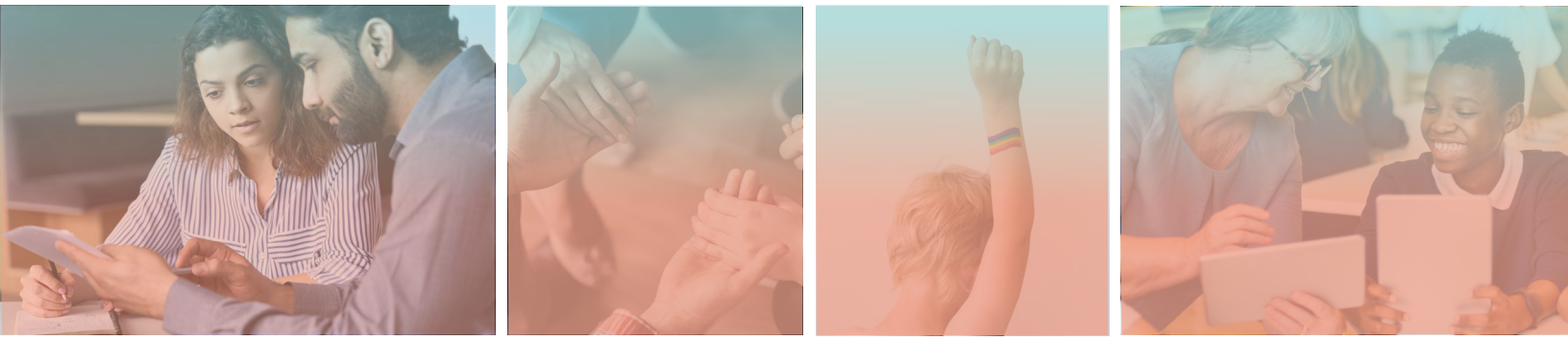
Allegheny County AFFIRM Caregiver Implementation:

Implementation with Resource Families

Project of the National Quality Improvement Center on Tailored Services, Placement Stability and Permanency for Lesbian, Gay, Bisexual, Transgender, Questioning, and Two-Spirit Children and Youth in Foster Care



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QIC LGBTQ2S

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The QIC-LGBTQ2S

The National Quality Improvement Center on Tailored Services, Placement Stability, and Permanency for LGBTQ2S Children and Youth in Foster Care (QIC-LGBTQ2S) was a project led by the Institute for Innovation and Implementation at the University of Maryland School of Social Work (UMSSW). UMSSW was funded by the U.S. Department of Health and Human Services' (HHS) Administration for Children and Families (ACF) Children's Bureau (CB) in 2016 to design, implement, and evaluate evidence based programs for LGBTQ+ and Two-Spirited children and youth in foster care. UMSSW selected four child welfare agencies following a competitive application process as local implemenation sites (LIS) to help design, implement, and evaluate promising models in Cuyahoga County, Ohio; Wayne, Oakland and Macomb Counties, Michigan; Allegheny County, Pennsylvania; and Prince George's County, Maryland. Together, these four LIS implemented over 15 interventions aimed at improving the outcomes for foster youth with diverse SOGIE and their families. To learn more about the other interventions and initiatives involved in the QIC-LGBTQ2S, visit www.sogiecenter.org.

Given the complexity of implementing evidence-informed and evidence-based models in child welfare, the QIC-LGBTQ2S established frameworks for LIS to follow as they implemented their selected interventions. Each LIS engaged in a Quality Learning Collaborative (QLC) process, which was guided by implementation science, using the HHS Permanency Innovations Initiative[1] (PII) framework, which was informed by the National Implementation Research Network (NIRN) model and designed to address implementation challenges. The NIRN/PII Approach entails six implementation stages: 1) Exploration, 2) Installation, 3) Initial Implementation, 4) Full Implementation, 5) Replication/Adaptation, and 6) Broad-Scale Rollout[2]. The QIC-LGBTQ2S team worked collaboratively with LIS to implement their identified interventions, following a rapid cycle improvement strategy called a Plan-Do-Study-Act (PDSA) cycle, to refine interventions throughout the implementation stages until their readiness for full implementation was demonstrated. The QIC-LGBTQ2S's theory of change included that, by paying attention to the three categories of NIRN's implementation drivers (competency, organization, and leadership), the LIS could be supported through the QLC model to design, implement, and participate in evaluating interventions that would improve outcomes for LGBTQ+ youth in child welfare.

A Note on Terminology

This Implementation Guide uses the acronym "LGBTQ2S" to describe the specific project name. For these purposes, the acronym stands for lesbian, gay, bisexual, transgender,

1 For more information on the Permanency Innovations Initiative, visit Permanency Innovations Initiative (PII) Project Resources | The Administration for Children and Families (hhs.gov)

2 Murray, A., Campfield, T., Dougherty, S., & Sweet, K. (2011). Timely permanency through reunification. Casey Family Programs. https://www.casey.org/media/TimelyPermanency.pdf; Fixsen, D., Blase, K., Naoom, S. & Duda, M. (2015). Implementation drivers: Assessing best practices. National Implementation Research Network (NIRN). https://nirn.fpg.unc.edu/ai-hub?o=nirn

questioning or queer, and Two-Spirit. This acronym is not inclusive of all diverse sexual orientations, gender identities, or expressions (SOGIE). In other places "diverse SOGIE" or "LGBTQ+" are used in order to be more inclusive. Language is always evolving, and older tools or resources provided within this guide, or linked to this guide, may use different letters to represent other identities. For more information on language, readers can visit the National Quality Improvement Center Website for an inclusive glossary of terms.

Purpose of this Implementation Guide

The purpose of this guide is to document the efforts, successes, and lessons learned from Allegheny County as a result of the implementation of the AFFIRM Caregiver program with foster parents within the county to better serve LGBTQ+ youth.

AFFIRM Caregiver Model

AFFIRM Caregiver is a group-based, education, and coaching series that is delivered in roughly 9 hours spread out over 3-4 sessions, depending on whether the series is offered in-person or virtually. AFFIRM Caregiver gives parents, or other caregivers, both the knowledge and skills to be able to provide affirming and supportive care for their LGBTQ+ youth. It helps caregivers identify the potentially traumatic impact of homo/bi/transphobia on LGBTQ+ youth and teaches them to understand their child's emotional and behavioral reactions through a trauma-informed lens. Through a variety of didactic and interactional activities, the Affirmative Caregiving model helps caregivers adopt an affirming approach toward their youth's LGBTQ+ identity as a critical step towards creating safe and healthy environments for LGBTQ+ youth. The primary goals associated with the Affirmative Caregiving approach includes:

1. Increasing knowledge and understanding about the impacts of homo/trans/bi phobic stigma (including parental rejection) on the lives of LGBTQ+ youth;
2. Recognizing the importance of affirmative reactions to LGBTQ+ youth;
3. Decreasing unhelpful thoughts, attitudes, and behaviors rooted in homo/trans/bi phobic stigma;
4. Understanding the potential role and impact of trauma on the lives of LGBTQ+ youth;
5. Providing identity affirming support to LGBTQ+ youth;
6. Accessing resources that support affirming caregiving strategies; and
7. Engaging in caregiver self-care.

AFFIRM Caregiver helps parents and other caregivers see the world through their child's eyes and helps them learn what to do to be the most supportive. Through the implementation of this intervention and other efforts to improve practice around serving LGBTQ+ youth and their families, Allegheny County has seen success in providing these services around sexual orientation, gender identity, and expression (SOGIE). Their work is documented in this guide to help other agencies start their own initiatives and programs towards the same goals.

Exploration (Pre-Implementation)

Population Background

Youth who identify as LGBTQ+ are more likely to experience negative interactions with child welfare professionals than their peers who identify as heterosexual and cisgender[3]. A Williams Institute study found that youth identifying as LGBTQ+ were twice as likely to report poor treatment by the foster care system. The same study found that they were twice as likely to be placed in residential facilities and three times more likely to be hospitalized for emotional reasons compared to their peers who identify as heterosexual and cisgender[4].

Many LGBTQ+ youth enter foster care for the same reasons as their heterosexual and cisgender peers; however, youth who identify as LGBTQ+ may have added trauma from being rejected or harassed because of their sexual orientation, gender identity, or gender expression[5]. Examples of this type of trauma may include LGBTQ+ youth being blamed for the SOGIE-related harassment and abuse they have experienced[6]. Crucial to reunification attempts, practitioners must be able to provide education, support, and guidance to families of youth who identify as LGBTQ+[7]. However, a lack of evidence-based practices, or even established programs, in child welfare for LGBTQ+ youth have left a gap in services for this population.

Selection as a Local Implementation Site for the QIC-LGBTQ2S

Allegheny County was one of four local implementation sites (LIS) nationally who were selected and supported by the QIC-LGBTQ2S to design, implement, and help evaluate select programs. Allegheny County, Department of Human Services, Office of Children, Youth and Families (CYF) applied in a competitive process to be considered and had to propose a set of interventions that would meet the goals of the QIC-LGBTQ2S. The interventions proposed had to meet the unique needs of children and youth with diverse SOGIE in foster care, with a focus on:

1. Appropriate methods for safe identification, assessment of individual needs, and data collection related to population demographics and permanency, well-being, and placement stability outcomes, with attention to addressing confidentiality and privacy issues
2. Engagement in effective community, group, family, and individual services

3 Wornoff, R., & Mallon, G.P. (Eds.). (2006). Lesbian, gay, bisexual, transgender and questioning youth in child welfare. Washington, DC: Child Welfare League of America.

4 Wilson, B. D., Cooper, K., Kastanis, A., & Nezhad, S. (2014). Sexual and gender minority youth in foster care: Assessing disproportionality and disparities in Los Angeles. Los Angeles: The Williams Institute, UCLA School of Law.

5 Matarese, M., Greeno, E. and Betsinger, A. (2017). Youth with Diverse Sexual Orientation, Gender Identity and Expression in Child Welfare: A Review of Best Practices. Baltimore, MD: Institute for Innovation & Implementation, University of Maryland School of Social Work.

6 Wilbur, S., Ryan, C., & Marksamer, J. (2006). Best practices guidelines: Serving LGBT youth in out-of-home care. Washington, D.C.: Child Welfare League of America (CWLA).

7 Ryan, C., Russell, S.T., Huebner, D., Diaz, R. & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. Journal of Child and Adolescent Psychiatric Nursing, 23(4), 205–213.

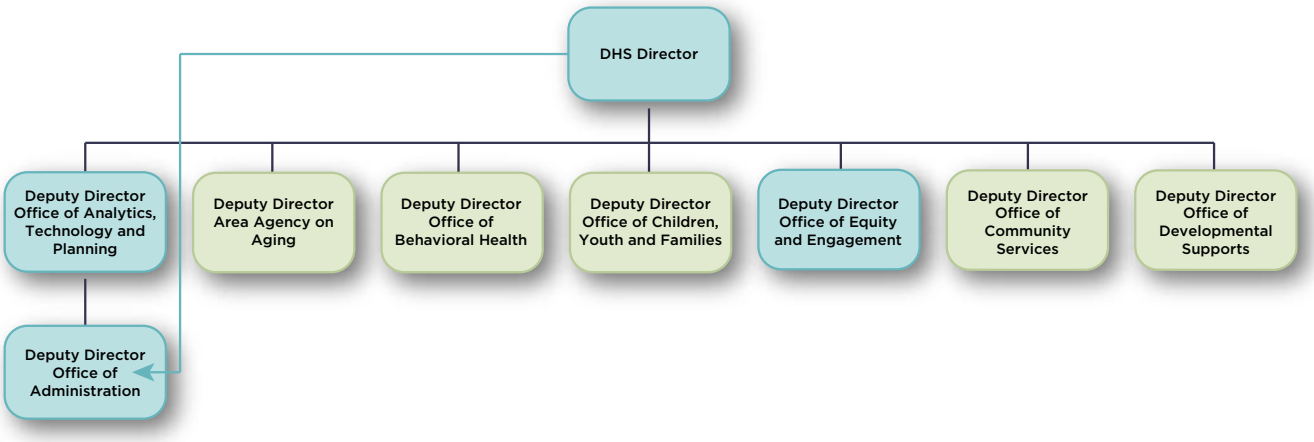
3. Placement stability supports to children, youth, and caregivers, including families of origin in reunification situations
4. Permanency innovations for those not reunified with families of origin
5. Increased knowledge, competence, and responsiveness of youth with diverse sexual orientations and gender identities and expression (SOGIE) by agency staff, caregivers, and service providers in congregate care settings.

The sections below will describe Allegheny County's efforts to improve their culture and service offerings for LGBTQ+ youth in foster care and their families.

Department of Human Services Background

The Allegheny County Department of Human Services (DHS) was created in 1997 to consolidate the provision of human services across Allegheny County. In addition to its Executive Office, DHS encompasses three support offices and five program offices.

Figure 1: Allegheny County Department of Human Services Organizational Chart



DHS is responsible for providing and administering publicly funded human services to Allegheny County residents and is dedicated to meeting these human service needs, particularly for the County's most vulnerable populations, through information exchange, prevention, early intervention, case management, crisis intervention and after-care services.

DHS provides a wide range of services, including services for older adults; mental health, and drug and alcohol services (includes 24-hour crisis counseling); child protective services; at-risk child development and education; hunger services; emergency shelters and housing for the homeless; nonemergency medical transportation; and services for individuals with intellectual and/or developmental disabilities. In any given year, DHS serves approximately 200,000 individuals (about one in six county residents) through an array of approximately 1,700 distinct services. Most services are administered through a network of about 300 contracted provider agencies.

Allegheny County, Pennsylvania

Allegheny County, home of the City of Pittsburgh, is one of 67 counties in the Commonwealth of Pennsylvania. The population size is approximately 1.2 million people, with about 300,000 living within city limits. The County's population is 82 percent White and 13 percent Black. The percentage of people of color is higher within the City of Pittsburgh at 23 percent (26% Black). The city is ranked among the top 20 most segregated cities based on analyses of 2010 Census data. The LGBTQ+ communities are geographically segregated by race in the same way as the general population.

A countywide anti-discrimination ordinance inclusive of protections based on sexual orientation, gender identity, gender expression, and marital status was passed on July 1, 2009, by the Allegheny County Council. As of December 2020, no statewide protections from discrimination based on sexual orientation, gender identity or gender expression (SOGIE) exist. The five counties immediately surrounding Allegheny County do not provide any legal protections from discrimination on the basis of SOGIE.

Marriage equity came to Pennsylvania on May 20, 2014, after a U.S. federal court judge ruled that the ban on recognizing same-sex marriages was unconstitutional. In 2016, Pittsburgh became the first municipality in Pennsylvania to ban sexual orientation and gender conversion therapy for minors. Allegheny County followed suit in February 2020.

Office of Children, Youth, and Families Background

Allegheny County's theory of change is grounded in the perspective that youth have better outcomes when they have safe, affirming, and loving caregivers. As such, the population for the AFFIRM Caregiver model focused on resource (foster/adoptive) families specifically recruited to provide care for teens in foster care as part of our Families for Teens programs. The intervention was also open to other interested resource caregivers from other foster/adoptive care agencies in Allegheny County, as well as kinship care providers.

As part of an overall effort by CYF to enhance their capacity to provide safe and supportive family homes for every teen involved in foster care, CYF was awarded a Diligent Recruitment grant through The Department of Health and Human Services in 2013. The Diligent Recruitment Initiatives were focused on recruiting, training, and supporting resource families for teens. CYF collaborated with their diversity partners in these efforts and focused on recruiting affirming families that identified as LGBTQ+ to meet the needs of all teens in care. These efforts were also focused on training current foster care staff and resource families in information related to SOGIE and developing standards for staff and resource parent training around this information. The Diligent Recruitment Initiative had also begun to provide coaching to internal casework staff to support them in improving their interactions with teens, including teens who identified as LGBTQ+, to promote a more engaging and relationship building efforts to improve outcomes.

In October of 2013, CYF launched the Families for Teens program in an ongoing effort to improve opportunities and outcomes for older youth in out-of-home care. The Families for Teens Initiative is a program made up of four partner agencies and was designed to expand foster care opportunities for older youth in foster care and decrease the number who must depend upon placement in group and/or congregate care. Strategies to support this initiative included stronger partnerships with providers of foster care services; a parent support network that offered help and guidance on fostering teens from experienced foster parents;

an advisory council of foster parents to inform policy and practice; and a marketing campaign to convince more families to open their doors to teens entering placement. A strong emphasis on serving LGBTQ+ youth was embedded into this initiative. This was an important effort since sexual and gender identity development is an evolving process for most people and there is no way of predicting when a youth might come out as LGBTQ+ while in care.

Prior to certification, all foster care applicants are required to participate in pre-service training, referred to in Allegheny County as "Tier 1". All certified Allegheny County foster parents are required to obtain 12 hours of training to maintain certification. Additions to that protocol included a second tier of training, or onboarding, for resource parents involved in the Families for Teens initiative that was to take place during the first year following a foster parents' certification and count toward their recertification training hours. This second-tier included the 9-hour AFFIRM Caregiver intervention, which was to be completed prior to the resource parents' recertification date. It is important to note, that the AFFIRM Caregiver intervention is not a training but was included in the training and certification process because that was the infrastructure that would allow for scale-up and sustainability of the intervention long-term.

System Readiness

Internal Readiness to Change

Organizational readiness for implementation refers to the extent to which an organization is both willing and able to implement and sustain a selected intervention[8]. When organizational readiness is high, effective, and sustained, implementation of a new program or practice is more likely; when readiness is low, change and implementation efforts are more likely to fail[9]. As such, assessing readiness is an important part of most change and implementation frameworks[10].

There are 3 primary factors that were investigated in Allegheny County:

- **Motivation** (e.g., belief in the need for and value of change, a shared commitment to change, compatibility and manageability of selected interventions, prioritization, and visibility of outcomes)
- **General capacity** (e.g., leadership, organizational innovativeness, culture, and climate that support change, resource availability and use, supportive structures, and staff capacity)
- **Intervention-specific capacity** (e.g., leadership buy-in and support, program champions, intervention-specific knowledge and skills, implementation supports, and relationships and networks)

8 Dymnicki, Wandersman, Osher, Grigorescu, & Huang. (2014). Willing, able, ready: Basics and policy implications of readiness as a kay component for scaling up implementation of evidence-based interventions. Office of the Assistant Secretary for Planning and Evaluation. Retrieved from Willing, Able -> Ready: Basics and Policy Implications of Readiness as a Key Component for Scaling up Implementation of Evidence-Based Interventions | ASPE (hhs.gov)

9 Weiner, B.J. (2009) A Theory of Organizational Readiness for Change. Implementation Science, 4, 67. http://dx.doi.org/10.1186/1748-5908-4-67

10 Meyers DC, Durlak JA, Wandersman A. The quality implementation framework: a synthesis of critical steps in the implementation process. Am J Community Psychol. 2012 Dec;50(3-4):462-80. doi:10.1007/s10464-012-9522-x.

Given the ongoing work being done in Allegheny County to build capacity for effectively and safely serving LGBTQ+ youth, the system, internal and external, was poised to support efforts in implementing the AFFIRM Caregiver intervention.

Putting practice expectations into writing was one of the most important actions taken to support workers. It was necessary because knowledge about best practices related to SOGIE was limited, and the culture within child welfare is one that is heavily policy driven. In the absence of written guidance, workers are reluctant to change their practice. That reluctance can be fueled by both a lack of clarity and fear of being reprimanded for acting out of alignment with agency practice. In 2015, DHS finalized and implemented six Standards of Practice related to SOGIE, with a seventh one finalized and rolled out in January 2017.

Standards of Practice

- Expectations for Serving LGBTQ+ Individuals
- Working with LGBTQ+ Individuals: Professional Expectations
- Communication Related to Sexual Orientation, Gender Identity, and Expression
- Housing and Placement with LGBTQ+ Individuals
- Making LGBTQ+ Appropriate Referrals
- Understanding Disclosure Related to SOGIE Information
- Documentation of Information Related to SOGIE

It should be noted that these standards applied to both the internal CYF staff as well as provider staff, including resource parents. In conjunction with the Standards of Practice, a train-the-trainer curriculum was developed in collaboration with a consortium of community organizations, child welfare staff, partner agencies, youth, and families to establish a network of trainers across Allegheny County. All CYF staff had been trained in this introductory level training, and the curriculum has been incorporated into CYF New Hire Orientation.

At the time of the implementation of the Standards of Practice and the roll-out of the train-the-trainer series, language was added to the specification manual for child welfare contracted providers, stating that all service providers are *"responsible for providing services to children, youth, and families regardless of their sexual orientation, gender identity, or gender expression. All sexual orientations, gender identities, and expressions are to be affirmed, and no efforts shall be made to change any client's identity or expression thereof. The provider is responsible for ensuring that all staff will be trained on sexual orientation, gender identity, and expression within six months of employment."*

While CYF was beginning the process to increase capacity to support healthy sexual and gender identity development for all children and youth in child welfare, consultation services were contracted with a local LGBTQ+ counseling center. These services included phone consultations, on-site consultation and case planning, special unit consultations, and specialist accompaniment. These services allowed for advanced clinical planning with expertise beyond what was available within CYF at that time. Because of limited community-based resources available locally to address the unique needs of the families served by CYF, developing a culturally responsive system to support families of youth who identify as LGBTQ+ requires

unwavering commitment from leadership, system readiness, and upfront investment. Support from the director of DHS, the child welfare deputy director, and the rest of the child welfare leadership team were invaluable in making this work possible.

As CYF continued to evaluate progress, critical gaps stood out. Figure 2 below highlights the key elements necessary to move the child welfare system to a place where LGBTQ+ youth and families are fully supported. The elements in green were those that CYF had been successful in strengthening through previous efforts. The remaining items were gaps the system still needed to address, including access to affirming caregivers for LGBTQ+ youth in out-of-home services.

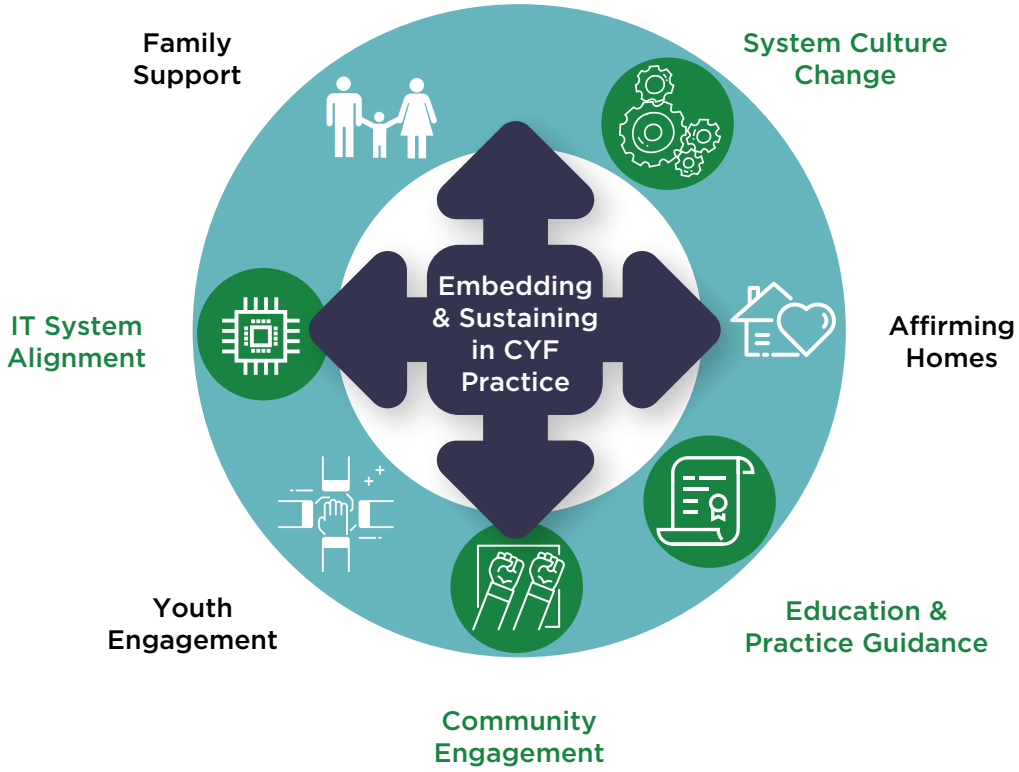


Figure 2: Key Elements to Move the Child Welfare System

Together, all of the existing practices and guidance noted above, and leadership support, provided a firm foundation for the implementation of an intervention that would build our capacity to access affirming caregivers for LGBTQ+ youth in out-of-home care.

Internal Readiness to Implement LGBTQ+ Programs

In Allegheny County, third party organizations administer services and supports to youth and families involved in the Child Welfare system, in collaboration with CYF. Providers are viewed as extensions of the system and not separate entities. So, when the work began in 2013 to intentionally improve the way they serve children, youth, and families around healthy

sexual and gender identity development, providers were included as essential partners in that process. Efforts such as the development and implementation of LGBTQ+/SOGIE Standards of Practice included providers at the table to provide feedback and vet the language. Afterall, they are also contractually bound by the policies, procedures, and Standards of Practice. When the Introduction to SOGIE curriculum was developed and a train-the-trainer program was implemented in hopes of creating sustainable capacity building support, Allegheny County partnered with providers to train their staff to become certified trainers of the curriculum and provided ongoing support for successful completers.

External Readiness

Each partner agency included in the planning and implementation of the AFFIRM Caregiver intervention had existing partnerships with both CYF, as well as the local LGBTQ+ community organization that had been working to support internal CYF staff. All four agencies had participated in the Introduction to SOGIE train-the-trainer program and had certified trainers on site. They had all been on a journey to improve their services and support to LGBTQ+ youth in their care, and supported one another through joint planning, capacity, and skill building for both staff and caregivers, and resource coordination. Understanding the needs of teens in foster care was crucial in this journey. An important part of that was understanding the importance of teens' sense of self and identity, which included expanded knowledge of the experiences of LGBTQ+ foster youth. Due to a strong working alliance and partnership between all four Families for Teens agencies, the provider team had a high level of collaboration from the start. The collective experience and expertise of the leaders in these agencies helped poise each provider to be an active member in the work ongoing. It is important to note that the AFFIRM Caregiving model was focused on resource parents who would potentially be providing care for LGBTQ+ youth. Although efforts were focused on four Families for Teens agencies, all resource parents and kinship caregivers in Allegheny County were eligible to participate.

Theory of Change

The theory of change begins with the understanding that every child deserves a loving and supportive permanent family, and that child welfare has the obligation to keep the promise of safety, permanency, and well-being for all children living in foster care, or other out-of-home placement options, regardless of sexual orientation, gender identity, and expression. It is rooted in the following principles[11]:

- All children deserve safety and acceptance in their home and community.
- All children need support and nurturance to develop and embrace all aspects of their evolving identities, including SOGIE.
- Children thrive when their caregivers affirm and respect their SOGIE, and family acceptance both protects against health risks and promotes overall health. Children

11 Wilber, S. (2013). Guidelines for Managing Information Related to the Sexual Orientation and Gender Identity and Expression of Children in Child Welfare Systems, Putting Pride Into Practice Project, Family Builders by Adoption, Oakland, CA.

experience negative health and mental health outcomes when their caregivers reject or fail to support their SOGIE.

- Children perceived by others to be lesbian, gay, bisexual, or gender diverse are exposed to the same risks as children who opening identify as LGBTQ+.
- Children are the principal owners of information related to their SOGIE.

Efforts to keep these promises must be centered on and driven by the family and youth to every extent possible. This effort requires a holistic approach that recognizes that all children need support and nurturance to develop and embrace all aspects of their evolving identities, including sexual orientation, gender identity and expression, and a recognition that children thrive when their caregivers affirm and respect their SOGIE, knowing that family acceptance both protects against health risks and promotes overall health, whereas family rejection contributes to negative health outcomes. Affirming caregivers are key.

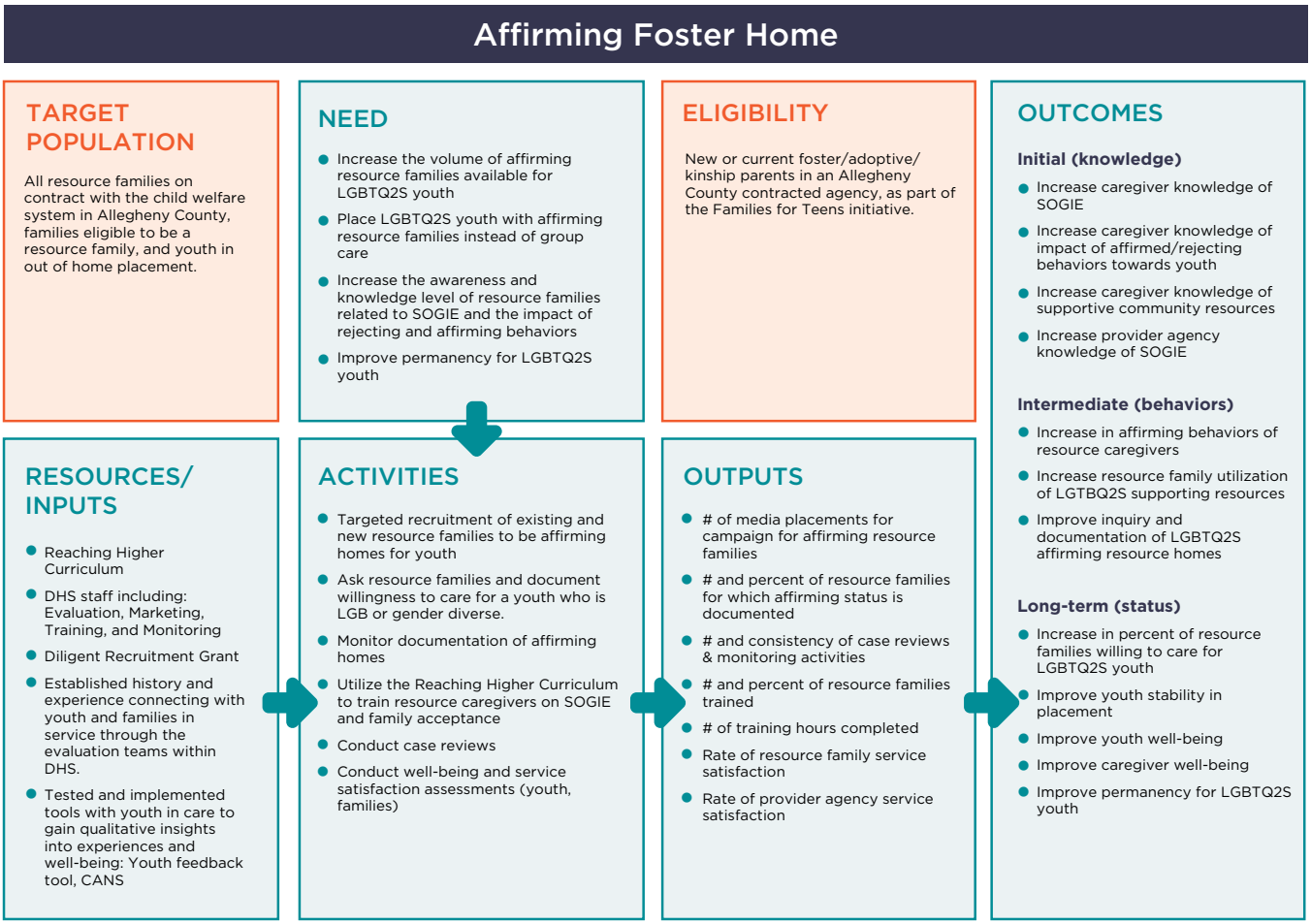


Figure 3: Affirming Foster Homes Flow Chart

 **Challenges**	• As of December 2020, there were no statewide protections from discrimination based on sexual orientation, gender identity or gender expression (SOGIE) and the five counties immediately surrounding Allegheny County did not provide any legal protections from discrimination on the basis of SOGIE.
 **What Worked Well**	• Having all stakeholders involved during the planning process was imperative for success and to ensuring an implementation plan was created with long-term sustainability in mind. • All stakeholders had an understanding of the challenges faced by LGBTQ+ youth and their families involved in Child Welfare services. • Identifying strengths and areas of need early on helped with thoughtful planning to avoid barriers to implementation.
 **Lessons Learned**	• Child welfare leaders should anticipate staff turn-over and have a plan in place to quickly certify new trainers in SOGIE content.

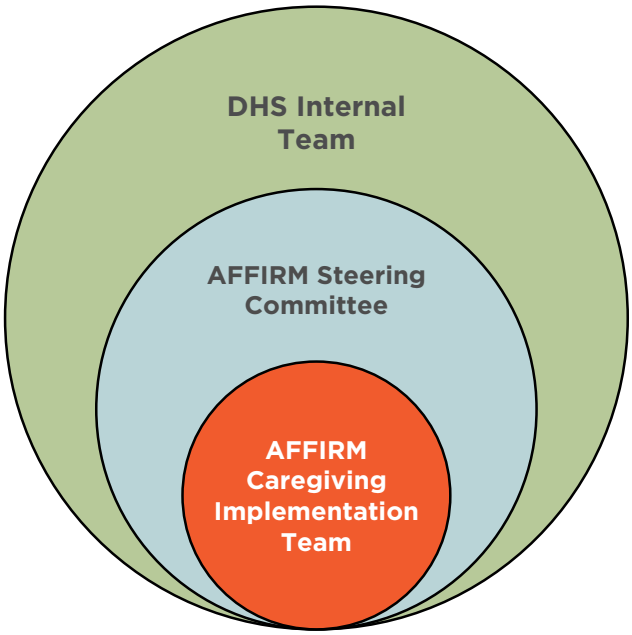
Installation

Implementation Team

For the AFFIRM Caregiver intervention, CYF used a multilevel teaming structure. A DHS/CYF internal team was formed to guide the larger grant work and problem solve internal barriers, an AFFIRM Steering Committee was created as the oversight body for the planning and implementation of the intervention, and adaptation of the implementation as needed through PDSA opportunities, and the implementation team was identified to put the intervention into practice.

At initial implementation, the AFFIRM Caregiver Implementation Team included a facilitator with LGBTQ+ expertise from our LGBTQ+ community partners and co-facilitators identified from the partnering agencies. However, through lessons learned from PDSA opportunities and turnover of agency staff, by full implementation, that structure had changed. At

full implementation, the AFFIRM Caregiver Implementation Team included the primary interventionist/facilitator from our LGBTQ+ community partner, and an agency host from each of the four partnering agencies. Initially, the AFFIRM Steering Committee was made up of representatives from the implementation agencies (Foster Care agency partners and the LGBTQ+ community partner), Youth Support Partner representatives with lived experience, a Family Support Partner with lived experience as a caregiver of an LGBTQ+ youth (who was also a faith leader in her community), resource parents, and DHS/Child Welfare representatives, including the following roles:



- Child Welfare Manager of Integrated Program Services
- Families for Teens Training Coordinator
- Provider Relations Supervisor
- Safety, Permanency, and Best Practice Specialist
- Child Welfare Senior Trainer Specialist
- Child Welfare Supervisor
- DHS Gender and Sexuality Advisor
- CYF Diversity and Inclusion Officer
- System Improvement Through Youth (SITY) Advisory Board Liaison
- Grant specific roles
    - Child Welfare Lead
    - Data Manager (specific to data related activities as part of the larger grant)
    - Principal Investigator

Membership in the steering committee changed as the needs for the implementation changed. *The DHS internal team* was made up of key players from the steering committee who had decision making power within the larger DHS/CYF system and ultimately included the primary interventionist. The role of the internal team was to guide the larger grant work and problem solve internal barriers. Although the internal team was able to create a structure that helped improve internal practice and provider/child welfare information loop, in actuality, the internal team didn't have much of an impact on the actual implementation of this particular intervention.

Partnering with a local LGBTQ+ community organization proved to be essential. Having decision makers in the room is an essential part of building any implementation team, but equally important is to have the voices of people with lived experience at the table to guide an implementation process that is grounded in real world experiences. Having a team drawn

from a broad and diverse coalition of social service organizations and community partners was beneficial, as it brought a variety of perspectives, experiences, and expertise to the table. This diversity helped the team to better anticipate and work through potential pitfalls and barriers to implementation. It also promoted cultural humility within the team. Ideally, all implementation teams should include a diverse array of people across races, ethnicities, ability levels, sexual orientations, gender identities, and other areas of diverse identity. Implementation teams should mirror the demographics of the youth/families being served.

It should be noted, it is never too late to make changes to the team. Continuing to reassess who is at the table, who isn't, and who should be is the hallmark of an evolving and improving process. Identifying power brokers within the child welfare system as well as those who are influential at recruitment and outreach on the provider side are critical because having those people at the table will help drive outcomes and referrals.

Questions to Consider

- Who should be in the room?
- Whose voice is missing?
- When should the team change?
- How can the voices of youth and families be included authentically? How can their voices lead the conversation?

Hiring and Selection of Interventionists

During the initial installation phase of the AFFIRM Caregiver intervention, facilitators were selected from implementing agency staff who had:

- Advanced knowledge in sexual orientation, gender identity, and expression,
- Comfort in talking about SOGIE with caregivers,
- Demonstrated affirming practice in their current roles,
- Experience facilitating trainings or groups,
- Interest in facilitating the AFFIRM Caregiver curriculum, and
- The approval of their supervisors to participate.

There was an initial desire to enlist the provider agency staff who had completed the certification process to become a trainer of the Introduction to SOGIE curriculum. The team also felt strongly that having representation in a co-facilitation model by both the foster care agencies and the LGBTQ+ community organization would be the most effective. Caregivers would then be connected to an LGBTQ+ organization and receive a high level of expertise in information related to SOGIE by the LGBTQ+ organization facilitator and have the support of the co-facilitator from the associated agency. The local LGBTQ+ organization provided the co-facilitators for this intervention alongside the foster care agency facilitators in order to build agency capacity and sustainability. The plan was to build in a coaching model up front for agency staff to receive an expert level of coaching related to SOGIE information from the

LGBTQ+ community organization facilitator, which would be critical for jurisdictions without funding capacity to support hiring external providers to assist in this work.

Onboarding Interventionists

The onboarding of implementers for any intervention is critical to the success of that intervention. It is imperative to assess the skills and competencies of the implementation team on a variety of topics specific to the population. It's often necessary to balance SOGIE competency with knowledge of child welfare systems, trauma competency, connections to community, flexibility to adapt and shift to support change for youth and families, and the ability to hold people accountable. Clinical expertise is also important, but at the core, having a deep understanding of family dynamics and the unique experiences of LGBTQ+ youth is essential to being able to support participants in becoming more affirming.

For the Allegheny County implementation of AFFIRM Caregiver, the following prerequisites for implementers to achieve prior to the roll out of the AFFIRM Caregiver intervention were identified:

- Strong knowledge of best practices for working with LGBTQ+ youth in child welfare – for CYF it was the completion of the Introduction to SOGIE – Child Welfare Training which included which included:
    - Disparities
    - Identity Concepts and Terminology
    - Personal Perspectives
    - Talking with youth about SOGIE
    - Best practices and Standards of Practice
- Successful completion of the AFFIRM Caregiving Model facilitator training
- Completion of Child Welfare 101 training
- Thorough understanding of local policies and practice standards, including the DHS Anti-discrimination Policy and the DHS LGBTQ+/SOGIE Standards of Practice
- Demonstration of affirming practice as determined by the supervision process and through an affirming practice assessment tool
- Experience with small group facilitation
- Supervisory approval and support

Prior to implementation (so that they understand the requirements of their role as facilitator of this model), interventionists were provided with:

- An AFFIRM manualized version of the content
- A practice profile detailing the essential functions and skills of facilitators
- A Fidelity, Coaching, and Supervision Plan (see Appendix B for the full plan)

Practice profiles are important for a variety of reasons. First and foremost, practice profiles provide interventionists with specific operational behaviors that make expectations clear for successful implementation. Practice profiles also offer supervisors and coaches a clear vision of where support is most needed for the interventionist and provide information as to when an intervention can move from initial implementation to full implementation. The Practice Profile for AFFIRM Caregiving can be found in Appendix A.

Team Communication

Communication in any implementation process is paramount to ensuring a successful implementation. Because of the multiple partners in this work, having a variety of communication processes was found to be most helpful.

Emails, in-person meetings, and video conferencing were all important pathways to communication as a team. In person, phone and video conferencing are more useful means of sharing and receiving updates and information as emails can sometimes get buried or be confusing. The team communication structure included the following:

- Bi-weekly meetings (internal team)
- Monthly Steering Committee meetings (full implementation/evaluation team)
- Email updates
- Ad hoc meetings, as needed

It is important to never stop communicating and communicate the same information in multiple ways. Building systems for regular feedback will help drive success. Interventionists should regularly be reviewing sessions with coaches and supervisors to ensure progress, but also communicating with the implementation team to assist with barriers and help find solutions. Creation of a steering committee with stakeholders will assist with buy-in from providers and system workers to help with engagement and referrals.

Challenges

- Partner agencies that didn't have leadership or highly invested staff at the table showed less commitment.
- Allegheny County DHS did not create MOUs or contractual obligations for provider agencies involved in the implementation, which limited accountability for getting Resource Parents to the intervention.

What Worked Well

- Many committee members openly identified as LGBTQ+.
- There was both personal commitment and passion for the work for the majority of team members.
- The steering committee included a variety of roles both within Child Welfare and from our provider network, which brought a broad range of perspectives to the table.

Lessons Learned

- It's never too late to make changes to team membership. Reevaluate the team regularly to make sure the right people are at the table.
- Partnering with a local LGBTQ+ community organization brought a level of expertise to the table that proved invaluable.

Initial Implementation

Intervention Adaptation for Child Welfare

The AFFIRM Caregiver intervention was fully packaged and manualized by the time CYF was ready to implement the model. The AFFIRM Caregiving model was designed as a nonclinical educational and coaching series, which emerged from the Affirmative CBT intervention that was developed using an Adapt and Evaluate framework. The resultant Affirmative approach has been adapted to ensure: (a) an affirming stance toward sexual and gender diversity, (b) recognition and awareness of LGBTQ+-specific sources of stress (e.g., homophobia, biphobia, transphobia, gender dysphoria, systematic oppression), as well as (c) the delivery of content within an affirming and trauma-informed framework[12].

The AFFIRM Caregiving model recognizes that pervasive exposure to homo/bi/transphobic attitudes, beliefs, and behaviors at multiple levels in society impacts the way caregivers may view and understand their child or youth's LGBTQ+ identity. Moreover, the approach helps caregivers identify the potentially traumatic impact of homo/bi/transphobia on LGBTQ+ children and youth and teaches them to understand their child's emotional and behavioral reactions through a trauma-informed lens. Through a variety of didactic and interactional activities, the AFFIRM Caregiving model helps caregivers adopt an affirming attitude toward their child or youth's LGBTQ+ identity, a critical step toward creating safe and healthy environments for LGBTQ+ children and youth. AFFIRM Caregiver can be implemented with foster parents, as in the case with CYF, birth parents and relative caregivers.

The AFFIRM Caregiving model is based on emerging research and practice evidence and helps parents and caregivers celebrate, honor, and validate a range of LGBTQ+ identities and experiences and recognize the impact of macro-level forces, including heterosexism, cisgenderism, and homo/bi/transphobia, on the well-being of LGBTQ+ children and youth.

Originally designed for work with caregivers of LGBTQ+ youth, the Allegheny County implementation sought to use the intervention as an onboarding series for resource families involved in our Families for Teens programming. The Allegheny County implementation of

12 Austin, A. & Craig, S.L. (2015). Transgender* Affirmative Cognitive Behavioral Therapy: Clinical considerations and applications. Professional Psychology: Research and Practice. 46(1), 21-29.

the intervention maintained fidelity to the group concept but most of the participants had not yet, to their knowledge, cared for LGBTQ+ youth.

During the intervention, resource and kinship caregivers participated in a 3 (2-3 hour) session series that included the following topics:

- LGBTQ+ Identities and Minority Stress
- Understanding the Impact of Anti-LGBTQ+ Attitudes and Behaviors
- The Traumatic Impact of Anti-LGBTQ+ Experiences
- Supporting LGBTQ+ Children and Youth During the Coming Out Process
- Compassionate Parenting and Self-Compassion
- Developing Safe, Supportive, and Affirming Caregiver and Youth Social Networks
- Overcoming Barriers and Building Hope through Affirmative Goal Setting
- Affirmative Transformation

One challenge that has been noted is implementing this intervention with foster families and caregivers who either have not had an LGBTQ+ youth placed with them or at least have not had a youth come out to them while in their care. Without personal experience, it can be more difficult for foster families to get invested in the content, particularly the first module. Although we do not believe that this challenge warrants only using this intervention with families who have LGBTQ+ youth in their home, it is recommended that facilitators have some capacity to navigate groups where there are no caregivers of LGBTQ+ youth and also – to navigate groups where it's mixed – particularly where there might be some resistance to the material. Facilitators should make sure that caregivers of LGBTQ+ youth are able to process their challenges within the group without fear or pushback, so their facilitation skills will be important in that process. With the groups that do not have caregivers with LGBTQ+ youth in their home, facilitators should be prepared to find ways to bring the material to life. Utilize local (or national) data about the experiences of LGBTQ+ youth. Find ways to highlight the importance of more affirming families throughout, and really dig into the idea that caregivers may have had/will have youth in their care that are not out to them, for example.

Outreach

Even though participation was required for resource families involved in the Families for Teens program, outreach to participants played a critical role in preparing caregivers to show up to the space with open minds and a willingness to fully engage in the process. Agency leads proved key in connecting with other agency staff and caregivers. Each agency was tasked with developing a communication plan that best met the needs of their organization. The primary intent was to use those communication channels that were already in place such as agency newsletters, agency emails, and staff meetings. Agencies were provided with flyers and language to include in their communications and in addition, the implementing agency created a video to be shared with caregivers that would provide them with an introduction to the person who would be leading the group.

Non-implementing staff in the foster care agencies involved in this model were provided detailed information on the intervention, or a similar education specific to their role, so that they could provide enhanced outreach to the caregivers they were working with and support their caregivers following the completion of the series.

Outreach emanating from Child Welfare included in-person presentations at regular stakeholder meetings such as:

- Families for Teens Provider meetings
- Foster Care Provider meetings
- Foster Parent Advisory Group

Additionally, the LGBTQ+ community organization that ultimately led the implementation of the intervention, created flyers and social media posts regarding the series, and also created a "getting to know you" video of the primary facilitator so that caregivers could build some connection with the facilitator prior to the initial session.

Referrals

Participants were required to attend because initial implementation was a part of the onboarding of resource families who were participating in a program focused on providing care for teens. Information about the intervention and invitations to participate were also shared broadly with all foster care agencies in the county.

Enrollment

The intervention of the AFFIRM Caregiving model was focused on resource parents who would potentially be providing care for LGBTQ+ youth. Although efforts were focused on the four Families for Teens agencies, all resource parents and kinship caregivers in Allegheny County were eligible to participate. Resource parents who were a part of the Families for Teen Initiative were required to participate because of their involvement in the initiative. Resource parents from other agencies and kinship caregivers were enrolled on a voluntary basis. Resource parents were not required to be currently caring for an LGBTQ+ child or youth to participate.

Resources parents who were already affirming, or at least on the journey to becoming so, were early adopters. They were the first to enroll and the most willing to fully participate. Resource parents who were more challenged by the topic or outright rejecting, resisted enrolling and, on a couple of occasions, did not complete the series. Jurisdictions considering this type of implementation would be well served to draft language up front that makes it clear what the expectations for participation are and develop accountability structures to address situations when resource parents refuse to participate, or do not complete the full intervention. In addition, clear boundaries and expectations should be set from the beginning related to what is required and expected

to receive credit, for example, setting a rule that missing more than 15 minutes of a session by either being late, leaving early, not returning from break in the allotted time, etc. would require participants to complete that session over or engage in a one-on-one with the facilitator to get caught up prior to the next scheduled session.

Facilitators should be aware of groups that may include individuals who are LGBTQ+ people or champions and individuals who have resistance. They will need to create a space where one person, whether affirming or rejecting, does not dominate conversation. It can be beneficial for facilitators to use language like – "wherever we are on our journeys – whether this is our first time engaging with this material, or whether we would consider ourselves content experts – there is always something that we can learn and do to take our next best steps to be affirming of LGBTQ+ youth."

Virtual Implementation

The implementation team worked with the purveyors to adapt content to facilitate virtual sessions during the COVID-19 pandemic and subsequent shut down of in-person events so as not to lose momentum. Implementing the intervention on a virtual platform brought some new and interesting insights. Some of the benefits to a virtual implementation included making the series more accessible to individuals who had travel barriers and limited time availability. It initially expanded the pool of participants. However, over time, pandemic fatigue set-in and it became challenging to maintain engagement virtually more than it had during in-person sessions. It is valuable to offer ongoing virtual sessions, in addition to in-person sessions, to provide multiple ways to connect and engage with individuals. Virtual sessions should not be the only ongoing method of facilitation however, because some of the engagement and participation is lost. There are also additional considerations for caregivers to be able to fully participate remotely while they have children at home. There is not the same ability to provide a separate space for children so that caregivers can participate fully when they are at home, especially those with younger children. Further, facilitators of virtual sessions should find creative ways to engage participants for virtual implementation by delivering supplies to participants' homes at the start of the series.

Figure 5: Logistics of in-person implementation versus virtual implementation

Type of Implementation	Number of sessions	Location	Time	Ideal Group Size
In-Person	3	Hosting Agency	3 hours/session (evening)	10-12 participants
Virtual	4	Zoom	2 hours/session	6-8 participants

Incentives

Use of incentives can be useful but will not guarantee participation. It can also be costly and difficult to sustain over time. With sustainability in the forefront, the team intentionally did

not offer stipends for caregivers' participation in the series. However, it was important to not significantly increase the burden to participants and to address potential barriers from the beginning. Due to the time of day and the length of the sessions, food was always provided. Additionally, because many of the participants were actively caring for children, offering childcare was imperative.

Using Incentives for Evaluations

Incentives can be used effectively to accomplish data collection activities, such as filling out surveys, that may help build or sustain programs. It is critical to be very clear up front about the when/how/timing of incentives. Outside of gift cards, other incentives should always be included. Make sure that individuals have food/snacks and materials to draw, doodle, etc. for in person sessions. Because implementation included an evaluation component, $25 VISA gift cards were offered for each survey completed (pre-, post-, 3 month follow up) and an additional gift card if all three surveys were completed. When using gift cards, it is important to note if and when they begin to lose value as some gift cards have a time restriction on use.

Fidelity

Fidelity refers to the degree to which a practice model is delivered as intended by the purveyor or developer. Ensuring fidelity to a particular model will determine whether the intervention works as it is intended and increases the ability to replicate outcomes.

Successful implementation and replication will require adherence to the manualized interventions. It's essential that interventionists are comfortable and able to adhere to the manual. Sharing information related to SOGIE is not a place where you want individuals to "just wing it" or "make it their own". It's easy, especially for those who have limited experience providing education related to gender and sexuality, to get off track and further stigmatize and perpetuate stereotypes. Even if the interventionist is a member of the LGBTQ+ community, that does not guarantee that they can facilitate groups or content with ease or that they hold no internalized bias. Therefore, the advice is to stick to the script. Utilize audio and video recording where possible to assure fidelity checks to the material. It will encourage interventionists to adhere to the material and will provide a check and balance to help the team understand if results are not where they should be with respect to improving outcomes for youth and families.

Allegheny County conducted fidelity checks by recording the audio to each session and uploading them to a secure share-drive to which the purveyors had access. The purveyors would then select random clips of audio to listen while scoring adherence to the model. After a session was reviewed, the purveyors and the interventionists would schedule a coaching call to go over things that went well, challenges the interventionist might have encountered, and anything not covered during the session. These coaching calls proved invaluable to ensure the interventionist was supported throughout implementation and that the intervention was implemented as intended.

Coaching

Existing research regarding effective implementation of evidence-informed interventions is clear; a strong coaching and supervision model is imperative to the successful implementation of any intervention but particularly around an intervention specific to LGBTQ+ individuals.

Effective implementation, which requires careful adherence to an intervention's conceptual and research model, is related to in-depth training of facilitators, as well as ongoing training and clinical supervision, referred to as "coaching" (Rakovshik & McManus, 2010; Rew et al., 2018). In particular, a review of several recent studies (Rakovshik & McManus, 2010; Sholomskas et al., 2005; Beidas et al., 2012; Harned et al., 2014) indicates that facilitator competency, skills related to core intervention concepts, and proficiency in delivering an intervention were significantly higher among facilitators who received ongoing coaching compared to those who received only the initial training.

The AFFIRM Caregiver Fidelity, Coaching, and Supervision Plan is rooted in this research and requires that all facilitators participate in the initial two-day experiential facilitator training, as well as ongoing supervision and weekly coaching during implementation which consisted of virtual coaching calls within a week following sessions, the submission of facilitator video recordings, facilitator self-reports, and random participant surveys. The fidelity tools and plan are located in the appendices.

Figure 6: AFFIRM Caregiving Fidelity Indicators

Fidelity Indicators	Behavior
Delivers Affirmative Caregiving intervention as intended	• Follows and completes all materials associated with each session in order. • Attends to all of the facilitator talking points. • Completes session delivery in time allotted.
Demonstrates an affirmative stance toward diverse sexual orientations and gender identities and expressions (SOGIE)	• Explicitly and consistently expresses value for diverse SOGIE (i.e., consistently and repeatedly expresses that all sexual orientations and gender identities are equally valuable). • Always models appropriate use of names, pronouns, terminology, and language. • Always identifies when biased language has been used. • Always corrects misinformation appropriately.
Presents psychoeducational material (on LGBTQ+ identities, minority stress, health outcomes, trauma, and resilience) using best available evidence and an LGBTQ+ affirmative stance	• Always accurately uses research and best practice information from the Affirmative Caregiving training and manual to present psychoeducational material. • Always uses research and best practice information from the Affirmative Caregiving training and manual to respond to questions/concerns within sessions. • Always presents material in a clear and digestible manner (always explains content thoroughly and presents all material at an appropriate level for the audience).

Helps caregivers understand the link between minority stress, discrimination, parental rejection, and poor emotional and behavioral outcomes – as well as the link between support, affirmation, parental acceptance and positive emotional and behavioral outcomes among LGBTQ+ youth.	• Always accurately explains the linkages between acceptance/reject, discrimination, and outcomes for LGBTQ+ youth. Explanations are adequate and accurate. • Consistently and accurately corrects misinformation, challenges myths, and improve understanding about the role of discrimination and rejection (as well as support and affirmation) on LGBTQ+ youth wellbeing. • Consistently and repeatedly emphasizes the importance of parental acceptance and support for youth well-being.
Facilitates critical exploration of anti-LGBTQ+ attitudes, beliefs, and behaviors in an open and non-judgmental manner.	• Session activities are kept focused and are consistently related back to the session concepts and material. • In all possible instances helps participants recognize the roots of negative views of self/LGBTQ+ identities. • Utilizes all opportunities to help caregivers identify and replace stigmatizing attitudes with more affirming attitudes.
Fosters participant directed behavior changes consistent with affirmative caregiving practices among participants while equally supporting small and large steps toward change.	• Always appropriately uses session activities to facilitate caregiver identification of and commitment to individual steps toward changes consistent with more affirmative caregiving. • Changes are consistently participant directed rather than facilitator directed. • Demonstrates a supportive and nonjudgmental stance toward all positive steps toward change (small or large).

Interventionists need regular coaching from the purveyors to assure sustainability and success overall. In general, coaching should include self-assessment, fidelity reviews, and then meetings to provide support and navigate barriers. This should occur at least once per series, and more in the beginning for new interventionists. Once the purveyors indicate that fidelity is consistently being met, coaching can reduce in frequency and phase out over time. Coaching tools (self-assessment/reflection sheets) should continue to be utilized ongoing to minimize drift and ensure fidelity to the model.

Supervision

In addition to coaching, supervision can play a key role in ensuring a successful implementation. In most cases, setting up regular supervision will be necessary to support interventionists. This should include case reviews, audits by the supervisor of their facilitation and reviews of coaching with the purveyors. This should occur regularly (bi-weekly or monthly) to prepare interventionists leading up to the groups, during groups, and in between groups, at a minimum.

Ongoing Training

Interventionists should be expected to participate in opportunities to grow and learn. If possible, find connections to others doing similar work, especially with virtual implementation and typical barriers being removed to remote cross-site learning. In addition, other training opportunities should be identified to increase skill and capacity to be able to support youth and families. Information around sexual orientation, gender identity and expression (SOGIE) is expanding rapidly. SOGIE training should be included for all interventionists at introductory and advanced levels.

Additional Staff Supports

Depending on the skill of your interventionist(s) and overall team, consider opportunities to bring in individuals who can provide support especially around outreach and marketing strategies. Including provider agency staff or peer support staff who can provide a warm hand-off will benefit the interventionist in their implementation to reduce barriers to engagement.

Intervention Refinement: Plan, Do, Study, Act (PDSA) Cycles

Not every jurisdiction will be able to implement this intervention in the exact same way. What works for one system may not be as effective in another system and each jurisdiction will have their own unique constraints. It was important to allow for trial and error when launching this model in Allegheny County using a Plan, Do, Study, Act (PDSA) approach to get a better sense of what would or would not work in our specific jurisdiction, and other jurisdictions would benefit from utilizing a similar model. Several iterations were tried, and it was important to identify audiences that were similar to the population up front so that the facilitators' skill, delivery, timing, etc. could be tested to get a sense of how this will best work for the population.

For example, in Allegheny County staff turnover led to some of the challenges. Every agency except one had turnover issues from beginning to end. Other agencies attempted to have other staff participate in the initial training and coaching process, but they ended up falling off and others stepped in. Some trainers exited and re-emerged and some lacked comfort with the content and were stretched too thin within their agency to be able to commit fully and relied on the expert trainer. In addition, foster care agency facilitators tended to defer to the facilitator from the LGBTQ+ community organization, specifically in cases when the group asked clarifying questions, or the interventionists needed to think "on their feet" to respond to deeper LGBTQ+ specific inquiries or unpack deep-seated bias "on the fly." Deferring to the LGBTQ+ community agency facilitator often prevented them from gaining the skills necessary for sustainability. Ultimately, time constraints for staff and staff turnover made a strong co-facilitation model all but impossible. By full implementation, the team had moved to a model of facilitation that included a primary facilitator from the LGBTQ+ community

organization and real-time support from the provider agency host, a contact from the agency where the resource parents were associated. During implementation, it was imperative to have someone from the hosting agency present to both address logistical concerns, as well as provide another set of eyes to assess the level of participation and integration of information by the caregivers. For Allegheny County, this shift in models did not impede sustainability, which will be noted later. Grant funding, in combination with an ongoing funding commitment from Allegheny County by way of program funding opened up the possibility of expert staff leading the way.

For jurisdictions unable to secure program funding, revisiting the co-facilitation/coaching model may prove to be more sustainable.

Challenges

- Balancing the number and length of sessions with caregivers' schedules and obligations.
- Timely registration of resource caregivers. Agencies often did not dedicate enough time to marketing and promotion of the series to find ways to connect with and engage with families. Communication regarding the series were primarily shared via agency newsletters and often through general agency-wide communication forums. Resource parents likely overlook these forms of communication, considered by some to be "white noise."
- The intervention was developed for use with caregivers of LGBTQ+ youth. Implementing the intervention with caregivers who had no experience or were not currently caring for an LGBTQ+ youth meant the facilitators had to develop new scenarios to make the content relevant for the audience.

What Worked Well

- Virtual implementation worked better for many families who lived further out. Some of the families would have had to travel 1-2 hours one way to participate in the in-person version of the intervention, which can be prohibitive for working families and families with children at home.
- Walking through the model with case managers who interface with resource parents helped them to understand some of the materials they would be exposed to and helped them to be able to describe to caregivers what we were asking them to participate in and why.
- Having an agency representative available at every session provided a familiar face for participants, support for the facilitator when logistical issues arose, and allowed for a more intimate assessment of the mindset of the resource parents.
- Having the opportunity to run multiple PDSAs with audiences similar to the audience provided a chance to work out timing and gain insight into unforeseen challenge areas that were not directly addressed by the curriculum - such as faith.
- The opportunity to receive coaching on the model directly from the purveyors enhanced the interventionists' abilities to work through challenging situations and adapt the intervention in real time.

Lessons Learned

- It is never too late to make changes to the team. Continue to reassess who is at the table, who isn't, and who should be. Identifying power brokers within the Child Welfare system as well as those who are influential at recruitment and outreach on the provider side are critical because having those people at the table will help drive outcomes and referrals.
- It would have benefitted resource parents if case managers, or those closest to the caregivers in the context of agency personnel, would have participated in the series (or some adaptation thereof) to (1) increase their capacity to serve LGBTQ+ youth, and (2) support resource parents in integrating the information into their daily interactions with the youth in their care.
- It is critical to dedicate time and energy to developing and disseminating marketing strategies and promotion of the series to find ways to connect and engage with families. Consistent messaging to families about the intervention and why they should participate is critical to getting families to sign on.
- Faith can be an asset or barrier to this work. It's important to find ways to leverage faith communities to support your work. Don't avoid the topic of faith and ensure that facilitators are able to navigate the importance of faith while setting clear boundaries about what it means to be an affirmative caregiver.

Long-Term Implementation

Impact and Outcomes of AFFIRM Caregiver

The data from AFFIRM Caregiver collected across Allegheny County and Cuyahoga County (another implementation site) found a significant improvement in foster parents' affirmative caregiving attitudes and behaviors, as well as confidence in their abilities to engage in affirmative caregiving skills with LGBTQ + youth (Austin, et al., 2021)[13]. Specifically, study findings indicate statistically significant improvements in affirmative attitudes and behaviors toward both LGB and transgender youth, as well as statistically significant improvements in affirmative caregiving competence for LGBTQ + youth immediately following the intervention as well as at the 3-month follow up assessment. Of particular importance is the finding that positive changes made at posttest were maintained at the 3-month follow up. During the 3 years of implementation described in this guide, Allegheny County had 149 caregivers complete the intervention.

Sustainability

Because the Allegheny County implementation of this intervention was used as a part of onboarding for resource parents who were part of a program specific to serving teens, it was implemented as a preparatory support and not intended to serve as a clinical intervention but rather to reduce the need for a clinical intervention. And because it was built in as part of onboarding for a specific set of resource parents, and evidenced positive outcomes, the county agreed that it would be included as part of the contractual agreements with all foster care providers. The intervention has received program funding to continue to implement the intervention within the foster care network and for situations in which it can be used as a support for caregivers struggling with understanding their LGBTQ+ children. It may eventually be included in the clearinghouse of interventions as part of the Families First legislation.

Challenges

- Identifying a sustainable flow of funding not dependent upon Child Welfare program funding.

What Worked Well

- Strong and committed leadership
- Working closely with Child Welfare leadership to imbed SOGIE support overall within the Regional Offices

13 Austin, A., Craig, S. L., Matarese, M., Greeno, E. J., Weeks, A., & Betsinger, S. A. (2021). Preliminary effectiveness of an LGBTQ+-affirmative parenting intervention with foster parents. Children and Youth Services Review, 127, 106107. https://doi.org/10.1016/j.childyouth.2021.106107

Lessons Learned

- Think about sustainability early and often throughout the implementation phases
- Lean into your fidelity models. Data are a key way to support sustainable funding for this intervention.
- This intervention would likely be eligible for CCBH funding if it were implemented as a mental health intervention for caregivers of LGBTQ+ youth as opposed to an onboarding series for caregivers.

Replication and Broad-Scale Roll-Out

The AFFIRM caregiver intervention can be implemented with foster parents, kinship caregivers, and families/parents with or without known LGBTQ+ youth in their homes. The intervention is also fully manualized and replicable. This intervention is an option agency leaders should consider when seeking programs that can help families and other caregivers learn how to support the LGBTQ+ youth in their care. Given that studies have found over 30% of youth ages 12-21 in foster care identify as LGBTQ+, it should be assumed that all foster families will at some point care for an LGBTQ+ youth (Matarese, et al., 2021)[14]. Given the outcomes of the AFFIRM Caregiver intervention in Allegheny County, agencies should consider this as a potential requirement for licensing and relicensing foster families.

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14 Matarese, M., Greeno, E., Weeks, A., Hammond, P. (2021). The Cuyahoga youth count: A Report on LGBTQ+ Youth's Experience in Foster Care. Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland School of Social Work. Retrieved from https://theinstitute.umaryland.edu/our-work/national/lgbtq/cuyahoga-youth-count/

Appendices

Appendix A: AFFIRM Caregiver Practice Profile

Practice Profile: AFFIRM Caregiver Facilitator			
Essential Function	**Standard Implementation**	**Developmental Practice**	**Unacceptable practice**
Demonstrates an affirmative stance toward diverse sexual orientations and gender identities and expressions (SOGIE)	Explicitly expresses value for diverse SOGIE	Sometimes explicitly expresses value for diverse SOGIE	Does not explicitly express value for diverse SOGIE
	Models appropriate use of names, pronouns, terminology, language	Inconsistently models appropriate use of names, pronouns, terminology, language	Doesn't model appropriate use of names, pronouns, terminology, language
	Identifies when biased language has been used corrects misinformation	Identifies some biased or does not correct the misinformation appropriately	Doesn't identify biased statement or does not correct misinformation
Delivers Affirm Caregiver intervention as intended	Follows and completes all materials associated with each session in order	Covers only some of the session materials or diverts from content without reason	Does not cover a majority of the session material
	Uses the facilitator talking points to guide implementation	Attends to some of the facilitator talking points, but does not attend to other some key facilitator talking points	Delivers material in a manner inconsistent with facilitator notes
	Completes intervention delivery in time allotted	Goes over allotted time in some instances but creates a feasible plan for completing intervention with participants	Does not complete full intervention with participants

Meets participants "where they are" while maintaining an LGBTQ+ affirmative stance	Recognizes and accepts without judgement that caregivers will represent a range of levels of LGBTQ+ awareness and acceptance while simultaneously modeling that an LGBTQ+ affirmative stance is the only best practice for supporting LGBTQ+ youth	Recognizes and accepts without judgement that caregivers will represent a range of levels of LGBTQ+ awareness and acceptance but does not consistently make clear that an LGBTQ+ affirmative stance is the only best practice for supporting LGBTQ+ youth	Fails to make clear that an LGBTQ+ affirmative stance is the only best practice for supporting LGBTQ+ youth
		Models that an LGBTQ+ affirmative stance is the only best practice for supporting LGBTQ+ youth but is not able to consistently demonstrate a non-judgmental approach to working with caregivers representing a range of levels of LGBTQ+ awareness and acceptance	Uses a judgmental and shaming approach to address different levels of LGBTQ+ awareness and acceptance among caregivers

Supports Diverse Intersectional identities while maintaining an LGBTQ+ affirmative stance	Recognizes and accepts without judgement that caregivers will have a range of intersecting identities and experiences that impact their attitudes and beliefs about LGBTQ+ identities while simultaneously modeling that an LGBTQ+ affirmative stance is the only best practice for supporting LGBTQ+ youth	Recognizes and accepts without judgement that caregivers will have a range of intersecting identities and experiences that impact their attitudes and beliefs about LGBTQ+ identities but does not consistently make clear that an LGBTQ+ affirmative stance is the only best practice for supporting LGBTQ+ youth	Fails to make clear that an LGBTQ+ affirmative stance is the only best practice for supporting LGBTQ+ youth
		Models that an LGBTQ+ affirmative stance is the only best practice for supporting LGBTQ+ youth butis not able to consistently demonstrate a sensitive and non-judgmental approach to working with caregivers representing a range of intersecting identities and experiences	Uses a judgmental approach when engaging caregivers with a range of intersecting identities and experiences
Presents psychoeducational material (on LGBTQ+ identities, minority stress, health outcomes, trauma, resilience) using best available evidence and an LGBTQ+ affirmative stance	Uses research and best practice information from the affirm caregiver training and manual to present psychoeducational material and respond to questions/concerns within sessions	Provides partially correct information	Uses personal opinions to answer questions that could have been answered using best practices and research
		Does not present material in a clear, digestible manner	Presents research-based material inaccurately

Help caregivers understand the link between minority stress, discrimination, parental rejection, and poor emotional and behavioral outcomes—as well as the link between support, affirmation, parental acceptance and positive emotional and behavioral outcomes among LGBTQ+ youth	Consistently utilizes existing research-based evidence from the manual and the training within sessions to correct misinformation, challenge myths, and improve understanding about the role of discrimination and rejection (as well as support and affirmation) on LGBTQ+ youth wellbeing	Inconsistently relies on research-based evidence when discussing discrimination/rejection and acceptance/affirmation	Rarely utilizes research-based evidence when discussing discrimination/rejection and acceptance/affirmation
		Does not provide all relevant information	Consistently fails to engage adequately attend to misinformation, myths, and understanding related to the impact of discrimination/rejection and acceptance/affirmation
Facilitates critical exploration of anti-LGBTQ+ attitudes, beliefs and behaviors in an open and non-judgmental manner	Demonstrates an understanding and non-judgmental stance while helping caregivers identify and critically examine their own anti-LGBTQ+ bias	Inconsistently utilizes a non-judgmental attitude	Fails to demonstrate a non-judgmental attitude
		Misses some opportunities to help caregivers identify and explore their own anti-LGBTQ bias	Misses all or most opportunities to help caregivers identify and explore their own anti-LGBTQ+ bias
Enhances participant knowledge about the importance of key sources of resilience and well-being among LGBTQ+ youth including engaging in identify affirming activities (online and offline), receiving identity affirming support (online and offline), having parents/caregivers that demonstrate acceptance	Uses research-based evidence from the training and the manual to facilitate participant knowledge about the importance of LGBTQ+ specific factors that support LGBTQ+ youth wellbeing	Provides partially accurate information	Consistently fails to make clear the importance of identity affirming activities and sources of support as for LGBTQ+ youth resilience
		Does not make clear the importance of LGBTQ+ specific sources of resilience /identity affirming aspects of resilience	

Fosters participant directed behavior changes consistent with affirmative caregiving practices among participants while equally supporting small and large steps toward change.	Appropriately uses session activities to facilitate caregiver identification of and commitment to individual steps toward changes consistent with more affirmative caregiving while demonstrating a supportive and nonjudgmental stance toward all positive steps toward change (small or large)	In some instances, the changes are facilitator directed rather than participant directed	Consistently directs/mandates participant steps toward change
		In some instances, small changes are met with less support than larger changes	Consistently fails to support small steps toward change
		In some instances, the identified behavior changes were not related to affirmative caregiving	Consistently fails to facilitate participant identification of behavior changes consistent with affirmative caregiving
Fosters a compassionate attitude toward self and others	Models a compassionate stance toward difference (e.g., affirmation of all identities and expression, non-judgmental attitude toward caregivers with wide range of values and beliefs)	Only sometimes models a compassionate stance toward difference (e.g., affirmation of all identities and expression, non-judgmental attitude toward caregivers with wide range of values and beliefs)	Rarely or never models a compassionate stance toward difference (e.g., affirmation of all identities and expression, non-judgmental attitude toward caregivers with wide range of values and beliefs)
	Uses research-based findings from training and manual to facilitate participant understanding and use of self-compassion in daily life	Inconsistently uses research-based findings from training and manual to facilitate participant understanding and use of self-compassion in daily life	Does not use research-based findings from the training and manual to facilitate participant use of self-compassion in daily life
	Clearly links the importance helping caregivers extend compassion to their LGBTQ+ youth	The link between self-compassion and extending compassion to LGBTQ+ youth is unclear	Fails to make the link between self-compassion and demonstrating compassion to LGBTQ+ youth

Appendix B: AFFIRM Caregiver Fidelity, Coaching, and Supervision Plan

AFFIRM CAREGIVER FIDELITY, COACHING AND SUPERVISION PLAN

Fidelity refers to the degree to which a practice model is delivered as intended by the purveyor or developer. Ensuring fidelity to a particular model will determine whether the intervention works as designed or if adaptations need to be made. When establishing an evidence base for an intervention or program, ensuring that implementers are adhering to the fidelity of the intervention is critical. The information below details the fidelity, coaching, and supervision plan for the AFFIRM Caregiver intervention.

Fidelity Methods

- ❑ Facilitator Video Recording
- ❑ Random Participant Survey
- ❑ Facilitator Self-Report

Fidelity Tools

- ❑ Facilitation Rating Guide
- ❑ Participant Survey
- ❑ Facilitator Self-Report Survey

Fidelity Administrators

- ❑ AFFIRM Caregiving Facilitators
  - Video Recording
  - Self-Report
- ❑ Client Experience Unit
  - Random Participant Survey (via telephone and entered into a Qualtrics link)

After Tool Administration

- ❑ Facilitator Video Recording
  - Video recordings will be uploaded to a private/confidential webserver that AFFIRM purveyors will have access to for 7 days.
  - AFFIRM purveyors will download the video recordings to review.
  - Video files will be purged by the server after 7 days.
- ❑ Random Participant Survey
  - Participants survey responses will be entered into Qualtrics

- ❑ Facilitator Self-Report Survey
  - Facilitator self-report survey will be administered via a Qualtrics link.

Frequency of Collection

- ❑ Facilitator video recording will occur during every session and uploaded to the MoveIT server within 72 hours. The Local Implementation Site will provide the AFFIRM purveyors with a start time for each session on the recording (e.g., Session 1 begins at 00:00, Session 2 begins at 58:00, etc.)
- ❑ Random participant surveys will be conducted after the completion of each series with at least 25% of participants from each series within 2 weeks of the final session. The ATP Data Manager will be responsible for providing the contact information for the randomly selected participants to the client experience specialist.
- ❑ Self-reports will be completed at the end of each session and uploaded to the server in conjunction with the video tape.

Frequency of Review

- ❑ **Purveyor Review:** For each AFFIRM cohort, the purveyors will review 3 randomly selected sessions. Prior to each cohort's start date, the QIC will send the purveyors a list of the three sessions randomly selected for review. The purveyors will conduct fidelity review for each selected session within one week of the session being uploaded to the MoveIT server.
- ❑ **Participant Surveys:** Random participant surveys will occur after the end of each series with at least 25% of participants. Responses will be reviewed within one week of receipt by the purveyors.
- ❑ **Facilitator Self Report:** Each facilitator will complete a self-report after each session. The self-reports will be reviewed weekly.

Time frame between intervention, review and feedback

- ❑ Purveyor's observations and facilitator self-observations will be reviewed within one week of completion and feedback will be returned within one week.
- ❑ The purveyor will review self-reports weekly and return feedback within one week of review.

Coaching Plan

- ❑ Frequency: Coaching/Debrief calls will occur within one week after each session of the intervention.
- ❑ Coach: AFFIRM purveyors will conduct coaching on the model, SOGIE competency, and general facilitation until the facilitation leads become proficient in the curriculum. Persad Center lead facilitator will provide coaching in real time during sessions.

Supervision Plan

- ❑ Frequency: Supervision will occur on a monthly basis and as needed.
- ❑ Supervisor: Facilitators are supervised by their agency leads.

Appendix C: Rater's Guide for Purveyor/Supervisor Observation of Affirmative Caregiving

Fidelity Indicator 1	Behaviors
Delivers Affirmative Caregiving intervention as intended	6. Does the Facilitator follow and complete all materials associated with the session in order? 7. Does the Facilitator use the facilitator talking points to guide implementation of the session? 8. Does the Facilitator complete session delivery in time allotted?

Scale:

0 = None/Minimal:

1. Does not cover a majority of the session material.
2. Delivers material in a manner inconsistent with facilitator talking points.
3. Does not complete full session with participants.

1 = Occasional/Infrequent:

1. Covers only some of the session materials or diverts from content without reason.
2. Attends to some of the facilitator talking points.
3. Goes over or under allotted time in some instances.

2 = Regular/Frequent:

1. Covers all of the session materials but occasionally diverts from content.
2. Attends to most of the facilitator talking points.
3. Goes over allotted time in some instances but creates a feasible plan for completing session material with participants.

3 = Extensive/Consistent:

1. Follows and completes all materials associated with each session in order.
2. Attends to all of the facilitator talking points.
3. Completes session delivery in time allotted.

Fidelity Indicator 2	Behaviors
Demonstrates an affirmative stance toward diverse sexual orientations and gender identities and expressions (SOGIE)s	1. Does the Facilitator explicitly express value for diverse SOGIE? 2. Does the Facilitator model appropriate use of names, pronouns, terminology, and language? 3. Does the Facilitator identify when biased language has been used? 4. Does the Facilitator correct misinformation?

Scale:

0 = None/Minimal:

1. Does not explicitly express value for diverse SOGIE (i.e., never expresses that all sexual orientations and gender identities are equally valuable).
2. Does not model appropriate use of names, pronouns, terminology, language.
3. Does not identify biased language.
4. Does not correct misinformation.

1 = Occasional/Infrequent:

1. Sometimes explicitly expresses value for diverse SOGIE (i.e., sometimes expresses that all sexual orientations and gender identities are equally valuable).
2. Inconsistently models appropriate use of names, pronouns, terminology, language.
3. Only occasionally identifies biased language (misses most opportunities to identify biased language).
4. Only occasionally corrects misinformation (misses most opportunities to correct misinformation).

2 = Regular/Frequent:

1. Often explicitly expresses value for diverse SOGIE (i.e., often expresses that all sexual orientations and gender identities are equally valuable).
2. Often models appropriate use of names, pronouns, terminology, language.
3. Often identifies biased language (misses some opportunities to identify biased language).
4. Often corrects misinformation appropriately (misses some opportunities to correct misinformation).

3 = Extensive/Consistent:

1. Explicitly and consistently expresses value for diverse SOGIE (i.e., consistently and repeatedly expresses that all sexual orientations and gender identities are equally valuable).
2. Always models appropriate use of names, pronouns, terminology, language.
3. Always identifies when biased language has been used.
4. Always corrects misinformation appropriately.

Fidelity Indicator 3	Behaviors
Presents psychoeducational material (on LGBTQ+ identities, minority stress, health outcomes, trauma, and resilience) using best available evidence and an LGBTQ+ affirmative stance.	1. Does the Facilitator use research and best practice information from the Affirmative Caregiving training and manual to present psychoeducational material? 2. Does the Facilitator use research and best practice information from the Affirmative Caregiving training and manual to respond to questions/ concerns from caregivers within sessions? 3. Does the Facilitator present material in a clear and digestible manner?

Scale:

0 = None/Minimal:

1. Presents research based and best practice psychoeducational material from the Affirmative Caregiving training and manual inaccurately.
2. Does not use research based and best practice to respond to questions; Uses personal opinions to answer questions that could have been answered using best practices and research.
3. Does not present material in a clear and digestible manner (does not sufficiently explain content or does not present material at an appropriate level for the audience).

1 = Occasional/Infrequent:

1. Often presents research based and best practice psychoeducational material from the Affirmative Caregiving training and manual inaccurately.
2. Often does not use research based and best practice to respond to questions; Sometimes uses personal opinions to answer questions that could have been answered using best practices and research.
3. Sometimes presents material in a clear and digestible manner (often does not sufficiently explain content or often does not present material at an appropriate level for the audience).

2 = Regular/Frequent:

1. Often accurately uses research and best practice information from the Affirmative Caregiving training and manual to present psychoeducational material.
2. Often uses research and best practice information from the Affirmative Caregiving training and manual to respond to questions/concerns within sessions.
3. Regularly presents material in a clear and digestible manner (usually explains content thoroughly and usually presents material at an appropriate level for the audience).

3 = Extensive/Consistent:

1. Always accurately uses research and best practice information from the Affirmative Caregiving training and manual to present psychoeducational material.
2. Always uses research and best practice information from the Affirmative Caregiving training and manual to respond to questions/concerns within sessions.
3. Always presents material in a clear and digestible manner (always explains content thoroughly and presents all material at an appropriate level for the audience).

Fidelity Indicator 4	Behaviors
Helps caregivers understand the link between minority stress, discrimination, parental rejection, and poor emotional and behavioral outcomes—as well as the link between support, affirmation, parental acceptance and positive emotional and behavioral outcomes among LGBTQ+ youth	1. Does the Facilitator accurately explain the linkages between acceptance/rejection, discrimination, and outcomes for LGBTQ+ youth? 2. Does the Facilitator correct misinformation, challenge myths, and improve understanding of the impact of discrimination and rejection (as well as support and affirmation) on LGBTQ+ youth wellbeing? 3. Does the Facilitator emphasize the importance of parental acceptance and support for the LGBTQ+ youth

Scale:

0 = None/Minimal:

1. Rarely accurately explains the linkages between acceptance/rejection, discrimination, and outcomes for LGBTQ+ youth. Explanations are inadequate or inaccurate.
2. Consistently fails to adequately attend to misinformation, myths, and understanding related to the impact of discrimination/rejection and acceptance/affirmation or does not provide accurate information
3. Never explains the importance of parental acceptance and support for youth well-being.

1 = Occasional/Infrequent:

1. Occasionally accurately explains the linkages between acceptance/rejection, discrimination, and outcomes for LGBTQ+ youth. Explanations are often inadequate or inaccurate.
2. Occasionally accurately corrects misinformation, challenges myths, and improve understanding about the role of discrimination and rejection (as well as support and affirmation) on LGBTQ+ youth wellbeing.
3. Occasionally emphasizes the importance of parental acceptance and support for youth well-being.

2 = Regular/Frequent:

1. Often accurately explains the linkages between acceptance/rejection, discrimination, and outcomes for LGBTQ+ youth. Explanations are occasionally inadequate or inaccurate.
2. Often accurately corrects misinformation, challenges myths, and improve understanding about the role of discrimination and rejection (as well as support and affirmation) on LGBTQ+ youth wellbeing
3. Often emphasizes the importance of parental acceptance and support for youth well-being.

3 = Extensive/Consistent:

1. Always accurately explains the linkages between acceptance/rejection, discrimination, and outcomes for LGBTQ+ youth. Explanations are adequate and accurate.
2. Consistently and accurately corrects misinformation, challenges myths, and improves understanding about the role of discrimination and rejection (as well as support and affirmation) on LGBTQ+ youth wellbeing.
3. Consistently and repeatedly emphasizes the importance of parental acceptance and support for youth well-being.

Fidelity Indicator 5	Behaviors
Facilitates critical exploration of anti-LGBTQ+ attitudes, beliefs and behaviors in an open and non-judgmental manner	1. Does the Facilitator use session activities to help caregivers explore how session concepts (affirmation/acceptance, rejection, discrimination, bias) are relevant to their own lives? 2. Does the Facilitator help participants recognize the roots of negative views of self/LGBTQ2S+ identities? 3. Does the Facilitator help caregivers identify and replace stigmatizing attitudes toward LGBTQ2S+ identities with more affirming attitudes?

Scale:

0 = None/Minimal:

1. Does not keep session activities focused and does not relate the session activities back to the session concepts and material.
2. Never helps participants recognize the roots of negative views of self/LGBTQ2S+ identities.
3. Does not take advantage of opportunities to help caregivers identify and replace stigmatizing attitudes with more affirming attitudes.

1 = Occasional/Infrequent:

1. Occasionally relates the session activities back to the session concepts and material.
2. In some instances, helps participants recognize the roots of negative views of self/ LGBTQ2S+ identities.
3. Occasionally helps caregivers identify and replace stigmatizing attitudes with more affirming attitudes but misses many opportunities to do so.

2 = Regular/Frequent:

1. Often relates the session activities back to the session concepts and material.
2. In most instances helps participants recognize the roots of negative views of self/ LGBTQ2S+ identities.
3. Often helps caregivers identify and replace stigmatizing attitudes with more affirming attitudes but misses some opportunities to do so.

3 = Extensive/Consistent:

1. Session activities are kept focused and are consistently related back to the session concepts and material.
2. In all possible instances helps participants recognize the roots of negative views of self/LGBTQ2S+ identities.
3. Utilizes all opportunities to help caregivers identify and replace stigmatizing attitudes with more affirming attitudes.

Fidelity Indicator 6	Behaviors
Fosters participant directed behavior changes consistent with affirmative caregiving practices among participants while equally supporting small and large steps toward change.	1. Does the Facilitator appropriately use session activities to facilitate caregiver identification of and commitment to individual steps toward changes consistent with more affirmative caregiving? 2. Does the Facilitator effectively facilitate participant-directed steps towards change? 3. Does the Facilitator support all positive steps towards change small and large?

Scale:

0 = None/Minimal:

1. Consistently fails to facilitate participant identification of behavior changes consistent with affirmative caregiving.
2. Consistently directs/mandates participant steps toward change.
3. Consistently fails to support small steps toward change.

1 = Occasional/Infrequent:

1. Occasionally uses session activities to facilitate caregiver identification of and commitment to individual steps toward changes consistent with more affirmative caregiving; some changes may not be consistent with affirmative caregiving.
2. In some instances, the changes are facilitator directed rather than participant directed
3. In most instances small changes are met with less support than larger changes.

2 = Regular/Frequent:

1. Usually uses session activities to facilitate caregiver identification of and commitment to individual steps toward changes consistent with more affirmative caregiving.
2. In most instances the changes are participant directed rather than facilitator directed.
3. In some instances, small changes are met with less support than larger changes.

3 = Extensive/Consistent:

1. Always appropriately uses session activities to facilitate caregiver identification of and commitment to individual steps toward changes consistent with more affirmative caregiving.
2. Changes are consistently participant directed rather than facilitator directed.
3. Demonstrates a supportive and nonjudgmental stance toward all positive steps toward change (small or large).

Appendix D: Purveyor/Supervisor Observation - Affirmative Caregiving Rating Form

(Refer to Affirmative Caregiving Rater's Guide for explanation of ratings)

Series Start Date: _____ Session Date: _____ Session #:_____

Facilitator Name: _____

If more than one facilitator is conducting the session, each facilitator should be rated as an individual on their own rating form.

Fidelity Indicator 1

Delivers Affirmative Caregiving intervention as intended

Behaviors	Rating
Does the Facilitator follow and complete all materials associated with each session in order?	0 1 2 3
Does the Facilitator use the facilitator talking points to guide implementation of the session?	0 1 2 3
Does the Facilitator complete session delivery in time allotted?	0 1 2 3
Fidelity Indicator 1 Sum:	
Score Justification/Reason (for any scores under 3):	

Fidelity Indicator 2

Demonstrates an affirmative stance toward diverse sexual orientations and gender identities and expressions (SOGIE)

Behaviors	Rating
Does the Facilitator explicitly express value for diverse SOGIE?	0 1 2 3
Does the Facilitator model appropriate use of names, pronouns, terminology, and language?	0 1 2 3

Does the Facilitator identify when biased language has been used?	0	1	2	3
Does the Facilitator correct misinformation?	0	1	2	3
Fidelity Indicator 2 Sum:				
Score Justification/Reason (for any scores under 3):				

Fidelity Indicator 3

Presents psychoeducational material (on LGBTQ+ identities, minority stress, health outcomes, trauma, resilience, coping) using best available evidence and an LGBTQ+ affirmative stance

Behaviors	Rating			
Does the Facilitator use research and best practice information from the Affirmative Caregiving training and manual to present psychoeducational material?	0	1	2	3
Does the Facilitator use research and best practice information from the Affirmative Caregiving training and manual to respond to questions/concerns from caregivers within sessions?	0	1	2	3
Does the Facilitator present material in a clear and digestible manner?	0	1	2	3
Fidelity Indicator 3 Sum:				
Score Justification/Reason (for any scores under 3):				

Fidelity Indicator 4

Helps caregivers understand the link between minority stress, discrimination, parental rejection, and poor emotional and behavioral outcomes—as well as the link between support, affirmation, parental acceptance and positive emotional and behavioral outcomes among LGBTQ+ youth

Behaviors	Rating
Does the Facilitator accurately explain the linkages between acceptance/rejection, discrimination, and outcomes for LGBTQ+ youth?	0 1 2 3
Does the Facilitator correct misinformation, challenge myths, and improve understanding of the impact of discrimination and rejection (as well as support and affirmation) on LGBTQ+ youth wellbeing?	0 1 2 3
Does the Facilitator emphasize the importance of parental acceptance and support for the LGBTQ+ youth?	0 1 2 3
Fidelity Indicator 4 Sum:	
Score Justification/Reason (for any scores under 3):	

Fidelity Indicator 5

Facilitates critical exploration of anti-LGBTQ+ attitudes, beliefs and behaviors in an open and non-judgmental manner

Behaviors	Rating
Does the Facilitator use session activities to help caregivers explore how session concepts (affirmation/acceptance, rejection, discrimination, bias) are relevant to their own lives?	0 1 2 3
Does the Facilitator help participants recognize the roots of negative views of self/LGBTQ2S+ identities?	0 1 2 3
Does the Facilitator help caregivers identify and replace stigmatizing attitudes toward LGBTQ2S+ identities with more affirming attitudes?	0 1 2 3
Fidelity Indicator 5 Sum:	

Score Justification/Reason (for any scores under 3):

Fidelity Indicator 6

Fosters participant directed behavior changes consistent with affirmative caregiving practices among participants while equally supporting small and large steps toward change.

Behaviors	Rating
Does the Facilitator appropriately use session activities to facilitate caregiver identification of and commitment to individual steps toward changes consistent with more affirmative caregiving?	0 1 2 3
Does the Facilitator effectively facilitate participant-directed steps towards change?	0 1 2 3
Does the Facilitator support all positive steps towards change small and large?	0 1 2 3
Fidelity Indicator 6 Sum:	
Score Justification/Reason (for any scores under 3):	

Grand Total: _____

Maximum Score: 57

Notes: _____
_____
_____
_____

Appendix E: Self-Observation: Affirmative Caregiving Facilitator

Facilitator Name: _____

Series Start Date: _____ Series End Date: _____

Please rate yourself on all items using the following scale:

- **No (0):** Did not complete the item at all or covered it in a way that substantially diverted from the Affirmative Caregiving manual/training.
- **Somewhat (1):** Partially completed the item as described in the manual/training. Item may not have been fully completed or may have diverted somewhat from the Affirmative Caregiving manual/training.
- **Yes (2):** Completed the item in its entirety as described in the Affirmative Caregiving manual/training.

If you are co-facilitating with another person, please rate only yourself (not your co-facilitator). Please circle how you would rate yourself on each item immediately after the session is complete.

Session 1

Date of Session: _____

Activity/Discussion	*Rating* No=0 Somewhat=1 Yes=2
Shared information on the current state of LGBTQ youth	No Somewhat Yes
Introduced the minority stress model	No Somewhat Yes
Completed Reflective Activity (including introducing the activity, conducting the activity, and debriefing the activity)	No Somewhat Yes
Session 1 Sum:	

Session 2

Date of Session: _____

Activity/Discussion	*Rating* No=0 Somewhat=1 Yes=2
Discussed homo/bi/transphobia	No Somewhat Yes

Completed activity "The Message behind the Message" (including introducing the activity, conducting the activity, and debriefing the activity)	No Somewhat Yes
Completed activity "Trash It" (including introducing the activity, conducting the activity, and debriefing the activity)	No Somewhat Yes
Session 2 Sum:	

Session 3

Date of Session: _____

Activity/Discussion	*Rating* No=0 Somewhat=1 Yes=2
Discussed trauma among LGBTQ youth and shared information on countering the negative impacts of anti-LGBTQ trauma	No Somewhat Yes
Showed two clips "Lead with Love" and "Mom and Dads for Transsexuality" and led discussion on supporting LGBTQ youth	No Somewhat Yes
Explored the coming out process and how caregivers can support the youth during that process	No Somewhat Yes
Session 3 Sum:	

Session 4

Date of Session: _____

Activity/Discussion	*Rating* No=0 Somewhat=1 Yes=2
Explored the topic of self-care and caregiving/ parenting and reviewed appendix 4A	No Somewhat Yes
Discussed three core components of self-compassion and reviewed appendix 4B	No Somewhat Yes
Discussed Compassionate Caregiving/Parent strategies and reviewed appendix 4C, 4D	No Somewhat Yes
Session 4 Sum:	

Session 5

Date of Session: _____

Activity/Discussion	*Rating* No=0 Somewhat=1 Yes=2
Discussed the role of anti-LGBTQ discrimination on connection and support	No Somewhat Yes
Explored identify affirming activities and completed the "Experiences that Affirm" worksheet	No Somewhat Yes
Identified affirmative social supports and completed activity "Social Support Network" and Action Plan	No Somewhat Yes
Session 5 Sum:	

Session 6

Date of Session: _____

Activity/Discussion	*Rating* No=0 Somewhat=1 Yes=2
Identified actions that empower LGBTQ youth in the face of stigma and discrimination	No Somewhat Yes
Identified and assisted with the creation of affirmative caregiving goals	No Somewhat Yes
Utilized the role play activity to help caregiver process their affirming caregiving/parenting goals	No Somewhat Yes
Session 6 Sum:	

Session 7

Date of Session: _____

Activity/Discussion	*Rating* No=0 Somewhat=1 Yes=2
Completed activity "Steps to engage in Affirmative Advocacy" (including introducing the activity, conducting the activity, and debriefing the activity)	No Somewhat Yes

Facilitator explored affirming resources through "My affirming resources" activity (including introducing the activity, conducting the activity, and debriefing the activity)	No Somewhat Yes
Completed "Caring Hands Past and Present" activity (including introducing the activity, conducting the activity, and debriefing the activity)	No Somewhat Yes
Session 7 Sum:	

Grand Total: _____

Maximum Score: 42

Please explain your scores. In particular, if you scored an item as No or Somewhat, please explain why (e.g., what content was missed, how did the activity deviate from the manual).

_____
_____
_____
_____
_____

Appendix F: Random Participant Survey (Via Phone)

Date of Survey: _____ Participant ID # Series #

Dates of Participation: _____ Facilitators' Name: _____

Introduction: Hi. Recently you participated in the AFFIRM Caregiving series. As part of our efforts to ensure that the program was delivered as intended, we would like to ask you a few questions about your experience. Would that be ok with you?

If yes: Great, we really appreciate your willingness to participate. I would like to start by reminding you that this survey shouldn't take longer than 10 minutes, and it will ask questions about your experience with the program. Would now be a good time for you to do this?

If yes: Before we start, I want to let you know that everything in this interview is completely confidential. Please be honest about what your experiences have been like, so that we can use that information to improve this program in the future. Also, if there are any questions during the interview that you don't feel comfortable answering, just say so and we will skip them. Do you have any questions?

If no: I would be happy to call back at another time. When would be good for you?

Begin survey: Please respond to the following questions by choosing a rating between 1 and 5 with 1 indicating "very good" and 5 indicating "very bad" that best describes how you feel about the AFFIRM Caregiving series.

Q#	Question	Response (1-5)	Comments
1	How do you feel about the AFFIRM series overall?		
2	How well did the AFFIRM series help you learn more about LGBTQ youth?		
How well were the facilitators able to:			
3	Present the information in a way that demonstrated an accepting and supportive attitude toward LGBTQ individuals and identities?		
4	Demonstrate empathy and nonjudgment?		
5	Cover all the material in the allotted time?		
6	Use evidence to respond to questions and share information?		

7	Provide opportunities for everyone to be heard.		
8	Create a safe space for you to express your thoughts and feelings?		
9	Provide enough time to work through activities?		

Appendix G: Glossary

**Please note: Words matter! This glossary is meant to provide the most general use of identity terms but please remember that most identity terms are limited because they are rooted in the gender binary. The words we use are important and we want to acknowledge people's agency to use whatever identity term that most resonates with them, or no terms at all. If an individual shares their identity with you, please be sure to ask them what that means for them and not make broad assumptions about the application of language.

Agender: A term used to describe a person who identifies as having no gender or being without any gender identity.

Androgynous: A term used to a describe a person who has a combination of masculine and feminine gender expression or the lack of gender identification; neither clearly masculine nor clearly feminine in appearance.

Asexual: A term used to describe a person with limited or no interest in sexual activity or attraction.

Biphobia: Aversion toward bisexuality or bisexual people as individuals. It can take the form of denial that bisexuality is a genuine sexual orientation, or of negative stereotypes about people who are bisexual. Other forms of biphobia include bisexual erasure.

Bisexual: An umbrella term for people who are attracted to more than one gender. Also used as a specific identity term to describe a person who is emotionally, romantically, or sexually attracted to more than one gender though not necessarily simultaneously, in the same way or to the same degree.

Cisgender: A term that is used to describe a person whose gender identity aligns with the sex they were assigned at birth.

Conversion Therapy: Any attempt to change a person's sexual orientation, gender identity or gender expression. For more information about the harmful effects of conversion therapy, check out https://www.glaad.org/conversiontherapy?response_type=embed.

CYF: [Allegheny County] Office of Children, Youth and Families

DHS: [Allegheny County] Department of Human Services

Gay: An identity term used by some male identified people who are attracted to male-identified people; sometimes used by the general public to refer to all people who are attracted to people of the same or similar gender.

Gender Diverse: A term used to describe a person whose behavior or gender expression does not match socially constructed norms for people perceived to be male or female based on sex assigned at birth. (Other terms describing the same concept are gender nonconforming, gender expansive or gender variant.)

Gender Expression: The ways in which a person communicates gender identity to other through such things as behavior, clothing, hairstyle, voice, body characteristics, roles, and other aspects.

Gender fluid: A term used by some individuals whose gender identity may vary at different points in time.

Gender Identity: A person's sense of themselves as being male, female, some combination of male and female, or neither male nor female.

Genderqueer: A term used by some individuals who identify as being between and/or other than male or female. They may feel they are neither or a little bit of both, or may simply feel restricted by gender labels.

Homophobia: Fear, hatred, discomfort with, or mistrust of people who are lesbian, gay, or bisexual.

Intersex[15]: An umbrella term for differences in sex traits or reproductive anatomy. People are born with these differences or develop them at a young age. Genitalia, hormones, internal anatomy, or chromosomes can develop in many ways.

Implementation Science: The scientific study of methods and strategies that facilitate the uptake of evidence-based practice and research into regular use by practitioners and policymakers.

Lesbian: An identity term used by some female identified people who are attracted to other female-identified people.

LGBTQ2S: Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Two-Spirit

LGBTQIA+: Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual/ Agender

LIS: Local Implementation Site

Pansexual: An identity term used by some individuals who experience attraction to individuals regardless of gender identity or who may experience attraction to all gender identities and expressions – sometimes included under the bisexual umbrella.

PDSA: Plan-Do-Study-Act. PDSA is shorthand for testing a change – by planning it, trying it, observing the results, and acting on what is learned.[16]

Queer: An identity term that has been reclaimed by many members of the LGBTQIA+ communities but not all. Queer can represent an umbrella of identities that are "not-heterosexual" and/or not cisgender. Queer can also represent a rejection of labels or norms/ societal expectations.

Questioning: A term some people use to describe themselves as in the process of exploring their sexual orientation, gender identity, and/or gender expression.

Sex Assigned at Birth:[17] A phrase that refers to the label a medical professional gives to a baby when they are born. A medical professional may say a baby is male, female or intersex, depending on what the medical professional observes about the baby's body. For example, a baby with a vulva will be a labeled a girl, and a baby with a penis will be labeled a boy. Some babies may have bodies or chromosomes that don't fit the typical [socially constructed] categories of male or female. A medical professional may label them as intersex. Sex assigned at birth is about how someone else sees our bodies and does not take into consideration how we feel inside.

15 https://interactadvocates.org

16 https://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

17 https://amaze.org/video/gender-identity-sex-at-birth/

Standards of Practice: A set of decision-making rules or general instructions related to providing services to clients or interacting with colleagues. Standards of practice are based on research and industry best practices.

Sexual Orientation: An enduring pattern of romantic or sexual attraction (or a combination of these) to people of one gender, more than one gender, all genders or none.

SOGIE: Sexual Orientation, Gender Identity, and Expression

Transgender: An umbrella term for individuals whose gender identity does not align with the sex they were assigned at birth.

Transphobia: A strong dislike, hatred, sense of disgust, or fear related to trans* people. It is observed in both conservative anti-LGBT+ circles and in some self-identified progressive communities, such as the trans-exclusionary radical feminist (TERF) movement. Transphobic beliefs and practices are a source of anxiety, violence, and systematic discrimination against transgender people.

Transphobia intersects significantly with other forms of hatred and discrimination, including homophobia and misogyny, and may take the form of transmisogyny. The word “transphobia” is related to, but distinct from, cissexism, although there is some overlap and some people use the terms interchangeably. Whereas cissexism is a belief that cisgender people are superior, transphobia is a hatred for people who are not cisgender.

Two Spirit: An umbrella term that bridges Indigenous and western understanding of gender and sexuality introduced by indigenous people to deepen understanding and learning. Two-spirit refers to another gender role to be common among most if not all First Nations. Two-Spirit people hold proper place and acceptance in communities - this term is rooted in spiritual understanding that all life is sacred.