which reviewers were able to find an explicit recognition of foster parents' trauma experiences or trauma symptoms. However, in the focus groups, staff mentioned the paucity of departmental focus on the trauma experiences of foster parents, suggesting a focus on caregiver trauma could support more intensive involvement of foster parents as sources of support for biological parents.

As discussed previously, trauma symptoms can often manifest themselves in externalizing behavior problems resulting in challenges in making and maintaining healthy relationships for children and their families (Cook et al., 2005; Perry et al., 1995; Schore, 2001). Behavioral issues can also be caused by ineffective parenting and exacerbated by placement changes. These behavioral issues contribute to increased risk of placement instability and ultimately LTFC (Lawder, Poulin, & Andrews, 1986; Landsverk, Davis, Ganger, & Newton, 1996). Research from Illinois suggests that foster home integration—perceptions of belonging in the foster home—can mediate the impact of behavioral issues in early adolescence on adoption (Leathers, 2006) and has a positive impact on permanency outcomes throughout adolescence (Leathers, Falconnier, & Spielfogel, 2010).

In addition, KEEP (Keeping Foster and Kin Parents Supported and Trained) is a parent management training intervention that teaches foster parents positive parenting and discipline skills in effort to improve child behaviors and placement stability. Chamberlain and colleagues conducted a large study using KEEP with 700 racially diverse foster parents in San Diego County. The program reduced child problem behaviors and improved placement outcomes when placement stability and reunifications were combined compared to standard training (Chamberlain et al., 2008; Price et al., 2008; DeGarmo, Chamberlain, Leve, & Price, 2009). A pilot study in Illinois also showed improvements in child behaviors (Leathers, Spielfogel, McMeel, & Atkins, 2011) for foster parents who received an adapted version of the KEEP intervention in either a group or home-visiting format.

It is hypothesized that without sufficient support and effective training for foster parents, foster home integration becomes difficult to attain, and children are then at increased risk of instability and, ultimately, at increased risk for LTFC.

Lack of safety net after state custody for guardians and adoptive parents. Another theme that emerged from the focus groups was the lack of services available to families post-case resolution (adoption or guardianship), which could deter some families from moving to permanency. Similarly, staff said that many guardians ad litem discourage youth from permanent placements because they will lose supportive services.

This perspective is supported by research comparing the satisfaction of adoptive parents who were engaged in supportive services (e.g., adoptive parent support groups) with parents who did not get supportive services. Those receiving supportive services reported higher satisfaction with parenting than those who did not. Additionally, parents who had unmet informal support needs reported lower relationship quality between the adoptive parent and child and reported more negative impact of the adoption on their family and marriage (Reilly & Platz, 2004). In research with families who have adopted or become legal guardians of former foster children in Illinois, caregivers also reported that a significant number of children had mental health issues and that they were unable to access services to address these needs (Koh & Rolock, 2010).

These findings suggest that a lack of available services may make some potential permanency resources hesitant to consummate an adoption or guardianship for fear that they will not be able to adequately care for the children. Without viable permanency resources, children are at risk for LTFC.

Court challenges. The qualitative review identified a few challenges related to the court practices. One issue can be summarized as disagreement between casework staff and court personnel on what was best for the child and family, which resulted in the court making decisions that the casework staff profoundly disagreed with. This was described in the focus group as a judge who wants to “do social work from the bench” (e.g., too much latitude given to the biological family or disrupting existing relationships that the case work staff identified as meaningful). A second issue can be summarized as court processes taking much longer than the casework staff thought reasonable (e.g., an adoption that seems to be ready to process, but years pass before it is finalized).

There is no evidence explicitly linking the court challenges identified in the qualitative review to longer stays in foster care. However, it is hypothesized that the delays observed in case records and the disconnect between what the caseworker and the judge believe to be in the best interest of the child could result in procedural delays and, for some children, result in permanency placements that take longer than expected or do not occur at all.

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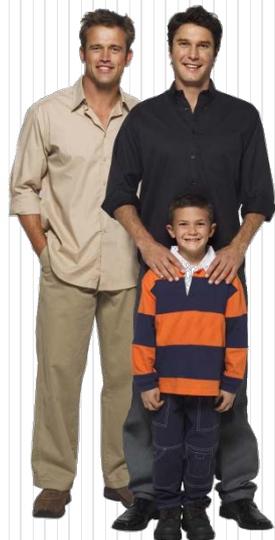
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Evaluating Trauma-Informed Child Welfare Interventions

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Permanency Innovations Initiative

- Aims to focus on reducing length of time in care for youth *at greatest risk* of long stays
- Provides an opportunity to apply and test innovative practices
- Rigorously evaluates the effectiveness of tested strategies

Illinois PII

- PII Project: Trauma-Focused Intervention to Reduce Long-Term Foster Care
- Convened by: Illinois Department of Children & Family Services
- Key partners
 - Contracted System of Care (wraparound) program providers
 - University Partners
 - Northwestern University
 - University of Chicago
 - University of Illinois – Chicago Jane Addams College of Social Work
- Decade-long commitment to trauma-informed assessment & application of trauma lens to addressing child & family needs

Background: Trauma informed child welfare practice in Illinois

- 2004 pilot implementation of 3 Evidence-Based Practices
 - Child-Parent Psychotherapy
 - Trauma-Focused Cognitive Behavioral Therapy
 - Structured Psychotherapy for Adolescents Responding to Chronic Stress
- 2010 Family-Focused, Strengths-Based, Trauma-Informed Practice model

Target Population

Youth ages 11-16, who at the 2-year anniversary of entry have either MH/trauma problems (as rated by the CANS) and/or placement instability risk

Decision-Making About Eligibility Criteria



Trauma Cluster Analysis

- Cluster One (25%) typical Complex Trauma profile
 - 95% met the Complex Trauma criterion
 - high rates of symptoms in all of the four trauma symptom groups
- Cluster Two (60%) less Symptom Complexity
 - 46% met Complex Trauma criterion
 - relatively lower rates of symptoms (13-18%), indicating a lower degree of comorbidity among symptom types
- Cluster Three (15%) highly Behaviorally Disordered
 - 53% met Complex Trauma criterion
 - 100% had behavioral dysregulation issues
 - high rates of affect dysregulation (85%)
 - disproportionately male (63%)
 - at least 25% had previous detention

Implications for Intervention Selection

- If applying a complex trauma intervention, as many as 60% meet criteria
- If applying a targeted trauma intervention, all youth with symptoms and trauma experiences other than neglect only (75%) are appropriate
- In 2 years of intervention, estimates of roughly 800 youth becoming available for intervention meeting criteria

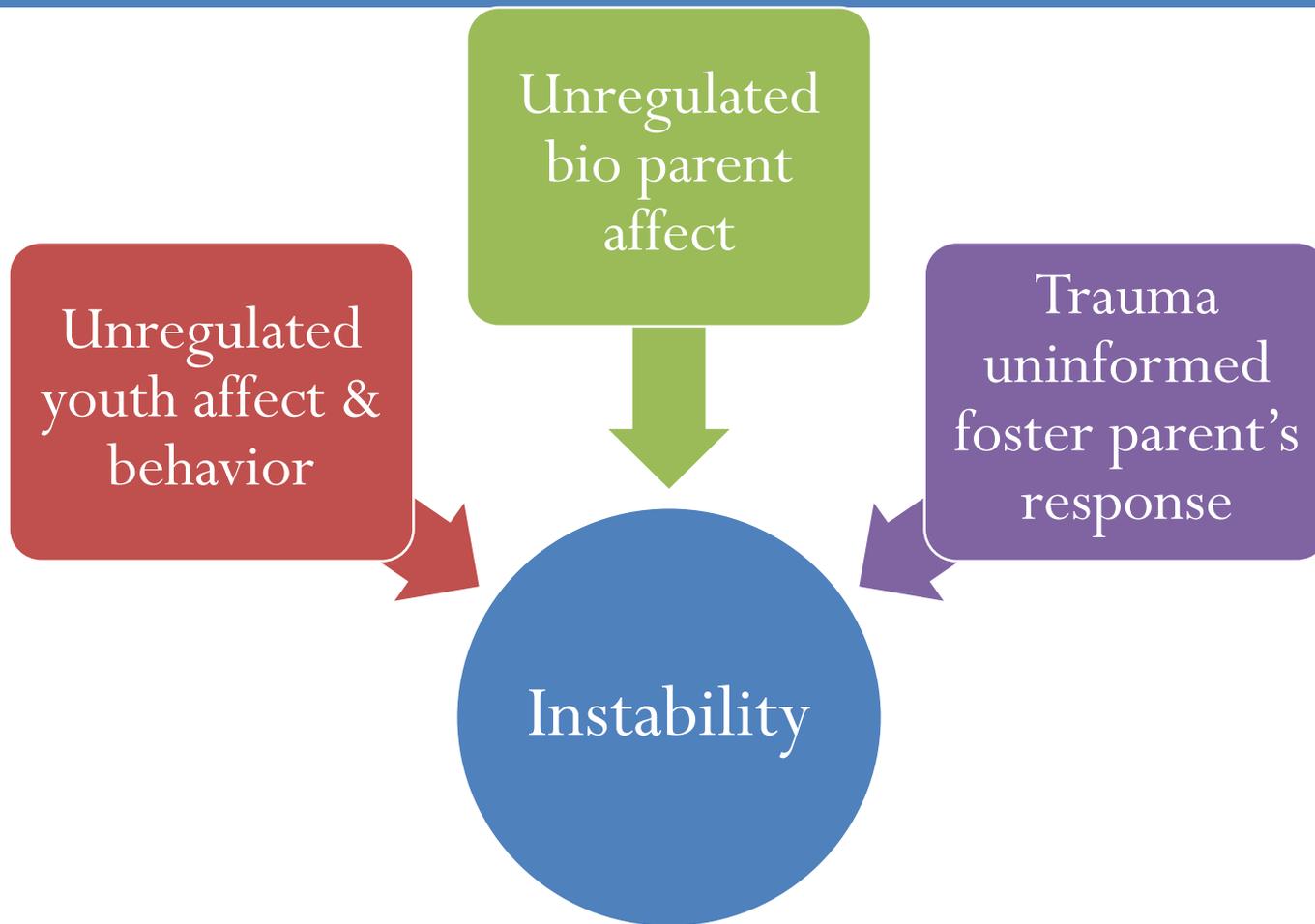
Transparency: Assumptions & Theory of Change

- Ideas about which subgroups have poorer outcomes than others
- Ideas about why subgroups of youth have poorer outcomes
- Theories about what will improve outcomes among at-risk groups

Underlying Assumptions

- Youth with trauma problems may have trouble regulating affect and behavior.
- Unregulated youth affect & behavior present challenges for foster parents who may be unaware of the impact of trauma and unprepared to respond appropriately.
- Unregulated parents may have trouble re-establishing connections with their children, establishing healthy social support networks, or completing needed services.

Trauma Impacts Outcomes Through Instability:



Theory of Change

- By educating youth, biological parents, and foster parents about trauma & strategies for healthy coping, we can improve
 - Appropriate (de-escalating) foster parent responses to youth
 - Opportunities for relationship-building between bio parent and youth
 - Youth ability to manage affect & behavior even in stressful situations
- Improvements in healthy functioning will stabilize placements and promote relationships, which will in turn make permanency achievable.

Selected Intervention: TARGET[©]

- Addresses affect dysregulation that is (1) caused by trauma and (2) results in behavioral problems that are challenging for foster parents to manage
- Can be used with foster parents, biological parents, and youth
- Is appropriate for all youth with trauma histories, not just those with discrete traumatic events
- Developers had implemented the intervention with youth in juvenile justice settings but were eager to modify, apply, and test intervention with child welfare population.

Trauma Affect Regulation: Guide for Education & Therapy

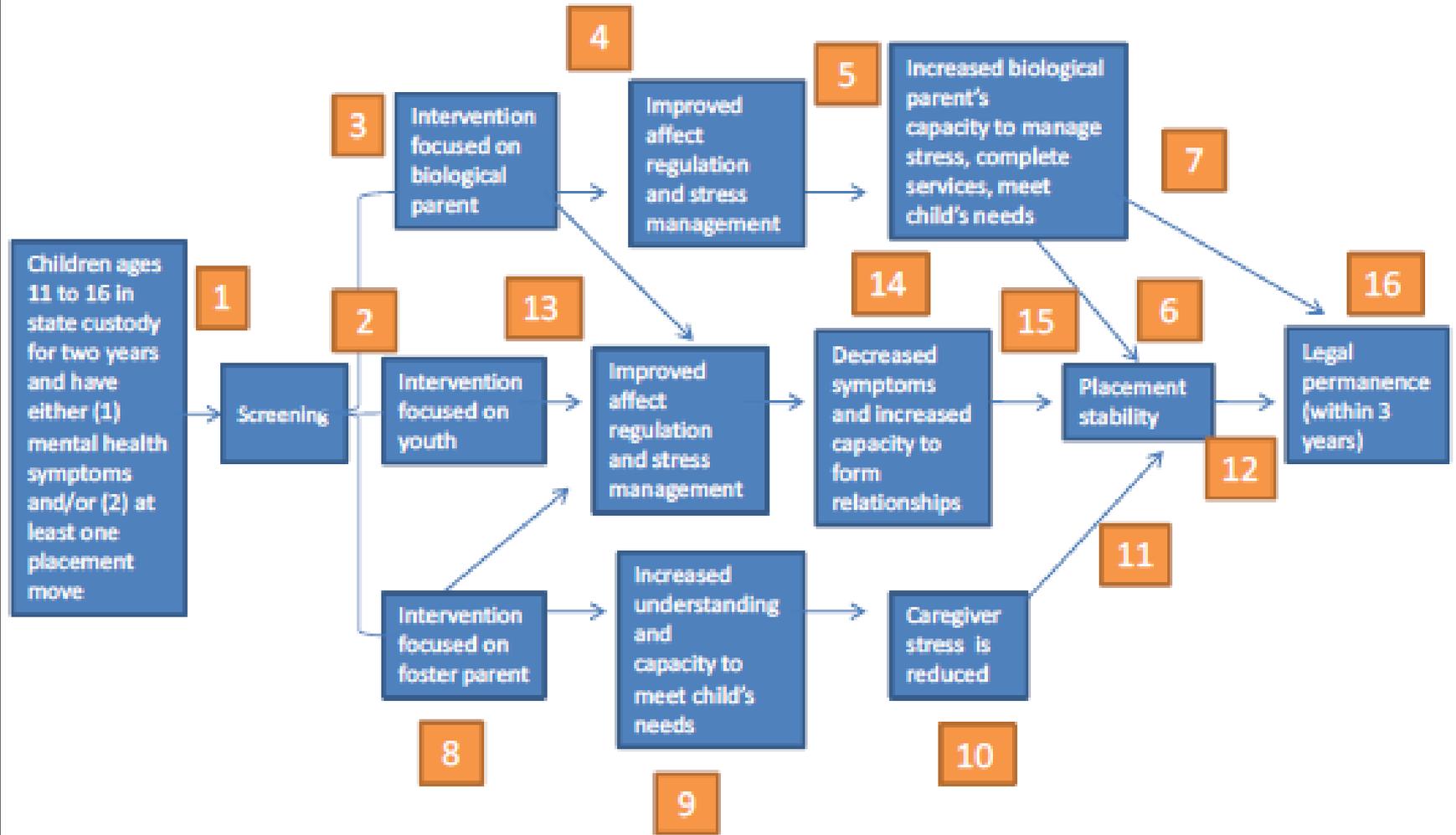
- Strengths-based, psycho-educational approach
- Delivered in-home 10-12 sessions that incorporate parental and caregiver involvement
- Frames PTSD symptoms as the result of the brain's "alarm center" overwhelming the brain's information retrieval ("filing") and executive functioning ("thinking") systems.
- Addresses symptoms by strengthening the "filing" and "thinking" centers rather than turning down the "alarm"

TARGET Core Skills: FREEDOM steps

- **Focus** the mind on one thought at a time (**SOS: Slow down, Orient, Self-check**)
- **Recognize** triggers for alarm reactions
- **Emotion** self-check
- **Evaluate** thoughts
- **Define** goals
- **Options** for behavioral response
- **Make** a contribution

TARGET Training: Staff Engagement

- Experiential Training – draws on examples from participants lives
- All participants go through “**SOS**” steps.
- Selected participants apply FREEDOM steps to examples from their own life histories.
- Training is facilitated in a manner that encourages participation and sharing of experiences.



Proximal Outcomes

Proximal Outcome	Measure
Increase in youths ability to regulate emotions	Affect Dysregulation Inventory (ADI)
Reduction in youth trauma & MH symptoms	CANS & Trauma Symptom Checklist
Increase in bio parent ability to regulate emotions	Affect Dysregulation Inventory (ADI)
Bio parent service participation & completion	Administrative Case Review (ACR)
Increase in bio parent social support	Social Provisions Scale (SPS)
Increase in foster parents' skills in responding to youth	Parenting Practices Chicago Survey- Parent Version (PPCS)
Increased placement stability	Administrative Data (CYCIS)

Distal Outcomes

Distal Outcome	Measures
Increase in rate of permanency	Adoption and Foster Care Analysis and Reporting System (AFCARS) & National Child Abuse and Neglect Data System (NCANDS)
Decrease in average length of stay	
Maintenance of low repeat maltreatment rate	

Anticipated Systemic Change

- Increased system-wide trauma awareness
- Increased capacity for sustained evidence-based practice delivery to address trauma needs among youth and their parents & caregivers

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Illinois Trauma Focus Model for Reducing Long-Term Foster Care: Project Overview

The Illinois Trauma Focus Model for Reducing Long-Term Foster Care is funded by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services, under grant number 90-CT-0156.



Permanency Innovations Initiative (PII)

Introduction—what we will cover today

- A model for reducing long-term foster care through trauma-informed intervention
- Why is this important to Illinois families and youth?
- How will this model be implemented?

Permanency Innovations Initiative (PII)

Background

What is PII?

- Multi-site federal demonstration project to improve permanency
- Focus on foster care children with serious barriers to permanency
- Introduces innovative intervention strategies
- Informed by relevant research

Support from the Children's Bureau

Children's Bureau awards grants to various states for proposed innovations to reduce long-term foster care placement.

Illinois DCFS applied and was awarded the grant!

- 6 grantee sites
 - **Arizona:** Fostering Readiness and Permanency Project
 - **California:** California Partners for Permanency
 - **Kansas:** Kansas Intensive Permanency Project
 - **Washoe County, Nevada:** Initiative to Reduce Long-Term Foster Care
 - **Los Angeles, CA:** RISE (Recognize. Intervene. Support. Empower)
 - **Illinois:** Trauma Focus Model for Reducing Long-Term Foster Care
- Grantees were charged with identifying the population most at risk for long term foster care and implementing a strategy to lower this risk.

The Challenge for Child Welfare

National Statistics:

Older Youth in Foster Care:

- 40- 48% of children in the foster care system are between 11- 16 years old
- 19% of youth in care are between 16- 21 years old
- Youth age 13 and older demonstrate more emotional, mental and behavioral problems
 - Harder to place in permanent homes
 - Remain in foster care longer, increasing the average length of stay in care
 - Many are emancipated without achieving family-based permanency

Permanency Outcomes for Older Youth:

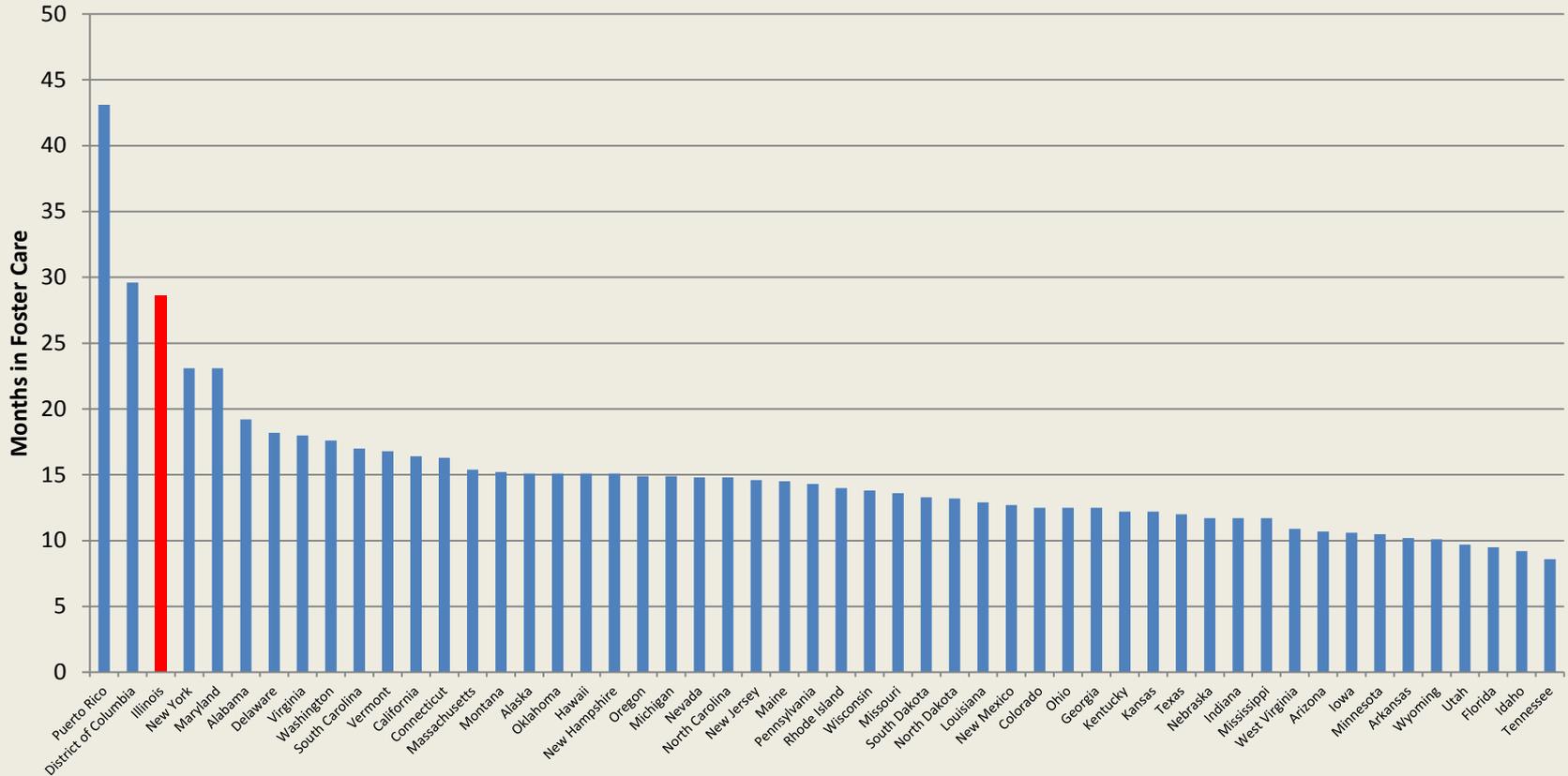
- Adoption decreases as age increases
- Odds of being adopted decrease starting at 13
- Only 30% of children from 11 to 18 achieve permanency before aging out

Service and Intervention Challenges for Illinois

Illinois Statistics:

- Fourth largest foster care system (after New York, California, Pennsylvania)
- 16,500 (approximately) children in out-of-home care:
 - 13,000 in foster care
 - 2,000 in residential care
 - 1,500 in various independent living placements
- Third longest length of stay in the U.S.—an average of 28 months.
 - 11 to 16 yr olds in care —17% less than 2 yrs; 25% 2 to 5 yrs; 25% 5 yrs and longer.
- Illinois has the third highest percent of children who age out (at 21 years old)—21%.

Median Length of Stay in Foster Care (2010)



Message from President Barack Obama

“My Administration is committed to achieving security for every child and supporting adolescents in foster care as they transition to adulthood. The Permanency Innovations Initiative ...is providing support to public-private partnerships focused on decreasing the number of children in long-term foster care. Over the next 5 years, this program will test new approaches to reducing time spent in foster care placements, and remove the most serious barriers to finding lasting, loving environments.”

Permanency Innovations Initiative (PII)

The At-Risk Population

Predictors of Risk for Length of Time in Foster Care

- Age (over nine at entry)*
- Parental rights (no TPR by 2 years)
- Region (Cook County)
- Placement type (ever placed in IGH)
- Placement Instability*
- Mental Health/Trauma Symptoms/Risk Behaviors*

*Predictors chosen for targeting by Illinois Project

Identified Barriers

- Emotional-behavioral issues related to histories of complex trauma
- Lack of parent engagement and service completion required to achieve reunification
- Insufficient or ineffective services to address parents' underlying issues related to child welfare involvement
- Lack of support and training to foster parents to address the needs and behaviors of the children in their care.

Permanency Innovations Initiative (PII)

The PII Project in Illinois

Target Population

Youth ages 11 to 16

- In traditional, relative, and specialized foster care
- Reaching their 2-year anniversary of entering care
- Experiencing mental health symptoms or 2+ placement changes

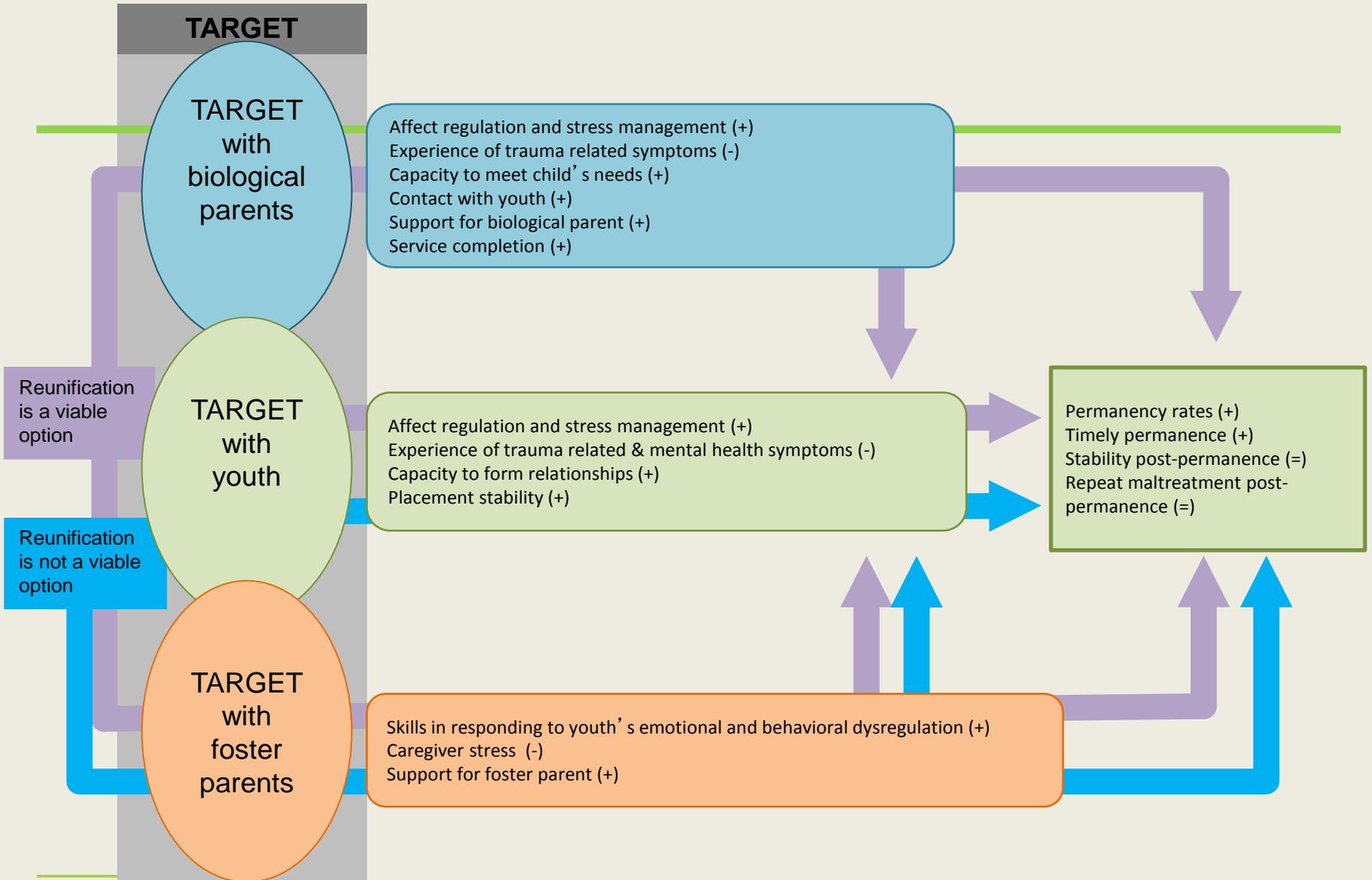
Trauma Affect Regulation: Guide for Education and Therapy (TARGET[©])

- Trauma Affect Regulation: Guide for Education and Therapy (TARGET) is a strength-based approach to education and therapy when youth and their families have been affected by trauma or experience a high level of stress related to adverse experiences.
- A strong psycho-educational component: the impact of trauma on cognitive, emotional, behavioral, and relational processes
- Teaches clients to identify their own stress triggers so that they can better regulate overwhelming feelings and make and achieve goals for themselves
- Provides skills training and aids (acronyms, graphics) to help individuals remember and use TARGET skills in the moment when they experience triggers for emotional dysregulation

Strengths of TARGET

- Evidence-based practice integrated into other practices
- Materials understood and received by youth & parents
- Addresses trauma symptomology and stress responses, (does not require PTSD diagnosis)
- Appropriate for emotional dysregulation for youth with behavioral disorders
- Strength-based, empowerment-focused
- Encourages family participation
- Developer expertise, availability, and involvement in implementation

Illinois PII Services Summary Diagram



Permanency Innovations Initiative (PII)

Research Design

Illinois Research Question

Do foster youth ages 11 to 16 placed in traditional, relative, and specialized foster homes throughout the state who, upon reaching the two-year anniversary of entering care, are experiencing mental health symptoms and/or have at least 2 placement changes have increased permanency rates within 3 years of entry if they receive TARGET services compared with similar youth who receive treatment as usual?

Evaluation Design

PII will evaluate TARGET intervention:

- Do youth have improvements in managing emotions and behaviors?
- Do youth and parents have increased contacts and enhanced relationships?
- Do foster parents improve skills in understanding and helping youth with emotional and behavioral difficulties?
- Does timeliness of permanency increase?

Evaluation Design

- Approximately 650 youth will participate in the study.
- To test the effectiveness of the intervention, half of the youth enrolled will receive the TARGET therapy in addition to services as usual; the other half will receive services as usual.
- PII project will be evaluated in partnership with local universities and federal consultants.

Westat

- Youth, foster parents, and parents (with return home goals) invited to participate in two interviews- at the start of their involvement in the study and 6 months after
- Calls foster parents to schedule consent and interview for youth and foster parent (50 min) in home
- Calls birth parents to gain consent and conduct 15 min individual phone interviews
- Gift card incentive for interview completion: youth (\$20), parent (\$15), foster parent (\$20)
- Westat data collectors may contact the caseworker to assist with coordinating the youth interview at the caseworker's office if the foster parent declines release of their contact info.

Eligibility Criteria 1:
1- second anniversary in care
2- living in relative, traditional or specialized foster home
3- between the ages of 11-16 (inclusive)
Youth must meet all these criteria

Eligibility Criteria 2:
Mental health symptom on the CANS

OR

Eligibility Criteria 3:
Two or more placement moves

PII Client Eligibility Screening (by caseworker):
Excludes youth who are not appropriate for TARGET

The DCFS Guardian will provide or deny consent for the youth to participate

Youth randomly assigned to control or experimental group;
current foster home receives same designation

TREATMENT GROUP

CONTROL GROUP

Westat: Consent for research*

Westat: Consent for research

Notification of Enrollment
Sent to therapist and caseworker

Data collected

TARGET
Orientation

*If youth or parents do not want to participate in the research, they will continue to be eligible for services.

Permanency Innovations Initiative (PII)

Casework Role & Activities

Caseworker Activities

When a youth is identified for PII:

- PII team will e-mail an Eligibility Screening Form to the caseworker; turn around ideally within 24 hours.
- The caseworker is asked to complete a current CANS if one has not been completed within the past 6 months.
- The PII team notifies the caseworker if youth is in the control group or intervention group.

Caseworker and Therapist Activities for Youth in the Intervention Group

Caseworker

- Sends the therapist a copy of most recent CANS, IA, and Service Plan
- Schedules a TARGET Orientation and includes the youth, foster parents, and parents
- Introduces therapist to the family and youth
- Participates in ongoing case coordination with the TARGET therapist at least monthly
- Participates in bi-weekly phone conferences with PII staff to share feedback

TARGET Therapist

- Initiates conference call with caseworker
- Describes TARGET process and provides caseworker with dates and times for TARGET Orientation with family
- Provides an overview of PII and TARGET during the TARGET Orientation

Caseworker/ Therapist Conference Call

- What is the current permanency goal?
- When was the this goal assigned?
- Do you feel it is a viable goal? Why or why not?

Permanency Innovations Initiative (PII)

Caseworker and Therapist

TARGET with Parents

TARGET Therapist

- Maximizes family engagement; involves role modeling of affect regulation by the helping professionals, using motivational approaches to promoting family “buy-in,” including parents and others even if the child is not in their custody or reside with them
- Empowers family to build and support constructive collaborative decision-making and problem solving by all family members
- Supports parent-child interaction; makes experience positive and affirming for youth and family
- Works with parents to restore ability to experience positive emotions essential in their care giving and to recognize and recover from negative emotions in the aftermath of trauma
- Demonstrates ways to teach child how to become emotionally regulated; role models/uses FREEDOM steps in order to show they are “walking the walk”
- Shares observations with caseworker. Coordinates with caseworker around agency processes in which family participates
- Communicates directly and frequently with Caseworker

Agency Caseworker

- Supports TARGET participation
- Facilitates assessment, planning and reviews; ensures work toward goal is progressing
- Shares developments, findings and recommendations from court process, critical decisions and changes in permanency plan with TARGET Therapist; incorporates TARGET recommendations into plan
- Engages parents in change process; ensures regular contact; addresses reason for protective service intervention
- Facilitates visitation and family contacts; provides coaching and skill building through visitation and parent-child contact; acknowledges parents application of TARGET skills
- Encourages parents increase in sole and shared parent experiences; enhances plan to increase role as parent demonstrates success
- Incorporates positive changes resulting from TARGET intervention into permanency plan
- Communicates directly and frequently with TARGET Therapist.

TARGET with Youth

TARGET Therapist

- Assists youth to identify personal goals, relationships, significant adults; works with youth, family and others to support lasting connections and relationships
- Identifies significant others supporting youth and family; as appropriate, includes in TARGET intervention; assists youth in skills to build and sustain meaningful and lasting relationships with significant persons
- Engages youth and family toward enhancing capacity and building skills; as capacity to self-regulate, manage stress and enhance significant relationships grow, stability in home, school and community increases
- Supports parent in the primary role as parent; provides opportunities within TARGET intervention for youth to experience parents modeling positive response; shares observations with caseworker
- Supports visitation and family contacts; provides parent with opportunity for success in parent-related roles and functions
- Assists foster caregiver to know and apply TARGET skills in support of youth's work toward affect regulation
- Identifies growth in self regulation and behavior management; documents observations and findings; makes recommendations to caseworker on how plan and enhanced tasks support goal achievement

Agency Caseworker

- Shares initial and on going Integrated Assessment, youth's portion of service plan, and most recent CANS
- Ensures diligent search is completed; identifies supportive relatives; identifies key persons in youth's life, both family and community
- Understands TARGET focus on self regulation skills; supports application of skills in all domains, home, school and community with special emphasis on youth's relationships with parents and caregiver
- Reinforces TARGET experiences; encourages youth and family in using skills to enhance relationships through visitation and family contact experiences; makes observations and shares with TARGET Therapist
- Encourages parents to increase sole/shared parent experiences; encourages parent's role in youth key life decisions
- As the youth works to improve affect regulation, the caseworker encourages the parent and foster parent to apply TARGET skills when responding to youth's needs.
- Collaborates and communicates directly with the TARGET Therapist; provides significant information on youth in all domains, home, school community; visitation, family (including sibling) interaction; discusses recommendations related to ongoing permanency plan and goal achievement

TARGET with Foster Caregiver

TARGET Therapist

- Engages and supports foster caregiver to create an environment for positive change to occur with both the child and the child's parents
- Provides support for foster caregivers' emotional well-being; educates foster caregiver that their affect regulation is a crucial part of the solution to the child's recovery from traumatic maltreatment
- Helps foster caregiver understand behavioral manifestations of affect dysregulation as post-traumatic (survival mode) reactions
- When maltreated children are able to regulate their emotions (affect), they can regain trust and emotional connectedness with caregivers – if the caregivers also are able to regulate their own emotions

Agency Caseworker

- Works with foster caregiver as member of the service team
- Provides support and advocates for services; identifies and provides resources for the foster caregiver to better meet the needs of the child
- Includes foster caregiver in all internal processes reviewing child's care and well being; supports foster caregiver contributions and adapts service plan to accommodate recommendations and requests
- Provides education and training on needs of child and behavioral management techniques (directly or through specialty services)
- Supports foster caregiver's work with child's parents; encourages in home visitation and shared parenting

Connection with Caseworker

Coordination: Caseworker shares Integrated Assessment, CANS and Family Service Plan with Therapist.

Communication: Caseworker and Therapist discuss their respective intervention, services, and progress on a monthly basis. Therapist sends Caseworker monthly progress report.

Collaboration: Caseworker and Therapist work together toward achieving outcomes of service completion, placement stability, and timely permanency.

How TARGET Skills Enhance Protective Factors

Protective Factors

TARGET

1. Parent Resilience
 1. TARGET is intended to mobilize a family's own resources and build on each member's internal strengths. **Restoring the parents ability to regulate emotions is the essential change that will enable them to feel and behave once again in a healthy manner.**
2. Social Connections
 2. One of the greatest contributions parents and families can make is to model how to regulate affect and to build healthy relationships that are based on mutual respect, love, and compassion. **It is important to help youth identify, build, and sustain key relationships with significant adults or people with whom they have mutual love, respect and trust.**
3. Knowledge of Parenting and Child Development
 3. **Education about trauma, stress, and the brain enables parents' to understand why their child reacts the way they do** and how they can teach their child to effectively manage emotional and behavioral reactions.

How TARGET Skills Enhance Protective Factors

Protective Factors

TARGET

- | | |
|---|---|
| 4. Concrete Support in Times of Need | 4. Even when parents have access to help, they struggle to achieve the success in re-establishing a secure and healthy family for their children and themselves unless the services help them to address the challenge of emotional dysregulation as well. |
| 5. Social and Emotional Competence of Child | 5. TARGET supports both the parents and child to establish/reinforce permanent connections and relationships with significant (trusted) adults. When the child becomes comfortable with the full range of their healthy emotions, they trust themselves and their relationship with their parents and family once again. |
| 6. Healthy Parent-child Relationship | 6. TARGET helps family to develop a secure attachment and emotional connection to one another; works with youth, parents, and caregivers to develop skills to build and sustain healthy relationships. |

Next Steps for Implementation

TASK	TIMEFRAME
Conduct Usability Testing (Cohort #1: 8 therapists)	Jan – March 2013
Begin Formative Evaluation (Cohort #2: 9 therapists)	May 2013
Train and deploy therapists (Cohort #3: 12 therapists)	October 2013
Train and deploy therapists (Cohort #4: 13 therapists)	November 2013
Begin Summative Evaluation	January 2014

Questions?

PII Staff	Phone	E-mail
PII Project Directors: Larry Small and Mark Holzberg	312-814-5987 312-814-0077	Larry.small@illinois.gov Mark.holzberg@illinois.gov
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PII Implementation Team Leader: Jane Hastings	312-814-0088	Jane.hastings@illinois.gov
Implementation Support: Alison Schneider	312-814-6824	Alison-schneider@northwestern.edu
Research Assistant: Carrie Keenan	312-503-9898	Carrie.keenan@northwestern.edu
Project Assistant: Amber Stone	312-814-8535	Amber.stone@illinois.gov



Evaluating Trauma-Informed Child Welfare Interventions

Jennifer O'Brien, PII Project Coordinator
Amber Stone, PII Project Assistant
Northwestern University

Illinois Department of Children & Family Services



Permanency Innovations Initiative

- Aims to focus on reducing length of time in care for youth *at greatest risk* of long stays
- Provides an opportunity to apply and test innovative practices
- Rigorously evaluates the effectiveness of tested strategies

Support from the Children's Bureau

Children's Bureau awards grants to various states for proposed innovations to reduce long-term foster care placement.

- 6 grantee sites
 - ***Arizona:** Fostering Readiness and Permanency Project
 - **California:** California Partners for Permanency
 - **Kansas:** Kansas Intensive Permanency Project
 - **Washoe County, Nevada:** Initiative to Reduce Long-Term Foster Care
 - **Los Angeles, CA:** RISE (Recognize. Intervene. Support. Empower)
 - **Illinois:** Trauma Focused Model for Reducing Long-Term Foster Care
- Grantees were charged with identifying the population most at risk for long-term foster care and implementing a strategy to lower this risk.

*The Arizona Department of Economic Security relinquished their grant effective June 30, 2013. Additional tools and/or lessons learned will be available in the future.

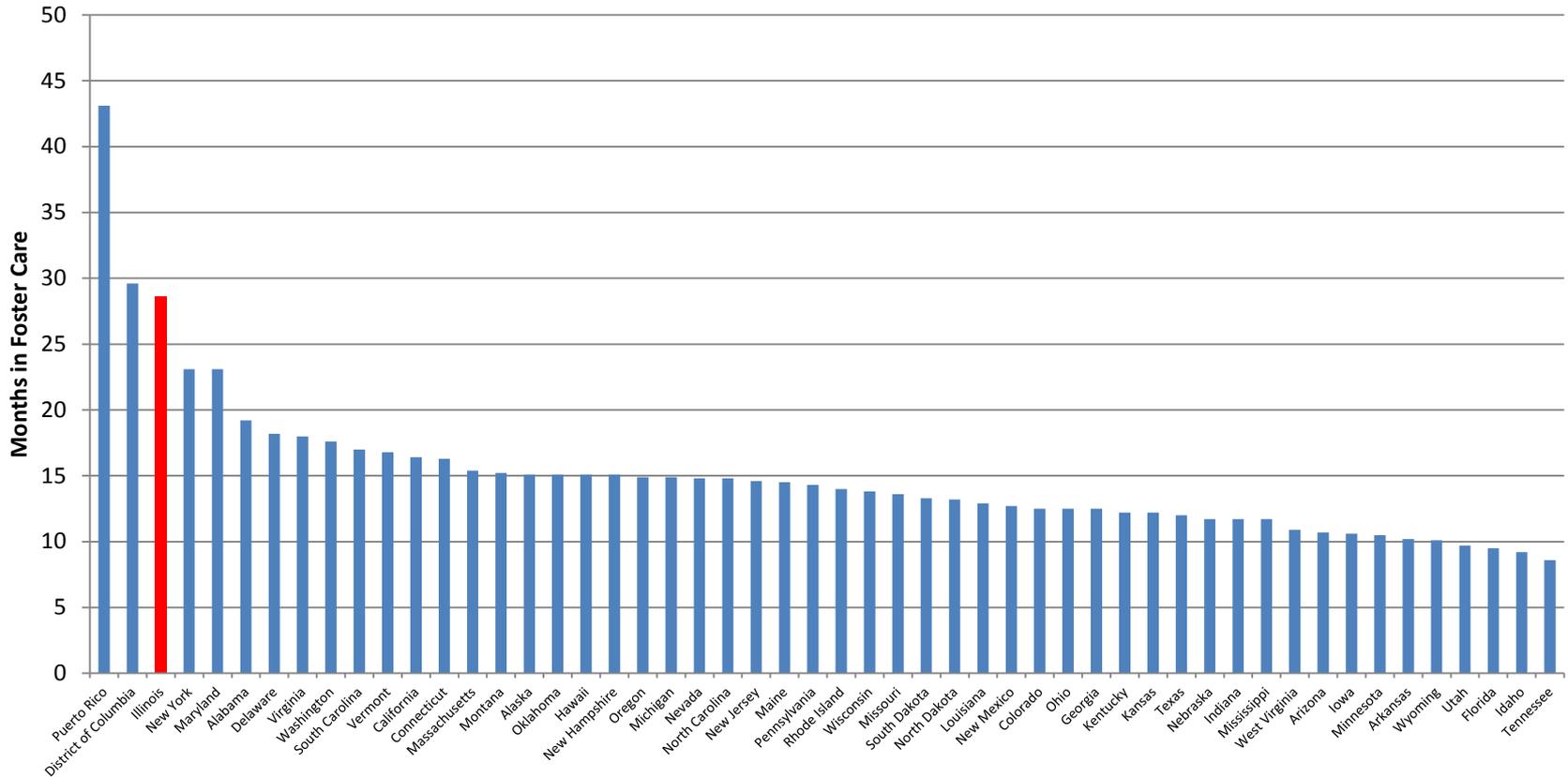
Service and Intervention Challenges for Illinois



Illinois Statistics:

- Fourth largest foster care system (after New York, California, Pennsylvania)
- 16,500 (approximately) children in out-of-home care:
 - 13,000 in foster care
 - 2,000 in residential care
 - 1,500 in various independent living placements
- Third longest length of stay in the U.S.—an average of 28 months.
 - 11 to 16 yr olds in care --17% less than 2 yrs; 25% 2 to 5 yrs; 25% 5 yrs and longer.
- Illinois has the third highest percent of children who age out (at 21 years old)--21%.

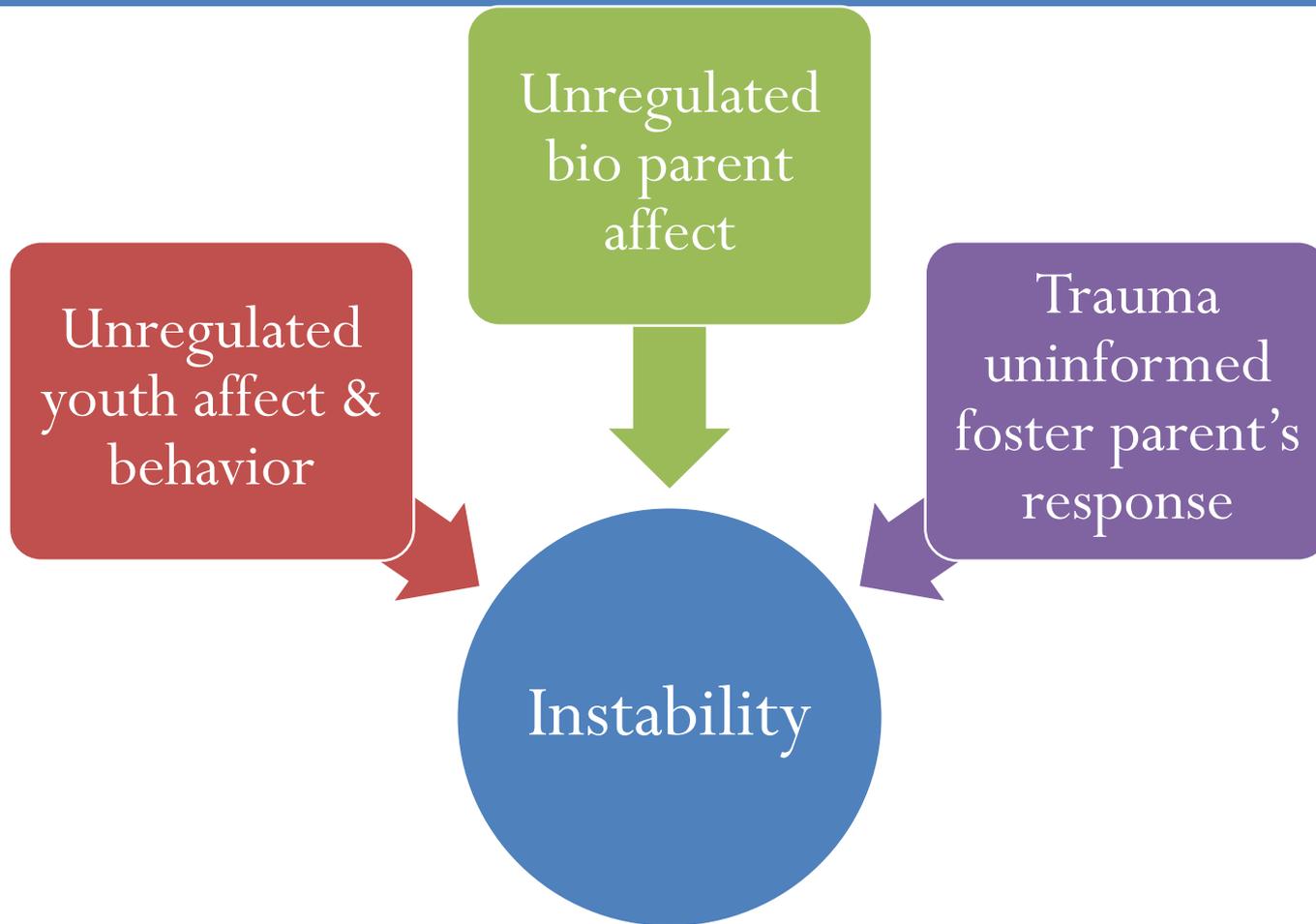
Median Length of Stay in Foster Care (2010)



Illinois PII

- PII Project: Trauma-Focus Model for Reducing Long-Term Foster Care
- Convened by: Illinois Department of Children & Family Services
- Key partners
 - Contracted System of Care (wraparound) program providers
 - University Partners
 - Northwestern University
 - University of Chicago
 - University of Illinois – Chicago Jane Addams College of Social Work
- Decade-long commitment to trauma-informed assessment & application of trauma lens to addressing child & family needs

Trauma impacts outcomes through instability:



Theory of Change

- By educating youth, biological parents, and foster parents about trauma & strategies for healthy coping, we can improve
 - Appropriate (de-escalating) foster parent responses to youth
 - Opportunities for relationship-building between bio parent and youth
 - Youth ability to manage affect & behavior even in stressful situations
- Improvements in healthy functioning will stabilize placements and promote relationships, which will in turn make permanency achievable.

Target Population

Youth ages 11 to 16:

- In traditional, relative, and specialized foster care
- Reaching their 2-year anniversary of entering care
- Experiencing mental health symptoms or 2+ placement changes

Role of the CANS

- The CANS is used as a part of the eligibility criteria
- Eligible youth have an elevated CANS score on one or more items from the following domains:
 - Traumatic Stress Symptoms
 - Life Domain Functioning
 - Behavioral/Emotional Needs
 - Risk Behaviors

Selected Intervention: TARGET

- Addresses affect dysregulation that is (1) caused by trauma and (2) results in behavioral problems that are challenging for foster parents to manage
- Can be used with foster parents, biological parents, and youth
- Is appropriate for all youth with trauma histories, not just those with discrete traumatic events
- Developers had implemented the intervention with youth in juvenile justice settings but were eager to modify, apply, and test intervention with child welfare population

Trauma Affect Regulation: Guide for Education & Therapy



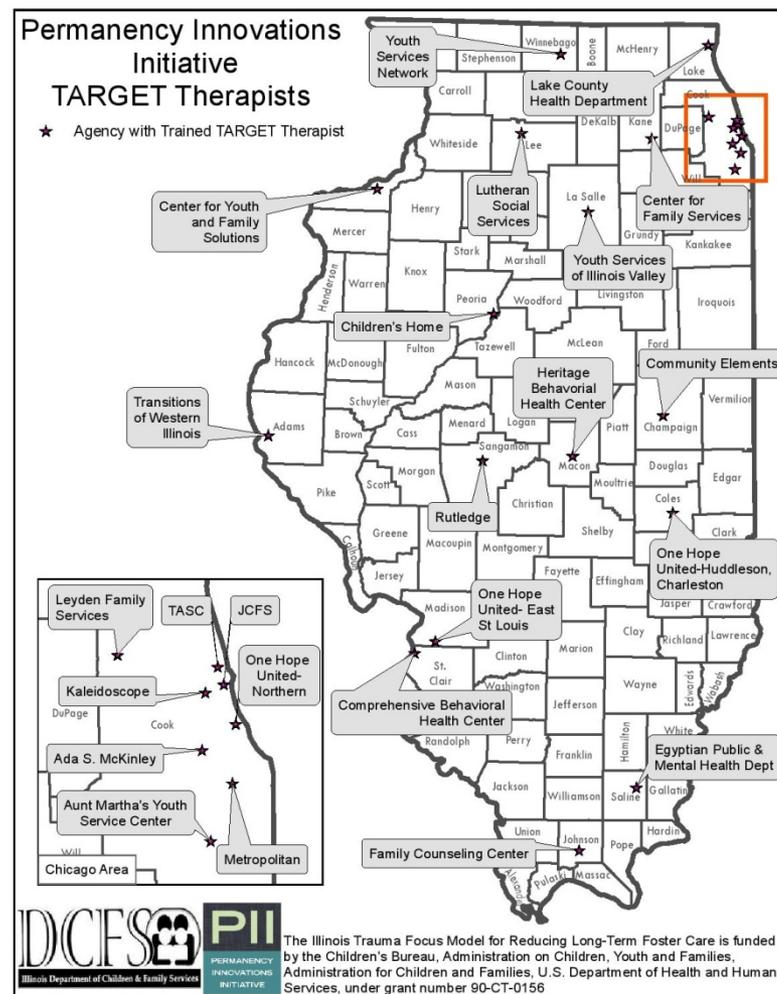
- Strengths-based, psychoeducational approach: Impact of trauma on cognitive, emotional, behavioral, and relational processes
- Delivered in-home 12-20 sessions that incorporate parental and caregiver involvement
- Frames PTSD symptoms as the result of the brain’s “alarm center” overwhelming the brain’s information retrieval (“filing”) and executive functioning (“thinking”) systems.
- Addresses symptoms by strengthening the “filing” and “thinking” centers rather than turning down the “alarm”
- Teaches clients to identify their own stress triggers so that they can better regulate overwhelming feelings and make and achieve goals for themselves

TARGET Core Skills: FREEDOM steps

- **Focus** the mind on one thought at a time (**SOS: Slow down, Orient, Self-check**)
- **Recognize** triggers for alarm reactions
- **Emotion** self-check
- **Evaluate** thoughts
- **Define** goals
- **Options** for behavioral response
- **Make** a contribution

Anticipated Systemic Change

- Increased system-wide trauma awareness
- Increased capacity for sustained evidence-based practice delivery to address trauma needs among youth and their parents & caregivers



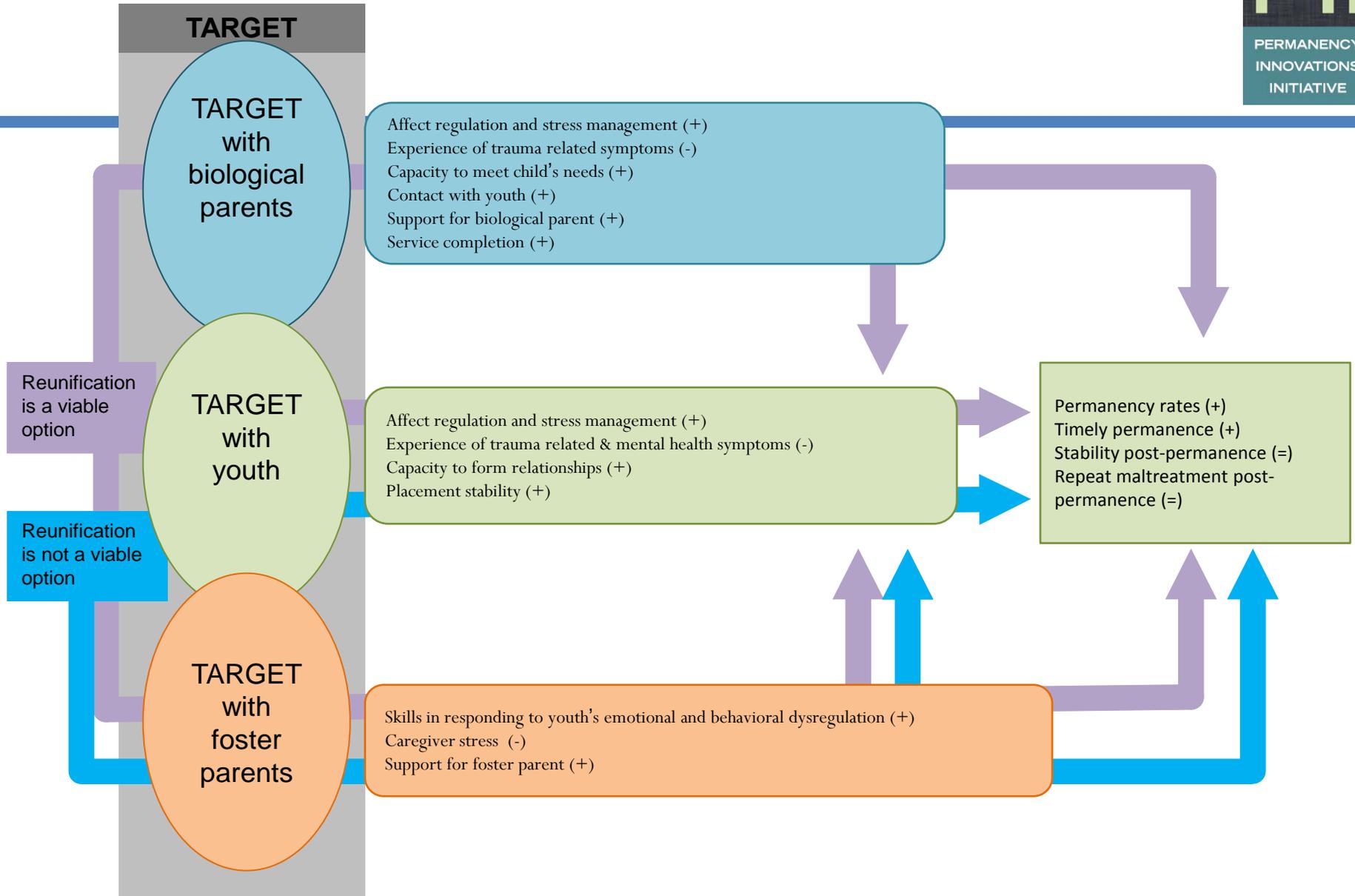
Proximal Outcomes

Proximal Outcome	Measure
Increase in youths' ability to regulate emotions	Affect Dysregulation Inventory (ADI)
Reduction in youth trauma & MH symptoms	CANS & Trauma Symptom Checklist
Youth capacity to form and maintain relationships	Youth social support measure and CANS
Increase in bio parent ability to regulate emotions	Affect Dysregulation Inventory (ADI)
Bio parent service participation & completion	Administrative Case Review (ACR)
Bio parent contact with youth	Bio parent contact with youth measure completed during youth interviews
Increase in bio parent social support	Social Provisions Scale (SPS)
Increase in foster parents' skills in responding to youth	Parenting Practices Chicago Survey- Parent Version (PPCS)
Increased placement stability	Administrative Data (CYCIS)

Distal Outcomes

Distal Outcome	Measures
Increase in rate of permanency	Adoption and Foster Care Analysis and Reporting System (AFCARS) & National Child Abuse and Neglect Data System (NCANDS)
Decrease in average length of stay	
Maintenance of low repeat maltreatment rate	
Placement stability post-permanence	

Illinois PII Services Summary Diagram



Evaluation Design - RTC

- Approximately 400 youth will participate in the evaluation study.
- To test the effectiveness of the intervention, half of the youth enrolled will receive the TARGET therapy in addition to services as usual; the other half will receive services as usual.
- PII project will be evaluated in partnership with local universities and federal consultants.

Primary Data Collection-Westat

- Youth, foster parents, and parents (with return home goals) invited to participate in two interviews- at the start of their involvement in the study and 6 months after
- Calls foster parents to gain consent and schedule interview for youth and foster parent (45 minutes) in home
- Calls birth parents to gain consent and conduct individual phone interviews (15 minutes)
- Gift card incentive for interview completion: youth (\$20), parent (\$15), foster parent (\$20)
- Westat data collectors may contact the caseworker to assist with coordinating the youth interview at the caseworker's office if the foster parent declines release of their contact info.

Impact to Date

- Approximately 50 eligible youth identified every 2 months and begin the enrollment process
- 319 youth randomized in the summative evaluation; 158 treatment, 161 control (*began Summative Phase August 22, 2013*)
- 28 graduates to date
- Expect a sample size of 400 by November 1, 2014
- Program intake extended to February 28, 2015

Lessons Learned

- Existing contractual relationships with therapists and strong monitoring key to successful implementation
- Identify core components of intervention for fidelity monitoring
- Consistent leadership team meetings comprised implementation and evaluation members
- Caseworker training and PII staff maintaining ongoing communication with the field is critical
- Outside evaluator (no peak – no tweak), implement satisfaction surveys to inform leadership and champions

Participant Satisfaction Survey Results

(As of 8/19/14)



- Youth Responses (N=21)
- Caregiver (N=14)
- Bio Parents (N=1)
- Likert Scale: 5=Strongly agree, 1=Strongly disagree
- Scores below represent the Mean

As a result of what you've learned in TARGET, are you able to:	Youth	Care-giver	Bio Parent
Understand how stress affects the brain's alarm system?	4.62	5.00	4.00
Use the seven FREEDOM Skills to manage stress reactions?	4.38	4.79	4.00
Use the SOS skills to help you focus in stressful situations?	4.67	4.86	5.00
Use the Stress and Control scales to do a self-check?	4.24	4.79	3.00
See how experiences in your life fit together with the Lifeline?	4.05	4.79	5.00

Tell us what you think about TARGET. Do you think:	Youth	Care-giver	Bio Parent
TARGET has helped me to understand stress in a new way.	4.71	4.86	4.00
TARGET therapists/teachers were organized, explained things clearly, made sessions interesting, and gave me good feedback.	4.76	4.93	5.00
I learned a lot from the TARGET activities and handouts.	4.71	4.86	4.00
TARGET provided enough time for me to practice FREEDOM skills with helpful feedback from therapist(s) and [if applicable] group members.	4.48	4.79	5.00
Using the FREEDOM skills helps me feel better about myself, get along better in my relationships, and achieve my goals.	4.52	4.71	5.00
The number of TARGET sessions was just right, not too many sessions and not too few sessions.	4.57	4.36	5.00
Compared to when I began TARGET, I am able to cope a lot better if I feel really upset.	4.71	4.50	5.00
Compared to when I began TARGET, I am handling stressful life experiences more effectively.	4.43	4.50	5.00
I am satisfied with TARGET.	4.76	4.93	5.00
I would recommend TARGET to other people.	4.71	4.93	5.00

Sustainability Planning and Dissemination



Aim is to sustain outcomes! It boils down to the “WHAT” and the “HOW”

- Five Illinois TARGET Trainers
- PII Champions and Stakeholder Involvement
 - Statewide PII Sustainability Workgroup - We would love to have Regional Clinical join the group; reach out to Jen O’Brien if interested
 - Dissemination newsletters and presentations
- Three categories of sustainability planning:
 - Implementation Infrastructure and Processes
 - Organizational Infrastructure and Processes
 - Fiscal Strategies/Resources

Illinois PII Contacts



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Appendix H: ILLINOIS PERMANENCY INNOVATIONS INITIATIVE (PII) TERMS OF REFERENCE

ILLINOIS PERMANENCY INNOVATIONS INITIATIVE (PII) TERMS OF REFERENCE

PII STEERING COMMITTEE

Background

The Illinois Child Welfare Advisory Committee (CWAC) was created by executive order of the Governor and codified in administrative rule in 1995 to provide a forum for collaboration between the public and private child welfare agencies in Illinois. The express purpose of the CWAC is to advise the Department of Children and Family Services (DCFS) on “programmatically and budgetary matters related to the provision of purchase of child welfare services” (Illinois Administrative Code §428.50). Comprised of twenty five members appointed by the Director of DCFS, the CWAC is co-chaired by the DCFS Director and a private child welfare agency executive. CWAC Subcommittees addressing various aspects of the child welfare system (e.g. Older Adolescents, Budget and Finance, Foster Care Infrastructure) were established. All CWAC subcommittees and workgroups have representatives from both the public and private sectors and are co-chaired in this same manner. For significant child welfare system reform efforts which involve multiple CWAC Subcommittees and workgroups, such as the implementation of performance based contracting, a project steering committee has been established under the auspices of CWAC to coordinate efforts and ensure alignment and prioritization of tasks. The Director finds that such a project steering committee is necessary to ensure the successful implementation of the Illinois Permanency Innovations Initiative (PII).

Creation

The PII Steering Committee is hereby established by the DCFS Director with terms of reference as set forth in this document.

Governance Structure

The PII Steering Committee operates under the auspices of the Child Welfare Advisory Committee (CWAC). The PII Steering Committee formed an Executive Committee, Population and Evaluation Workgroup, Intervention Design Workgroup, Implementation Workgroup and four Regional Implementation Teams.

Purpose

The purpose of the PII Steering Committee is to provide leadership and vision through both collaboration and a focus on permanency for children and youth. This Steering Committee will serve in an advisory capacity to provide input regarding the refinement of the target population, development of the intervention strategy and guidance throughout the implementation and evaluation of the PII initiative in Illinois.

Functions and Responsibilities

The functions of the PII Steering Committee include, but are not limited by, the following:

- Collaboratively strategize and advise on existing and/or emerging complex child welfare issues related to long term stays in foster care.

- Communicate, coordinate and align PII project efforts and recommendations with relevant CWAC Subcommittees and workgroups.
- Provide input and expert advice through the progression of the PII initiative in Illinois, inclusive of refinement of the target population, development of the intervention strategy, implementation, and project evaluation.
- Provide input regarding the development and deployment of a communication plan to message the PII project by effectively communicating and marketing the PII project to the field, the courts and the public at large.
- Informed by the evaluation results and subsequent to the term of the demonstration project, provide input on the continuation, modification, or dissolution of the tested intervention and, as indicated, provide expert advice on sustainability.

Membership

Members of the PII Steering Committee are appointed by the Director. The PII Steering Committee includes a diverse group of child welfare researchers and professionals. The current membership of the workgroup is as follows. Additional members may be added as needed:

- Shaun Lane, Department of Children and Family Services, PII Project Director
- Mike Shaver, Children's Home + Aid
- Anita Shannon, Casey Family Programs
- Dr. Cynthia Tate, Department of Children and Family Services
- Dr. Dana Weiner, Northwestern
- Debra Dyer, Department of Children and Family Services
- Debbie Reed, Chaddock
- Dawn Rubio, Administrative Office of Illinois Court
- Dr. Gene Griffin, Northwestern
- Marge Berglind, Child Care Association of Illinois
- Jeanie Ortega-Piron, Department of Children and Family Services
- Joan Nelson-Phillips, Department of Children and Family Services
- Kara Teeple, Department of Children and Family Services
- Larry Chasey, Department of Children and Family Services
- Lawrence Grazian, Cook County Juvenile Court
- Margaret Vimont, Jewish Child and Family Services
- Mary Hollie, Lawrence Hall
- Mark Nufer, Lawrence Hall
- Mary Shahbazian, Allendale
- Nichole Anyaso, ABJ
- Norman Brown, Department of Children and Family Services
- Dr. Raquel Ellis, Westat
- Roseana Bess, JBS International
- Robert Stanek, Department of Children and Family Services
- Nancy Rolock, UIC

- Tom Finnegan, Kaleidoscope
- Trish Fox, Center for Youth and Family Solutions
- Janet Barnes, Office of the Public Guardian
- Twana Cosey, Department of Children and Family Services
- Tanesha McGhee-Davis, Department of Children and Family Services
- Bill Gillis, One Hope United
- Jackie Bright, Department of Children and Family Services
- Dr. Cassie Kisiel, Northwestern
- Emily Fisher, JBS International
- Dr. Sonya Leathers, UIC
- Treva Hamilton, Department of Children and Family Services
- Marilyn Panichi, Adoption Unlimited, Inc.

Role of Members

Members of the PII Steering Committee are senior child welfare leaders and are expected to represent the views of, and provide expertise and advice in relation to the constituency they represent as well as for the betterment of the Illinois child welfare system as a whole. Individually the role of members is to:

- Participate collaboratively with one another following the principles of CWAC;
- Provide advice and support to the PII Project working groups;
- Contribute to the collective knowledge of the field by strategizing to address complex issues;
- Problem solve to overcome implementation challenges;
- Support and respect ongoing positive, open and candid communication.

Term of Appointment

Appointees to the PII Steering Committee shall be initially appointed for the life of the collaborative agreement with the Administration of Children, Youth and Families of the United States Department of Health and Human Services for the federal Permanency Innovations Initiative.

Co-Chairpersons

The PII Steering Committee shall be co-chaired by the DCFS PII Project Director and a private agency representative appointed by the Director of DCFS. The PII Steering Committee is currently co-chaired by Mike Shaver, Children's Home + Aid, and Shaun Lane, DCFS.

Meetings

The PII Steering Committee shall meet face-to-face quarterly and can increase or decrease frequency of meetings as necessary and warranted. Teleconferencing will be made available for those members who cannot attend in person. Teleconference or web-based meetings may take place between face-to-face meetings as needed.

Attendance

Appointees to the PII Steering Committee are expected to attend meetings either in person or telephonically and not designate others to attend in their place or on their behalf.

Quorum

There shall be a quorum present for PII Steering Committee meetings when a majority of members are present either in person or by teleconference.

Decision Making and Consensus Building

The PII Steering Committee will support active participation of members, encourage consideration of diverse viewpoints, and strive for consensus decision-making. In the event a consensus is not reached on a given issue, the committee may advance its recommendation with agreement of a majority of members.

Minutes

Minutes shall be kept at every meeting that summarize the discussion and suggestions provided by the PII Steering Committee. The minutes shall be distributed to its members for review prior to the next meeting. Minutes will be prepared by an individual appointed by the PII project director who will also maintain a record of all minutes.

Task Teams/Workgroups

Three standing workgroups are hereby established for this project: the Population and Evaluation Workgroup, Intervention Design Workgroup, and Implementation Workgroup. In addition, an Executive Committee composed of the leadership of each workgroup is hereby established for the purpose of providing coherency and integration across the activities of the workgroups and throughout each phase of the initiative. Terms of reference for these workgroups shall be developed consistent with those establishing the PII Project Steering Committee.

Reporting

Task Teams/Workgroups will provide a progress report of their work at each PII Steering Committee meeting.

The PII Steering Committee Co-Chairs will serve as liaisons between the PII Steering Committee and the Illinois Child Welfare Advisory Committee and advise the CWAC of the status of the PII Project at each CWAC meeting. Following each PII Steering Committee meeting a synopsis of key discussions, and outcomes will be published in the weekly *Monday Report* by the Child Care Association of Illinois, the ICOY Highlights by the Illinois Collaboration on Youth. Representatives of the PII Project Steering Committee who concurrently serve as Co-Chairs of CWAC Subcommittees and Workgroups will be responsible for establishing communication and feedback loops to align and coordinate PII project efforts across all relevant CWAC Subcommittees and workgroups.

ILLINOIS PERMANENCY INNOVATIONS INITIATIVE (PII) TERMS OF REFERENCE

PII EXECUTIVE COMMITTEE

Background

The Permanency Innovations Initiative is a complex undertaking that requires broad participation and input, specialized expertise, active communication and coordination, and clear decision making.

Moreover, the process for completing the work occurs in distinct phases each requiring distinct specialized expertise – target population, intervention design, implementation, and evaluation. Yet, the work of each phase is influenced by and impacts the others in an ongoing iterative process. An agile core leadership group that is empowered to achieve coherency and integration across the entirety of the project is essential for success. Due to its size, composition, and function, the PII Steering Committee is unable to provide such level of support. Therefore, a PII Executive Committee is formed to provide more active stewardship of initiative as described below.

Creation

The PII Executive Committee is hereby established by the PII Steering Committee with terms of reference as set forth in this document.

Governance Structure

The PII Executive Committee serves as a coordinating and decision making group supporting the three workgroups formed by the PII Steering Committee and operating under the auspices of the Child Welfare Advisory Committee (CWAC).

Purpose

The purpose of the PII Executive Committee is to provide overarching stewardship of the initiative, ensuring integration and coordination across workgroups and project phases, maintaining fidelity to the process for the development, implementation, and evaluation of program innovations as prescribed by the Children’s Bureau, and facilitating sound and clear decision making.

Functions and Responsibilities

The functions and responsibilities of the PII Executive Committee are as follows. Additional specific functions and responsibilities may be added as needed.

- Maintain active linkages, communication, and coordination across workgroups and phases of the initiative
- Maintain reciprocal communication with the PII Steering Committee, utilizing the input and expert advice of this diverse group of stakeholders

- Serve as the locus for critical project decisions, ensuring integrated and informed decision-making that synthesizes the input of various workgroups and stakeholders, anticipates impacts across the whole of the project, fulfills grant expectations and requirements, and maintains congruence with defined priorities of the Department
- Serve as the clearance point for each major project deliverable, initially consisting of the target population template, intervention template, and implementation plan. In addition, provides coordinated input into the evaluation plan and related templates.
- Ensures both transparency and accountability for project activities, milestones, and decision making
- Meets regularly with and utilizes the expertise and support of the PII technical assistance team

Membership

The PII Executive Committee is composed of the PII Steering Committee co-chairs, each workgroup chairperson, and key leaders as designated by the PII Steering Committee co-chairs. The current membership of the PII Executive Team is as follows. Additional members may be added as needed.

- Mike Shaver, Children’s Home + Aid, PII Steering Committee
- Shaun Lane, DCFS, PII Steering Committee
- Dr. Dana Weiner, Northwestern University, Population and Evaluation Workgroup Chairperson
- Dr. Gene Griffin, Northwestern University, Intervention Design Workgroup Chairperson
- Jackie Bright, DCFS, Implementation Workgroup, Co-chair
- Bill Gillis, One Hope United, Implementation Workgroup, Co-chair
- Tom Finnegan, Kaleidoscope, Inc.,

Role of Members

Members of the PII Executive Committee are a diverse group of child welfare professionals. Individually the role of members is to:

- Exercise an overriding commitment to the project goals
- Participate collaboratively with one another and with related groups;
- Contribute expertise adding to the collective knowledge of the team;
- Learn from others and use available information to inform decisions;
- Problem solve to overcome implementation challenges;
- Support and respect ongoing positive, open and candid communication.

Term of Appointment

Appointees to the PII Executive Committee shall be initially appointed for the life of the collaborative agreement with the Administration of Children, Youth and Families of the United States Department of Health and Human Services for the federal Permanency Innovations Initiative.

Workgroup Chairperson

The PII Steering Committee co-chairs will serve as the co-chairs for the PII Executive Committee. The current co-chairs are Mike Shaver, Children’s Home + Aid, and Shaun Lane, DCFS.

Meetings

The PII Executive Committee will meet bi-weekly and can increase or decrease frequency of meetings as necessary and warranted. All meetings will be held by teleconference and in-person when necessary.

Attendance

Appointees to the PII Executive Committee are expected to attend meetings either in person or telephonically and not designate others to attend in their place or on their behalf.

Quorum

There shall be a quorum present for the PII Executive Committee meetings when a majority of members are present either in person or by teleconference.

Decision Making and Consensus Building

The PII Executive Committee will support active participation of members, encourage consideration of diverse viewpoints, and strive for consensus decision-making. In the event a consensus is not reached on a given issue, the committee may advance its recommendation with agreement of a majority of members.

Minutes

Summary minutes shall be kept at every meeting of the PII Executive Committee and distributed to its members for review prior to the next meeting. Minutes will be prepared by an individual designated by the PII project director who will also maintain a record of all minutes.

Task Teams/Workgroups

Additional task teams and workgroups may be established as appropriate.

ILLINOIS PERMANENCY INNOVATIONS INITIATIVE (PII) TERMS OF REFERENCE

POPULATION AND EVALUATION WORKGROUP

Background

The Illinois Child Welfare Advisory Committee (CWAC) was created by executive order of the Governor and codified in administrative rule in 1995 to provide a forum for collaboration between the public and private child welfare agencies in Illinois. The express purpose of the CWAC is to advise the Department of Children and Family Services (DCFS) on “programmatic and budgetary matters related to the provision of purchase of child welfare services” (Illinois Administrative Code §428.50). Comprised of twenty five members appointed by the Director of DCFS, the CWAC is co-chaired by the DCFS Director and a private child welfare agency executive. CWAC Subcommittees addressing various aspects of the child welfare system (e.g. Older Adolescents, Budget and Finance, Foster Care Infrastructure) were established. All CWAC subcommittees and workgroups have representatives from both the public and private sectors and are co-chaired in this same manner. For significant child welfare system reform efforts which involve multiple CWAC Subcommittees and workgroups, such as the implementation of performance based contracting, a project steering committee has been established under the auspices of CWAC to coordinate efforts and ensure alignment and prioritization of tasks. The Director finds that such a project steering committee is necessary to ensure the successful implementation of the Illinois Permanency Innovations Initiative (PII). The PII Steering Committee has established three workgroups to inform its work including the Population and Evaluation Workgroup.

Creation

The Population and Evaluation Workgroup is hereby established by the PII Steering Committee with terms of reference as set forth in this document.

Governance Structure

The Population and Evaluation Workgroup serves as a workgroup of the PII Steering Committee and operates under the auspices of the Child Welfare Advisory Committee (CWAC)

Purpose

The purpose of the Population and Evaluation Workgroup is to compile and analyze data to inform decision making of the PII Steering Committee, PII Executive Committee and other relevant child welfare stakeholders on issues related to the PII project and permanency for children and youth.

Functions and Responsibilities

The functions of the Population and Evaluation Workgroup include, but are not limited by, the following:

- Work in close collaboration with the PII Steering Committee, PII Executive Committee and Intervention Design and Implementation Workgroups, contributing to the iterative formulation

and execution of the Illinois PII initiative and providing for the specific data needs of the workgroups.

- Maintain reciprocal communication with the PII Steering Committee, utilizing the input and expert advice of this diverse group of stakeholders
- Conduct a broad analysis of the long-term foster care population to support the identification of a target population for the PII initiative; define and apply selection criteria for recommending a target population for the PII initiative
- Work collaboratively with the PII designated national evaluation team, contributing to the development and implementation of the Illinois PII evaluation plan.
- Identify specific PII information and data collection needs, including data required for fidelity monitoring, outcome measurement, and national PII evaluation.
- Assess existing data sources and identify any additional data system development required.
- Design the methods for sharing data with internal and external stakeholders including the national PII evaluation team

Membership

Members of the Population and Evaluation Workgroup are appointed by the co-chairs of the PII Steering Committee and include child welfare researchers and professionals. The current membership of the workgroup is as follows:

- Dr. Dana Weiner, Northwestern University, Evaluation Liaison
- Dr. Andy Zinn, Chapin Hall, University of Chicago
- Dr. Robert Goerge, Chapin Hall, University of Chicago
- Thomas Finnegan, Kaleidoscope, Inc.
- Nancy Rolock, University of Illinois at Chicago
- Dr. Rob Luske, The BabyFold
- Joan Nelson-Phillips-DCFS, Deputy Director, Division of Quality Assurance, DCFS
- Gary M. McClelland, Northwestern University

Role of Members

Members of the Population and Evaluation Workgroup are a diverse group of child welfare researchers and professionals. Individually the role of members is to:

- Participate collaboratively with one another and related groups;
- Provide expert data analysis and recommendations to the PII Project Steering Committee, PII Executive Committee, Intervention Design Workgroup and Implementation Workgroup;
- Contribute to the collective knowledge of the field by disseminating evaluation findings;
- Assist in problem solving to overcome implementation challenges;
- Support and respect ongoing positive, open and candid communication.

Term of Appointment

Appointees to the Population and Evaluation Workgroup shall be initially appointed for the life of the collaborative agreement with the Administration of Children, Youth and Families of the United States Department of Health and Human Services for the federal Permanency Innovations Initiative.

Workgroup Chairperson

The PII Evaluation Liaison, Dr. Dana Weiner, serves as the chairperson for the workgroup.

Meetings

The Population and Evaluation Workgroup will meet face-to-face monthly and can increase or decrease frequency of meetings as necessary and warranted. Teleconferencing will be made available for those members who cannot attend in person. Teleconference or web-based meetings may take place between face-to-face meetings as needed.

Attendance

Appointees to the Population and Evaluation Workgroup are expected to attend meetings either in person or telephonically and not designate others to attend in their place or on their behalf.

Quorum

There shall be a quorum present for Population and Evaluation Workgroup meetings when a majority of members are present either in person or by teleconference.

Decision Making and Consensus Building

The Population and Evaluation Workgroup will support active participation of members, encourage consideration of diverse viewpoints, and strive for consensus decision-making. In the event a consensus is not reached on a given issue, the committee may advance its recommendation with agreement of a majority of members. Recommendations of the workgroup are directed to the PII Executive Committee.

Minutes

Summary minutes shall be kept at every meeting of the Population and Evaluation Workgroup and distributed to its members for review prior to the next meeting. Minutes will be prepared by an individual designated by the PII project director who will also maintain a record of all minutes.

Task Teams/Workgroups

Additional task teams and workgroups may be established as appropriate.

ILLINOIS PERMANENCY INNOVATIONS INITIATIVE (PII) TERMS OF REFERENCE

PII INTERVENTION DESIGN WORKGROUP

Background

The Illinois Child Welfare Advisory Committee (CWAC) was created by executive order of the Governor and codified in administrative rule in 1995 to provide a forum for collaboration between the public and private child welfare agencies in Illinois. The express purpose of the CWAC is to advise the Department of Children and Family Services (DCFS) on “programmatic and budgetary matters related to the provision of purchase of child welfare services” (Illinois Administrative Code §428.50). Comprised of twenty five members appointed by the Director of DCFS, the CWAC is co-chaired by the DCFS Director and a private child welfare agency executive. CWAC Subcommittees addressing various aspects of the child welfare system (e.g. Older Adolescents, Budget and Finance, Foster Care Infrastructure) were established. All CWAC subcommittees and workgroups have representatives from both the public and private sectors and are co-chaired in this same manner. For significant child welfare system reform efforts which involve multiple CWAC Subcommittees and workgroups, such as the implementation of performance based contracting, a project steering committee has been established under the auspices of CWAC to coordinate efforts and ensure alignment and prioritization of tasks. The Director finds that such a project steering committee is necessary to ensure the successful implementation of the Illinois Permanency Innovations Initiative (PII). The PII Steering Committee has established three workgroups to inform its work including the Intervention Design Workgroup.

Creation

The PII Intervention Design Workgroup is hereby established by the PII Steering Committee with terms of reference as set forth in this document.

Governance Structure

The PII Intervention Design Workgroup serves as a workgroup of the PII Steering Committee and operates under the auspices of the Child Welfare Advisory Committee (CWAC).

Purpose

The purpose of the PII Intervention Design Workgroup is to work collaboratively to develop an intervention strategy that will be tested for its efficacy in reducing the occurrence of long-term foster care for the selected target population.

Functions and Responsibilities

The general functions and responsibilities of the PII Intervention Design Workgroup are as follows. Additional specific functions and responsibilities may be added as needed.

- Work in close collaboration with the Population and Evaluation Workgroup, PII Executive Committee and Implementation Workgroup, contributing to the iterative formulation and execution of the Illinois PII initiative.
- Maintain reciprocal communication with the PII Steering Committee, utilizing the input and expert advice of this diverse group of stakeholders
- Develop an intervention strategy based on research evidence that addresses the needs and barriers to permanency for the identified target population.

Membership

Members of the PII Intervention Design Workgroup are appointed by the co-chairs of the PII Steering Committee and include a diverse group of child welfare researchers and professionals. The current membership of the workgroup is as follows. Additional members may be added as needed:

- Dr. Gene Griffin, Northwestern University
- Dr. Cynthia Tate, Deputy Director, Division of Clinical Services, DCFS
- Dr. Cassie Kissel, Northwestern University
- Dr. Kim Mann, Chicago State University
- Dr. Jamie Germain, DCFS
- Dr. Larry Small, DCFS
- Jennifer Marett, Northwestern
- Dr. Sonya Leathers, UIC
- Nancy Rolock, UIC
- Jill Spielfogel, UIC
- Mike Shaver, Children's Home + Aid

Role of Members

Members of the PII Intervention Design Workgroup are a diverse group of child welfare researchers and professionals. Individually the role of members is to:

- Participate collaboratively with one another and with related groups;
- Contribute expertise adding to the collective knowledge of the workgroup;
- Learn from others and use available information to inform decisions;
- Problem solve to overcome intervention challenges;
- Support and respect ongoing positive, open and candid communication.

Term of Appointment

Appointees to the PII Intervention Design Workgroup shall be initially appointed for the life of the collaborative agreement with the Administration of Children, Youth and Families of the United States Department of Health and Human Services for the federal Permanency Innovations Initiative.

Workgroup Chairperson

Dr. Gene Griffin, Northwestern University, serves as the chairperson for the workgroup.

Meetings

The PII Intervention Design Workgroup will meet face-to-face weekly and can increase or decrease the frequency of meetings as necessary and warranted. Teleconferencing will be made available for those members who cannot attend in person.

Attendance

Appointees to the PII Intervention Design Workgroup are expected to attend meetings either in person or telephonically and not designate others to attend in their place or on their behalf.

Quorum

There shall be a quorum present for the PII Intervention Design Workgroup meetings when a majority of members are present either in person or by teleconference.

Decision Making and Consensus Building

The Intervention Design Workgroup will support active participation of members, encourage consideration of diverse viewpoints, and strive for consensus decision-making. In the event a consensus is not reached on a given issue, the committee may advance its recommendation with agreement of a majority of members. Recommendations of the workgroup are directed to the PII Executive Committee.

Minutes

Summary minutes shall be kept at every meeting of the PII Intervention Design Workgroup and distributed to its members for review prior to the next meeting. Minutes will be prepared by an individual designated by the PII project director who will also maintain a record of all minutes.

Task Teams/Workgroups

Additional task teams and workgroups may be established as appropriate.

ILLINOIS PERMANENCY INNOVATIONS INITIATIVE (PII) TERMS OF REFERENCE

PII IMPLEMENTATION WORKGROUP

Background

The Illinois Child Welfare Advisory Committee (CWAC) was created by executive order of the Governor and codified in administrative rule in 1995 to provide a forum for collaboration between the public and private child welfare agencies in Illinois. The express purpose of the CWAC is to advise the Department of Children and Family Services (DCFS) on “programmatically and budgetary matters related to the provision of purchase of child welfare services” (Illinois Administrative Code §428.50). Comprised of twenty five members appointed by the Director of DCFS, the CWAC is co-chaired by the DCFS Director and a private child welfare agency executive. CWAC Subcommittees addressing various aspects of the child welfare system (e.g. Older Adolescents, Budget and Finance, Foster Care Infrastructure) were established. All CWAC subcommittees and workgroups have representatives from both the public and private sectors and are co-chaired in this same manner. For significant child welfare system reform efforts which involve multiple CWAC Subcommittees and workgroups, such as the implementation of performance based contracting, a project steering committee has been established under the auspices of CWAC to coordinate efforts and ensure alignment and prioritization of tasks. The Director finds that such a project steering committee is necessary to ensure the successful implementation of the Illinois Permanency Innovations Initiative (PII). The PII Steering Committee has established three workgroups to inform its work including the PII Implementation Workgroup.

Creation

The PII Implementation Workgroup is hereby established by the DCFS Director with terms of reference as set forth in this document.

Governance Structure

The PII Implementation Workgroup serves as a workgroup of the PII Steering Committee and operates under the auspices of the Child Welfare Advisory Committee (CWAC). The Workgroup communicates its recommendations and coordinates its activities with the PII Executive Committee and PII Steering Committee.

Purpose

The purpose of the PII Implementation Workgroup is to provide advice and make recommendations to the Department in support of the effective implementation of the Permanency Innovations Initiative. Working collaboratively with the Department, the workgroup provides guidance for the operational planning and initial and ongoing implementation of the PII initiative.

Functions and Responsibilities

The general functions and responsibilities of the PII Implementation Workgroup are as follows. Additional specific functions and responsibilities will be added subsequent to the identification of the target population and selection of intervention(s).

- Work in close collaboration with the Population and Evaluation Workgroup, Executive Committee and Intervention Design Workgroup, contributing to the iterative formulation and execution of the Illinois PII initiative.
- Maintain reciprocal communication with the PII Steering Committee, utilizing the input and expert advice of this diverse group of stakeholders
- Develop a comprehensive implementation plan including provision for necessary capacity and organization drivers, usability testing, achievement of intervention model fidelity, and other factors as necessary to ensure successful implementation of the initiative.
- Provide ongoing refinement and adjustment of the implementation strategy utilizing the principles of plan-do-study-act to support information-based decision-making and continuous learning.

Membership

Members of the PII Implementation Workgroup are appointed by the co-chairs of the PII Steering Committee and include child welfare researchers and professionals. The current membership of the workgroup is as follows. Additional members may be added as needed:

- Bill Gillis, One Hope United
- Jackie Bright, Department of Children and Family Services
- Mayra Burgos-Biott, Department of Children and Family Services
- Dr. Cassie Kisiel, Northwestern University
- Dora Maya, Arden Shore
- Nancy Dorfman-Schwartz, Jewish Child and Family Services
- Dr. Jamie Germain, Department of Children and Family Services
- Greg Westbrooks, Center for Youth and Family Solutions
- Treva Hamilton, Department of Children and Family Services
- Jane Hastings, Department of Children and Family Services
- Valda Haywood, Department of Children and Family Services
- Jason Keeler, Camelot Care
- Jill Spielfogel, UIC
- Yolanda Jordan, Department of Children and Family Services
- Kathy Henke, Child Care Association of Illinois
- Tracy Levine, Lawrence Hall
- Karen Major, Babyfold
- Marc Smith, Aunt Martha's
- Marcia Weflen, Lutheran Social Services of Illinois
- Mark Bouie, Illinois Mentor
- Melissa Ludington, Children's Home and Aid Society of Illinois
- Nancy Rolock, UIC
- Larry Small, Department of Children and Family Services
- Dr. Sonya Leathers, UIC
- Kara Teeple, Department of Children and Family Services
- Dr. Dana Weiner, Northwestern University
- Scott Wiseman, Department of Children and Family Services
- Bill Franklin, Lutheran Social Services of Illinois

Role of Members

Members of the PII Implementation Workgroup are a diverse group of child welfare professionals. Individually the role of members is to:

- Participate collaboratively with one another and with related groups;
- Contribute expertise adding to the collective knowledge of the workgroup;
- Learn from others and use available information to inform decisions;
- Problem solve to overcome implementation challenges;
- Support and respect ongoing positive, open and candid communication;
- Serve as an ambassador to their respective organizations and other committees and groups they participate in, both communicating information about the project and soliciting input from broader constituencies;
- Exercise fidelity to the overall purpose of the project, moderating advocacy for individual and organizational self-interest

Term of Appointment

Appointees to the PII Implementation Workgroup shall be initially appointed for the life of the collaborative agreement with the Administration of Children, Youth and Families of the United States Department of Health and Human Services for the federal Permanency Innovations Initiative.

Workgroup Chairperson

Jackie Bright, Department of Children and Family Services and Bill Gillis, One Hope United, serve as the co-chairs for the PII Implementation Workgroup.

Meetings

The PII Implementation Workgroup will conduct weekly web-based meetings. The meeting frequency can increase or decrease as necessary and warranted.

Attendance

Appointees to the PII Implementation Workgroup are expected to attend meetings either in person, telephonically or by videoconference, when available. Participation in workgroup meetings is limited to workgroup members. In support of continuity of participation, summary notes will be available following each meeting and members may have direct discussion with staff and/or co-chairs when unable to attend one or more meetings. All members have opportunity for obtaining information and providing input whether before, during, or after workgroup meetings.

Quorum

There shall be a quorum present for PII Implementation Workgroup meetings when a majority of members are present either in person or by teleconference.

Decision Making and Consensus Building

The Implementation Workgroup will support active participation of members, encourage consideration of diverse viewpoints, and strive for consensus decision-making. In the event a consensus is

not reached on a given issue, the committee may advance its recommendation with agreement of a majority of members. Recommendations of the workgroup are directed to the PII Executive Committee.

Minutes

Summary minutes shall be kept at every meeting of the PII Implementation Workgroup and distributed to its members for review prior to the next meeting. Minutes will be prepared by an individual designated by the PII project director who will also maintain a record of all minutes.

Task Teams/Workgroups

Additional task teams and workgroups may be established as appropriate.

ILLINOIS PERMANENCY INNOVATIONS INITIATIVE (PII) TERMS OF REFERENCE

DRAFT (Rev. 7.26.12)

PII IMPLEMENTATION SUPPORT TEAM

Background

The Illinois Child Welfare Advisory Committee (CWAC) was created by executive order of the Governor and codified in administrative rule in 1995 to provide a forum for collaboration between the public and private child welfare agencies in Illinois. The express purpose of the CWAC is to advise the Department of Children and Family Services (DCFS) on “programmatic and budgetary matters related to the provision of purchase of child welfare services” (Illinois Administrative Code §428.50). Comprised of twenty five members appointed by the Director of DCFS, the CWAC is co-chaired by the DCFS Director and a private child welfare agency executive. CWAC Subcommittees addressing various aspects of the child welfare system (e.g. Older Adolescents, Budget and Finance, Foster Care Infrastructure) were established. All CWAC subcommittees and workgroups have representatives from both the public and private sectors and are co-chaired in this same manner. For significant child welfare system reform efforts which involve multiple CWAC Subcommittees and workgroups, such as the implementation of performance based contracting, a project steering committee has been established under the auspices of CWAC to coordinate efforts and ensure alignment and prioritization of tasks. The Director finds that such a project steering committee is necessary to ensure the successful implementation of the Illinois Permanency Innovations Initiative (PII). The PII Steering Committee has established three workgroups to inform its work including the Implementation Workgroup. The Implementation Workgroup has established the PII Implementation Support Team and four Regional Implementation Teams that will inform its work.

Creation

The PII Implementation Support Team is hereby established by the DCFS Director with terms of reference as set forth in this document.

Governance Structure

The PII Implementation Support Team serves as a team of the PII Implementation Workgroup and operates under the auspices of the Child Welfare Advisory Committee (CWAC). The implementation support team will communicate its recommendations and coordinate its activities with the PII Implementation Workgroup, PII Executive Committee and PII Steering Committee.

Purpose

The purpose of the PII Implementation Support Team is to support the effective implementation of the Illinois Permanency Innovations Initiative at the practice-level. Specifically, the team will conduct ongoing review of critical project performance measures, identify barriers to implementation, and creatively problem-solve.

Functions and Responsibilities

The general functions and responsibilities of the PII Implementation Support Team are as follows. Additional specific functions and responsibilities will be added as needed.

- Work in close collaboration with the Population and Evaluation Workgroup, Executive Committee and Intervention Design and Implementation Workgroups, contributing to the iterative formulation and execution of the Illinois PII initiative.
- Work collaboratively with the PII Regional Implementation Teams to provide active staff support and ground level monitoring of implementation using principles and frameworks of implementation science.
- Provide direct coordination, support, and communications with involved agencies for the project.
- Review fidelity and implementation data across the project to ensure consistent, high-fidelity implementation of the initiative.
- Maintain contact with agencies, identify barriers, and review performance data with their assigned agencies on an ongoing basis to promote procedural compliance and project fidelity.

Membership

Members of the PII Implementation Support Team will be appointed by the co-chairs of the PII Steering Committee and include child welfare researchers and professionals. The current membership of the workgroup is as follows. Additional members may be added as needed:

- Jane Hastings, Northwestern
- Shaun Lane, PII Project Director, Department of Children and Family Service
- Dr. Sonya Leathers, UIC
- Nancy Rolock, UIC
- Dr. Dana Weiner, Northwestern
- Dr. Cassie Kisiel, Northwestern
- Dr. Larry Small, Department of Children and Family Services
- Jill Spielfogel, UIC
- Allison Schneider, Northwestern
- Twana Cosey, Department of Children and Family Services

Role of Members

Members of the PII Implementation Support Team are a diverse group of child welfare researchers and professionals. Individually the role of members is to:

- Participate collaboratively with one another and with related groups;
- Contribute expertise adding to the collective knowledge of the team;
- Learn from others and use available information to inform decisions;
- Problem solve to overcome implementation challenges;
- Support and respect ongoing positive, open and candid communication;
- Serve as an ambassador to their respective organizations and other committees and groups they participate in, both communicating information about the project and soliciting input from broader constituencies;

Term of Appointment

Appointees to the PII Implementation Support Team shall be initially appointed for the life of the collaborative agreement with the Administration of Children, Youth and Families of the United States Department of Health and Human Services for the federal Permanency Innovations Initiative.

Workgroup Chairperson

Jane Hasting, SOC contract monitor will serve as the chairperson for the PII Implementation Support Team.

Meetings

The PII Implementation Support Team will meet weekly and can increase or decrease frequency as necessary and warranted. The meetings will be fact to face and teleconferencing will be made available for those members who cannot attend in person.

Attendance

Appointees to the PII Implementation Support Team are expected to attend meetings either in person, telephonically or by videoconference, when available. Participation in team meetings is limited to team members. In support of continuity of participation, summary notes will be available following each meeting and members may have direct discussion with staff and/or co-chairs when unable to attend one or more meetings. All members have opportunity for obtaining information and providing input whether before, during, or after workgroup meetings.

Quorum

There shall be a quorum present for PII Implementation Support Team meetings when a majority of members are present either in person or by teleconference.

Decision Making and Consensus Building

The Implementation Support Team will support active participation of members, encourage consideration of diverse viewpoints, and strive for consensus decision-making. In the event a consensus is not reached on a given issue, the committee may advance its recommendation with agreement of a majority of members. Recommendations of the team are directed to the Implementation Workgroup.

Minutes

Summary minutes shall be kept at every meeting of the PII Implementation Support Team and distributed to its members for review prior to the next meeting. Minutes will be prepared by an individual designated by the PII project director who will also maintain a record of all minutes.

Task Teams/Workgroups

Additional task teams and workgroups may be established as appropriate.

ILLINOIS PERMANENCY INNOVATIONS INITIATIVE (PII) TERMS OF REFERENCE

DRAFT (Rev. 7.26.12)

PII REGIONAL IMPLEMENTATION TEAMS

Background

The Illinois Child Welfare Advisory Committee (CWAC) was created by executive order of the Governor and codified in administrative rule in 1995 to provide a forum for collaboration between the public and private child welfare agencies in Illinois. The express purpose of the CWAC is to advise the Department of Children and Family Services (DCFS) on “programmatic and budgetary matters related to the provision of purchase of child welfare services” (Illinois Administrative Code §428.50). Comprised of twenty five members appointed by the Director of DCFS, the CWAC is co-chaired by the DCFS Director and a private child welfare agency executive. CWAC Subcommittees addressing various aspects of the child welfare system (e.g. Older Adolescents, Budget and Finance, Foster Care Infrastructure) were established. All CWAC subcommittees and workgroups have representatives from both the public and private sectors and are co-chaired in this same manner. For significant child welfare system reform efforts which involve multiple CWAC Subcommittees and workgroups, such as the implementation of performance based contracting, a project steering committee has been established under the auspices of CWAC to coordinate efforts and ensure alignment and prioritization of tasks. The Director finds that such a project steering committee is necessary to ensure the successful implementation of the Illinois Permanency Innovations Initiative (PII). The PII Steering Committee has established three workgroups to inform its work including the Implementation Workgroup. The Implementation Workgroup has established the PII Implementation Support Team and four Regional Implementation Teams that will inform its work.

Creation

The PII Regional Implementation Teams are hereby established by the DCFS Director with terms of reference as set forth in this document.

Governance Structure

The PII Regional Implementation Teams serve as a workgroup of the PII Implementation Workgroup and operates under the auspices of the Child Welfare Advisory Committee (CWAC). The regional teams communicate its recommendations and coordinate its activities with the PII Implementation Workgroup, PII Executive Committee and PII Steering Committee.

Purpose

The purpose of the PII Regional Implementation Teams is to support implementation at the local level and enable reciprocal communication between the project management team and local staff.

Functions and Responsibilities

The general functions and responsibilities of the PII Regional Implementation Teams are as follows. Additional specific functions and responsibilities will be added as needed.

- Work in close collaboration with the PII Implementation Support Team, Population and Evaluation Workgroup, Executive Committee and Intervention Design and Implementation Workgroups, contributing to the iterative formulation and execution of the Illinois PII initiative.
- Review fidelity and implementation data specific to their region to ensure consistent, high-fidelity implementation of the intervention.
- Identify barriers to implementation in that specific region and make decisions regarding the ongoing refinement and adjustment of the implementation strategy utilizing the principles of plan-do-study-act to support information-based decision-making and continuous learning.

Membership

Members of the PII Regional Implementation Teams will be appointed by the co-chairs of the PII Steering Committee. Each regional team will be composed of a regional implementation coordinator, representatives from participating System of Care (SOC) Agencies, the Placement Agencies, PII Project Coordinator, and the SOC contract monitor. Implementation Workgroup members will attend these meetings as needed. Additional members may be added as needed.

Role of Members

Members of the PII Regional Implementation Teams are a diverse group of child welfare professionals. Individually the role of members is to:

- Participate collaboratively with one another and with related groups;
- Contribute expertise adding to the collective knowledge of the team;
- Learn from others and use available information to inform decisions;
- Problem solve to overcome implementation challenges;
- Support and respect ongoing positive, open and candid communication;
- Serve as an ambassador to their respective organizations, both communicating information about the project and soliciting input from constituents;
- Exercise fidelity to the overall purpose of the project, moderating advocacy for individual and organizational self-interest

Term of Appointment

Appointees to the PII Regional Implementation Teams shall be initially appointed for the life of the collaborative agreement with the Administration of Children, Youth and Families of the United States Department of Health and Human Services for the federal Permanency Innovations Initiative.

Workgroup Chairperson

The chairperson for each team will be designated by PII Steering Committee co-chairs.

Meetings

The PII Regional Implementation Teams will meet monthly and can increase or decrease frequency as necessary and warranted. The meetings will be fact to face and teleconferencing will be made available for those members who cannot attend in person.

Attendance

Appointees to the PII Regional Implementation Teams are expected to attend meetings either in person, telephonically or by videoconference, when available. Participation in workgroup meetings is limited to workgroup members. In support of continuity of participation, summary notes will be available following each meeting and members may have direct discussion with staff and/or co-chairs when unable to attend one or more meetings. All members have opportunity for obtaining information and providing input whether before, during, or after team meetings.

Quorum

There shall be a quorum present for PII Regional Implementation Team meetings when a majority of members are present either in person or by teleconference.

Decision Making and Consensus Building

The PII Regional Implementation Teams will support active participation of members, encourage consideration of diverse viewpoints, and strive for consensus decision-making. In the event a consensus is not reached on a given issue, the committee may advance its recommendation with agreement of a majority of members. Recommendations of the team are directed to the Implementation Support Team.

Minutes

Summary minutes shall be kept at every meeting of the PII Regional Implementation Team and distributed to its members for review prior to the next meeting. Minutes will be prepared by an individual designated by the PII project director who will also maintain a record of all minutes.

Task Teams/Workgroups

Additional task teams and workgroups may be established as appropriate.