Partnerships in Individualized Planning

Introduction

Increasingly, both mental health policy and consumer/family advocates describe **individualized planning** as a necessary route to **community integration** and **recovery**, as well as other positive outcomes for children and youth with emotional or behavioral disorders and their families. There is also growing research evidence that supports the efficacy of individualized planning undertaken through **youth-family-provider partnerships**. Unfortunately, it appears that individualized planning that includes families and youth often falls far short of the vision of full partnership. However, there is good reason to believe that the level of partnership in planning can be increased when certain types of key practices are used during preparation for planning and during the planning process itself.

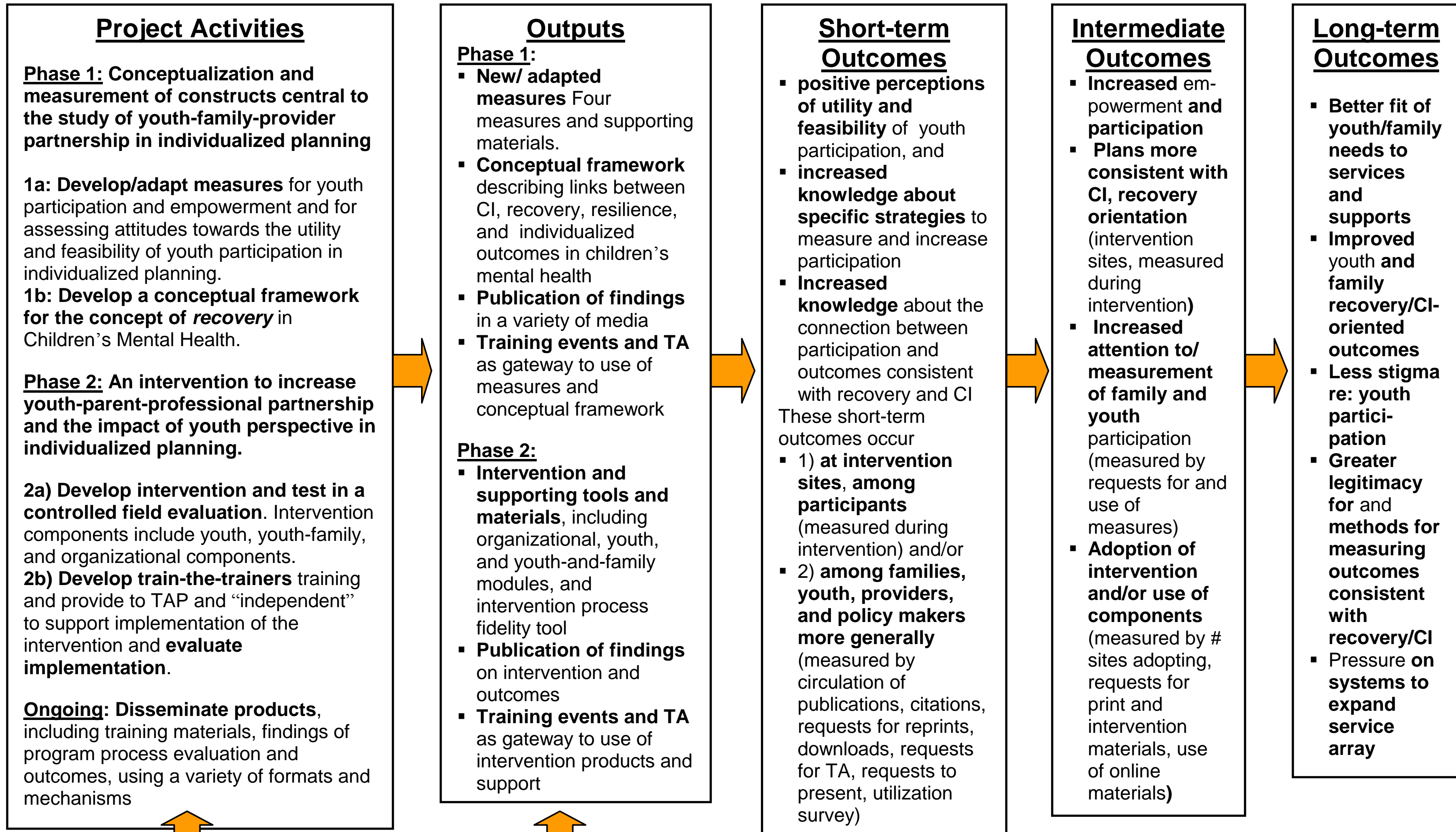
The central goal of this project is to develop and evaluate a cost-effective intervention to increase partnership that can be used across a variety of individualized planning contexts, including system of care, IEP, and transition from out-of-community placements. A second goal is to develop or adapt a series of measures to tap key aspects and outcomes of partnership in planning. A third project goal is to develop a conceptual framework for understanding how ***recovery***—an idea that has been seminal as adult consumers advocate for greater individualization in mental health service systems—applies to children and adolescents with emotional and behavioral disabilities, and to their families. Finally, an overall goal of the project is to demonstrate the feasibility and practicality of building partnerships in planning, thereby helping to reduce the **stigma** that currently prevents youth and their families from realizing the benefits of individualized planning. This research builds on the Center's ongoing research and national leadership in the areas of individualized planning; participation, empowerment, and self-determination.

Literature Review and Rationale

The President's New Freedom Commission places at the core of its vision of a transformed mental health system the idea that every child with a serious emotional disturbance will have a comprehensive, individualized plan of care (New Freedom Commission on Mental Health, 2003). Such plans are to be developed by youth, families, and providers working in full partnership to select treatment goals and strategies, and to monitor progress. A similar vision is expressed in the principles that guide systems of care for children's mental health, which highlight the need to develop consumer-family-professional partnerships across all levels within systems of care (Stroul, 2002) and to provide care in a manner that is individualized to meet the unique needs of particular children and families.

The system of care principles and the New Freedom Commission report are both clear in expressing a philosophical commitment to the need for mental health plans that are individualized and derived in partnership with consumers and families. Both thus reflect values that have emerged from the consumer and family advocacy movements, and that have increasingly informed mental health policy at local, state, and national level. The Commission's recommendations on individualized planning have also been importantly influenced by the concept of *recovery*, which was introduced by adult consumers as they argued that it possible for them to live personally meaningful and satisfying lives, and to take on desired roles in society, despite serious mental illness (Anthony, 1993; Deegan, 1988). Central to recovery is the idea that a consumer is best served when he or she is empowered to make decisions and exercise self-direction while working towards personally valued goals and a personal vision of community integration.

Figure (R-3.1) Partnership in Individualized Planning Logic Model



Beyond philosophical imperatives, there is reason to believe that individualized planning undertaken in partnership can be an effective means for achieving positive outcomes for children with emotional and behavioral challenges and for their families. The New Freedom Commission report cites a series of potential benefits, including: increased community integration; improved service quality, coordination, and array; and, ultimately, higher quality of life. Growing research evidence bolsters arguments for the importance of family and youth participation in treatment planning. For example, parent and youth participation in planning for children with emotional and behavioral difficulties has been linked to enhanced selection of treatment goals and strategies (Williams, 1988), improved treatment outcomes (Byalin, 1990; Williams, 1988) and service coordination (Koren et al., 1997), and increased family empowerment (Curtis & Singh, 1996). Within the context of Individualized Education Planning (IEP) for students with disabilities, greater student participation has been credited with increased graduation rates and better employment and post-secondary outcomes (Benz, Lindstrom, & Yovanoff, 2000). Active, empowered participation in individualized planning is also consistent with the development of self-determination (Van Reusen & Bos, 1994), and self-determination has been linked to positive post-secondary outcomes for students with disabilities (Wehmeyer & Palmer, 2003; Wehmeyer & Schwartz, 1997). Partnering with youth and families in individualized planning thus represents a potentially powerful mechanism for improving the often poor outcomes of youth with emotional and behavioral disabilities during the period of adolescence and young adulthood.

Unfortunately, individualized planning that includes families and youth often falls far short of the vision of full partnership expressed in the Commission's report. Evidence suggests that providers are often not supportive of the idea of family/parent participation (Johnson et al., 2000). Regarding partnership with youth, one study (Doucette, Andrade, Rauktis, McDonough, & Boley, 2004) found that mental health counselors were relatively unconcerned with treatment goals that a young person might have for him or herself, while the youth in the study believed this to be the most important aspect of a positive therapeutic relationship. More generally, several studies demonstrate poor level of agreement between youth and professionals and among youth-parent-provider triads regarding either the youth's needs or the goals of mental health treatment (Hawley & Weisz, 2003; Yeh & Weisz, 2001). In the IEP context, students have re-ported low participation and that they do not feel "ownership" of the goals included on their plans (Lovitt & Cushing, 1994; Powers, Turner, Matuszewski, Wilson, & Loesch, 1999). Our own and others' research has also documented a sense among providers that they lack knowledge about how to involve youth more effectively in planning (Snyder & Shapiro, 1997; Walker & Schutte, in press b). These findings are particularly important given that agreement on desired outcomes across stakeholder groups may be associated with improved outcomes from care (Kendall, Panichelli-Mindel, & Sugerman, 1997).

There is reason to believe that carefully constructed practices can increase partnership in planning. Several studies have shown that family and/or youth participation in individualized planning can be increased through the use of various practices related to meeting preparation and/or process (Brinckerhoff & Vincent, 1986; Powers et al., 2001; Van Reusen & Bos, 1994). A far greater body of research focuses on the more general question of how to increase participa-tion and influence of people who are relatively disempowered during group and team discussion and decision making. This literature documents the effectiveness of a range of specific practices or "mini-interventions." (We review these findings at length, as well as their implications for practice within the context of individualized service/support planning in Walker & Schutte, in press a).

Thus it appears there is the possibility for--and much to be gained from—increasing the level of family-youth-provider collaboration and partnership in individualized planning. The central goal of this

project is to develop and evaluate an intervention to increase partnership that can be used across a variety of individualized planning contexts, including system of care, IEP, and transition from out-of-community.

For the intervention, we will particularly focus on increasing the use of a **small number of specific, concrete *practices*--**strategies, interpersonal behaviors, or techniques—for which there is research evidence suggesting a significant influence on the nature and impact of participation through a) preparing meeting participants (including youth and families participating in individualized planning) before meetings and b) increasing the impact of relatively disempowered perspectives (particularly family and youth perspectives) during group discussions and decision making (including specifically during individualized planning). We will also consider practices that are consistent with available research and that have been described and submitted as best practices to the National Wraparound Initiative (Bruns, Osher, Walker, & Rast, in press) by people recognized as national leaders with high levels of expertise in that particular form of individualized planning. Other best practices can be extracted from the many published curricula for self-determination.

Several interventions have been shown to increase student participation in IEPs (e.g., Abery et al., 1994; Field & Hoffman, 1996; Powers et al., 2001; see also the review in Test, et al, 2004); however, many of the interventions, particularly those with the greatest amount of evidence for effectiveness, require significant amounts of time and resources to carry out. Furthermore, few of these approaches focus on the inclusion of parents or other caregivers, and studies of effectiveness tend to have relatively weak designs, to lack fidelity measures, and to focus on youth with learning disabilities (Test, et al., 2004). In contrast, the proposed intervention proposes to measure fidelity, to include caregivers, to focus on youth with emotional and behavioral disorders, and to intervene in a targeted but fairly circumscribed manner. By focusing on a limited number of potentially powerful practices, and also by intervening at the organizational level to make an existing planning process more hospitable to youth and family participation, we plan to produce an intervention that organizations and agencies can implement without needing to devote large amounts of time or new resources to the effort.

We recognize that we will need appropriate tools to evaluate the intervention. Thus one goal of the project's first phase is to develop or adapt a series of measures for key aspects of partnerships and outcomes that we expect. We also anticipate that such measures will be of use to the field, as increasing attention is focused on youth and family participation and empowerment in planning. Another goal of the project's first phase is to develop a conceptual framework for understanding how *recovery*—an idea which has been seminal as adult consumers advocate for community integration and self-determination—applies to children and adolescents with emotional and behavioral disabilities, and to their families; and how recovery relates to the allied themes of strengths/assets, resilience, and community integration. Finally, an overall goal of all of the research, training, and dissemination activities of the project is to combat perceptions that it is not feasible or desirable to build planning partnerships with adolescents and youth with emotional or behavioral disorders. Demonstrating the feasibility and practicality of such an approach will help to reduce the *stigma* that currently prevents these young people from accessing the benefits of individualized planning.

Hypotheses/Research questions

Existing measures can be adapted for use in assessing important elements related to youth/family participation in comprehensive individualized care planning across contexts including system of care, individualized education planning, and residential care/transition; and these measures will display acceptable psychometric properties.

(Research question) How can the concept of recovery as described in the literature on psychiatric rehabilitation for adults be applied within the context of service delivery in children's mental health?

Compared to the comparison group, youth participating in the *PIP* intervention will report higher levels of empowerment, participation in planning, ownership of goals, perceptions of the utility and feasibility of their participation in planning, and contributions to their plans.

Compared to family members in the comparison group, families participating in the intervention will report higher levels of empowerment, participation in planning, perceptions of the utility and feasibility of youth participation in planning, and contributions to their children's plans.

Compared to their counterparts in the comparison group, families and youth in the intervention group will report greater agreement with one another regarding the goals on the plan and higher levels of collaboration in producing the plan.

Compared to pre-intervention ratings, post-intervention staff ratings will indicate more favorable perceptions of the utility and feasibility of youth participation in planning.

Compared to plans produced during the pre-intervention control period, plans produced during and after the intervention period will include a greater variety of goals and more goals that are consistent with a community integration and recovery orientation.

The intervention can be disseminated to organizations (including family organizations and human service agencies) serving diverse communities, with positive results, through the use of train-the-trainer and self-implementation models.

Methods

Cultural Competence, Family/Youth Involvement, and Advisors

Key aspects of methods are summarized in the Table (C.1), Research Projects at-a-Glance, on page **Error! Bookmark not defined.** and described in detail by phase, below. Throughout our project we intend to pay special attention to working in a manner that expresses a commitment to youth and family participation and to cultural competence as informed by the Cultural Competence Research Standards outlined by the Work Group on American Indian Research and Program Evaluation Methodology (Davis et al., 2002). We will strive to work in a collaborative and participatory manner, and have already begun consulting with youth and family members as project advisors. In collaboration with the other two projects focusing on transition-aged youth (projects R1 and R2), we will continue to convene advisory groups including diverse youth and family members throughout the project's work, and we expect their active participation in all phases of the project, from the further specification of research questions and methods to the analysis of data and dissemination of findings. Also in collaboration with the other two projects, we anticipate ongoing input from a group of advisors with considerable expertise in the areas of transition, individualized planning, and community integration (See Appendix D). This project expects to benefit in particular from the expertise of Eric Bruns, Stephanie Lane, and Josie Bejarano. We are also committed to including youth and families from diverse cultural and socio-economic backgrounds in the study sample for measure development in phase 1 of the project and in the intervention test sites for phase 2.

Phase 1a.

In this phase of the project, we will adapt a series of measures for use in assessing key aspects related to youth and family partnership in individualized planning. The Youth Empowerment Scale-Services (YESS) and the Youth Partnership in Planning Services scale (YPPS) will be adapted from scales used to measure similar constructs with adult family members of children with mental health challenges. (Friesen & Pullman, 2002; Koren, DeChillo, & Friesen, 1992) (α=.95 and α=.86, respectively). The Beliefs about Youth Partnership in Planning (BYPP) measure will be adapted from two of the subscales from the Measure of Beliefs about Participation in Family-Centred Services (MBP-FCS) (King et al., 2002)(α=.69 to .79). This measure is intended to capture respondent's perceptions about the feasibility and utility of partnering with youth in individualized planning. For the adaptation of each youth measure, the first step will be to reword the existing items and develop a pool of additional items from the literature of youth views on participation and services. We will then ask adolescents and young adults from diverse backgrounds (n=12) to respond to the proposed items and suggest changes in wording or other alterations, soliciting their feedback through a semi-structured interview. If our review of the literature and emerging results suggest that the adult versions of the MBP-FCS also require revision for our purposes, we will conduct similar interviews with family members and service providers.

During this same time period, we will be developing and pilot testing a semi-structured interview, the Contributions to Planning Interview (CPI). The CPI interview will go through an individualized plan goal by goal to elicit ratings of the extent to which the interviewees feel they had a role in creating that goal, the extent to which they endorse the goal, and the extent to which the goal is important or meaningful to them. We will pilot test the CPI interview with a sample of youth, family members, and providers (n=30), later debriefing them about their understanding of the questions and asking them to amplify their responses.

Based on the feedback from these activities, we will select items and wording to be included in the measures that will be administered by telephone interview to approximately 200 youth who are currently participating in comprehensive individualized planning either a) as part of case management or wraparound in systems of care, b) within an IEP process, or c) in preparation for transition back to the community from an out-of-home setting (Letters of collaboration from several agencies providing such services are included in Appendix D). Collaborating agencies and family organizations have agreed to distribute information and informed consent forms to potential participants. After they return these forms to us, along with contact information, we will contact them to arrange an interview. Interviewees will be asked to respond to the three scales. Additionally, they will be asked to respond to selected items from the CPI; however for the purposes of this interview, respondents will be asked to identify goals and then rate the goals in terms of the extent to which they (the respondents) felt they had a role in creating the goal, the extent to which the goal is personally meaningful to them, etc.

Data analysis will use standard factor analytic procedures to examine item loadings and the internal consistency for the scales. Items may be dropped to shorten the measure or due to loading. Test-retest validity will be computed on the sub-sample of responding to the instruments twice. Validity will be examined by comparing patterns of results across the measures and between the measures and the ratings and open-ended items (e.g. naming one or two goals from the plan) drawn from the CPI.

At the completion of phase 1a, we expect to have finalized the content of the three measures and the structure for the CPI interview. Expected products include the measures themselves, technical

assistance packages to support use of each measure, and research reports about the measures' properties and development.

Phase 1b.

In this phase, we plan to develop a conceptual framework for understanding how the concept of recovery applies within the context of services and supports for children with mental health challenges and their families. We intend to begin with a review of literature as a means of developing a conceptual framework showing the interrelationships between themes of recovery, resilience, strengths, assets, self-determination, and community integration. Working with the Project on *Community Integration for Transition-Age Youth (Project R-1)* we also plan to develop questions for the focus groups on these topics and to integrate findings within the conceptual framework. After drafting a framework and narrative, we will distribute it to our advisory group as well as additional stakeholders for review. After acquiring feedback from the group, we will revise the framework and narrative and prepare products, including descriptions of the framework that are accessible through a variety of formats.

Phase 2a.

The initial version of the intervention will be developed through a strategy focusing on the research findings outlined in the literature review. For the intervention, we will particularly focus on increasing the use of *a small number of specific, concrete practices* that help build partnership and increase participation through a) preparing meeting participants (including youth and families participating in individualized planning) before meetings and b) increasing the impact of relatively disempowered perspectives (particularly family and youth perspectives) during group discussions and decision making (see the discussion in the concluding sections of the literature review for this project about the nature of and sources for these practices). The goal is to select for the intervention a small number of potentially powerful and specific *key practices* that can be recognized by all participants when the practices occur. Based on the practices included in the intervention modules, we will develop a *PIP* process fidelity tool. The tool, a pencil-and-paper checklist, is designed to be self administered in about two minutes, and will assess each participant's views of whether or not the *specific practices* that the intervention prescribes have indeed occurred. Participants will fill out one part of the tool at the conclusion of the preparation sessions, and a different part of the tool after each planning meeting. The tool is intended to serve not only as a test of whether or not the practices occurred, but also as a constant reminder—particularly during the planning process—of the small set of key practices that are the focus of the intervention.

When the first draft of the intervention is completed, we will seek feedback from advisors, as well as additional families, youth, and providers. Following revisions, we will pilot test the preparation phases with a small number of youth/families and pilot test the organizational training in a local agency, with final revisions made.

For the "alpha" (first generation) testing of the intervention, we will partner with two agencies in the community (Portland and Seattle areas) that are providing individualized planning (letters of collaboration from agencies open to serving as intervention sites are included in Appendix D). We plan to randomize team care coordinators/facilitators into the intervention condition within each site so that approximately 25 youth are receiving the intervention at each site, for a total of 50 youth (together with their families) in the intervention condition. We have discussed with agency management ways of forming year-long supervisory groups such that intervention staff receive their training and group

supervision together, while non-intervention ("wait-list") staff receive similar hours of supervision and training as usual. Care coordinators/ facilitators with a total caseload of approximately twenty-five youth will form the comparison sample, for a total of 50 youth with their families in the comparison group. Data will be collected before planning commences (T1), after the third planning meeting (T2), and 10 weeks later (T3). Data will be collected during telephone interviews, and the measures to be used at each time are listed Table (R3-1). In addition to the measures listed in the table, family and youth information will be gathered at T1, and ratings of progress toward goal attainment will be assessed at T3. Telephone interviews will be administered by project staff.

Table (R-3.1) Measures used in the evaluation of the PIP intervention		
T1 Before planning	T2 After meeting 3	T3: T2+10 weeks
Youth: BYPP YESS	YPPS BYPP CPI	YPPS YESS BYPP CPI
Caregiver: BYPP FES	FPP FES CPI	FPP FES BYPP CPI
Staff: (pre-training) BYPP		(6 mos. out) BYPP

Implementation of the intervention will begin with the organizational training component. We plan for the training to take place in one half-day session followed by four hour-long sessions that will occur before any youth and families enter the intervention. Meeting facilitators and other key personnel will have the opportunity to learn and rehearse the intervention practices. Further 20-minute training sessions will be scheduled once per month for the duration of the intervention. Training sessions will include video- or DVD-based simulations of meeting portions that will be discussed and rated (using the fidelity tool) by participants. Fifty youth, together with their parents or other caregivers (where feasible) will receive the preparation during two 90-minute sessions prior to planning. The first session will be with youth only, and will focus on explaining the individualized planning process, developing goals, and strategies for communicating around goals. The second session will include youth and families, and will focus on joint goal building. During this session, youth and families will also be given video- or DVD-based materials to practice recognizing the key intervention planning practices. All participants (youth, family, and care coordinators/facilitators) will learn how to recognize target intervention practices, and how to use the fidelity tool. To analyze the data, we plan to use appropriate approaches of inferential statistics (hierarchical linear modeling (HLM), multiple regression/MANOVA, log-linear modeling, non-parametric methods) to test the study hypotheses.

Phase 2b.

Based on feedback and results of phase 1a, final training materials will be developed and packaged. Materials will include the video- or DVD-based simulations for learning about key intervention practices. The intervention will then be ready for "beta" testing. In this phase, we will evaluate the intervention using a strategy similar to the alpha test; however the agencies or organizations themselves will implement the organizational training, provide the youth and family preparation, and gather the data, while we provide technical assistance and data analysis. We plan to pursue this beta testing through two channels. The first of these is through a partnership with the Technical Assistance Partnership at the American Institutes for Research, which provides TA to grantee sites of the Comprehensive Community Mental Health Services for Children and their Families Program. We will train their TA providers who will, in turn, provide support for intervention implementation at two CMHS grantee sites. The other channel for beta testing is through working with agencies or organizations (e.g. a family organization) wishing to implement the intervention independently. Evaluation in these sites would be based on a pre-

post model where baseline data would be gathered for several months of "treatment as usual" prior to the intervention. In both sorts of beta test sites, we envision that the activities involved in the implementation would be undertaken by existing personnel, through making minor changes to their job duties and expectations. Many agencies using individualized service planning approaches already do engagement and preparation, and the intervention activities would represent mostly a restructuring of these efforts. The precise nature of the data needed for beta test evaluation will depend on the outcomes of phase 2a; however, it is possible that only a small number of measures will be needed. Data analysis will likely be similar in nature to that envisioned in phase 2a.

Training activities and products

We anticipate demand for training for organizations or communities interested in using the measures developed in phase 1 of the project. To meet that demand, we plan to offer brief (single session events of 1.5-4 hours/event) training sessions to introduce potential users to the measures and provide information about the measures' development and properties, as well as information about when their use is appropriate, how to collect data, and so on. Training will be offered at national and local conferences, institutes, and/or training meetings, and we estimate that at least 200 participants will attend. To support this training, we will develop a training packet handout that covers the same information that is presented during the training session. Training participants will be able to take this printed information back to their home organizations to share with others involved in the selection of data gathering tools. We will also provide participants with links to our web based TA packets (see TA products, below) and ordering information so that they can receive appropriate information if they decide to explore use of the measures further.

We will also offer training to sites participating in the alpha test of the intervention. This training will focus on a) providing background information and an orientation to the purposes and logic of the intervention, b) teaching staff the key practices from the intervention, c) providing opportunities for staff to rehearse the practices, and d) learning to use the CPI tool. A set of materials will be developed to support this training. These training products will include a print workbook that summarizes key information to be presented during the training sessions and provides space for written reflection and responses to activities. We will also develop video- or DVD-based simulations that demonstrate the practices, and that provide a stimulus for participants to critique or respond to simulated meeting events or interactions. Some of these simulated situations will be reenacted meeting segments videotaped in our earlier research projects (Powers et al., 2001; Walker, Schutte, & Van Wormer, in press).

For the beta testing, we will develop a full package of materials so that others will be able to provide the organizational training in the beta test sites. The package will include the workbook and simulations, as well as session outlines and descriptions of associated activities. We will offer train-the-trainer training to staff members of the TAP to support implementation of the intervention in beta test sites as described in phase 2b, above. This training will provide an outline of information and activities that need to be covered in order to train staff to a) orient the youth and family to the purpose of the planning and their expected roles in it (including helping to monitor fidelity to a partnership model for planning); b) implement a series of specific steps in a strengths-based process to assist the youth/family in developing specific goals; c) teach the youth and family to recognize the key intervention practices so that they can recognize when participants in the planning process (including the youth and family themselves) are using the practices, and d) show youth/families how to use the process fidelity tool to indicate which key intervention practices have occurred during a planning session. We will offer a similar train-the-

trainer training materials and/or TA to agencies that are self-implementing the intervention as described in section 2b.

Technical Assistance Activities and Products

We anticipate receiving requests by phone and email, or through our website, for technical assistance related to use of the measures developed in phase 1. In order to respond to these requests (via phone, email, or local on-site consultation), we plan to prepare a TA packet that includes information about measure development, appropriate use, properties, and scoring and that includes the measure itself. We will also prepare parallel information in a non-technical FAQ (Frequently Asked Questions) format. These materials will be available in print and electronic versions, and will be available to support customized TA as well as for more general dissemination.

We also anticipate requests for TA to be offered directly to sites implementing the intervention during the beta test, as well as those sites choosing to implement it completely independently. For sites in the beta test, we will offer consultation and a small number of site visits. For the other sites, we will offer consultation and dissemination products via phone, mail, and email.

Dissemination products and activities

We will prepare for general dissemination in both print and web-based electronic versions all of the training and TA products described above, including the TA package and FAQ for each of the measures developed in phase 1 and the training package for the organizational and family/youth preparation components of the *PIP* intervention. This latter will also include video- or DVD-based components described above for use in learning to identify and rehearse the key intervention practices. In addition, we plan to prepare reports based on our findings and the practical implications of the findings. These reports will be made available through a variety of formats and media, including articles in peer-reviewed journals; articles in non-technical reviews, journals and magazines, including *Focal Point*; web-based informational pages on our website; and research summaries to be disseminated through *Data Trends*. Finally, we plan to record a brief video/DVD/CD-ROM that features information about our findings interspersed with youth telling their stories of successful participation in individualized planning. In addition to the normal center-wide dissemination channels, we plan to partner with the TAP to distribute our materials to the CMHS grantee sites. We also plan to provide informational about our research results during sessions at several national conferences, with estimated participants of about 400.

Table (R-3.2) Partnerships in Individualized Planning Timeline

	RTC Year 1				RTC Year 2				RTC Year 3				RTC Year 4				RTC Year 5			
	Oct-Dec 04	Jan-Mar 05	Apr-Jun 05	Jul-Sept 05	Oct-Dec 05	Jan-Mar 06	Apr-Jun 06	Jul-Sept 06	Oct-Dec 06	Jan-Mar 07	Apr-Jun 07	Jul-Sept 07	Oct-Dec 07	Jan-Mar 08	Apr-Jun 08	Jul-Sept 08	Oct-Dec 08	Jan-Mar 09	Apr-Jun 09	Jul-Sept 09
Convene advisory group																				
Phase 1a: Measure development																				
Identify sites/participants																				
Literature review /revise measures																				
Feedback on revised measures																				
Gather data																				
Analyze																				
Phase 1b: Concept of recovery																				
Literature review																				
Draft theory paper/feedback																				
Feedback from youth and families																				
Incorporate focus group findings																				
Develop and disseminate products																				
Phase 2a: Develop intervention, “alpha” test																				
Identify alpha test sites																				
Develop/pilot test intervention components & process fidelity tool																				
Deliver organizational training																				
“Booster” training sessions																				
Deliver intervention and gather data																				
Analyze data, write up																				
Phase 2b: “Beta” test intervention																				
Work with TAP to identify sites																				
Revise/package intervention materials																				
Train TAP staff /Training and/or TA to “independent” sites																				
Collect data from “beta” sites																				
Analyze data, complete products																				