Evaluation Results from

Texas

Final Evaluation Report
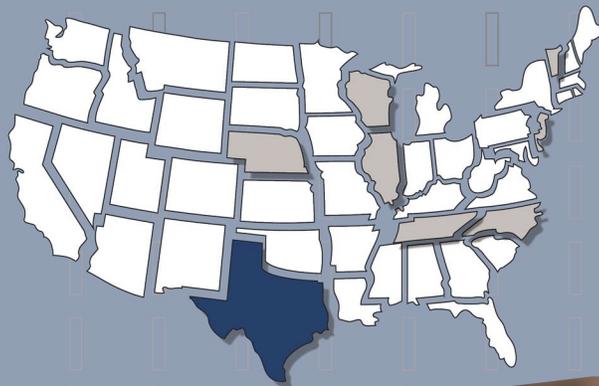
September 2019

Chapter 3: Texas

Note to the reader of this report

The QIC-AG evaluation involved eight sites and eight evaluation reports. The full evaluation report has one chapter per site. For site-specific reports (what you are reading here), we have included a background section (Chapter 1), the individual site report (Texas is Chapter 3), and a cross-site evaluation (Chapter 10). The chapter numbers reflect the chapters designated in the full report.

Report Authors

Laura Marra, MSSW | Research Director
Texas Institute for Child & Family Wellbeing
The University of Texas at Austin, Steve Hicks School of Social Work

Rowena Fong, EdD | Co-PI, QIC-AG | Ruby Lee Piester Centennial Professor
Fellow, American Academy of Social Work and Social Welfare
The University of Texas at Austin, Steve Hicks School of Social Work

Monica Faulkner, PhD, LMSW | Research Associate Professor | Director
Texas Institute for Child & Family Wellbeing
The University of Texas at Austin, Steve Hicks School of Social Work

Catherine LaBrenz, PhD | Research Coordinator
Texas Institute for Child & Family Wellbeing
The University of Texas at Austin, Steve Hicks School of Social Work

Shontell Smith | Doctoral Student
Department of Educational Psychology
The University of Texas at Austin, College of Education

Nancy Rolock, PhD| Co-PI, QIC-AG | Associate Professor
Jack, Joseph and Morton Mandel School of Applied Social Sciences
Case Western Reserve University

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

Acknowledgements

Evaluation Results from Texas

PROJECT PARTNERS

QIC-AG partnered with the **Texas Department of Family Protective Services (DFPS)**

CONTINUUM PHASE

Focused Services

INTERVENTION

Texas DFPS implemented **Pathways to Permanence 2: Parenting Children Who Have Experienced Trauma and Loss** (Pathways 2). Pathways 2 is a seven-session (21-hour) group-delivered interactive series for caregivers that helps caregivers understand the impact of trauma and loss on all aspects of a child's development.

STUDY DESIGN

Quasi-Experimental

The target population included **children and youth up to the age of 18 years old in Texas Permanent Managing Conservatorship** (PMC)

Children in Region 8 were assigned to the comparison group and received services as usual

Children in Region 7 were assigned to the intervention group and received Pathways 2

RESEARCH QUESTION

Will children in Permanent Managing Conservatorship (PMC) of Texas DFPS in Region 7 who do not have a finalization hearing scheduled within 60 days of screening experience: increased permanency outcomes; decreased time to finalization/permanence or time in care; increased placement stability; improved child and family wellbeing; and improved behavioral health for children and youth if families are provided with Pathways to Permanence 2 compared to families who receive services as usual in DFPS Region 8?

Findings

PARTICIPATION

☑ **135** CAREGIVERS WHO RECEIVED PATHWAYS 2 ATTENDED 5+ SESSIONS (76%)

☑ **117** CAREGIVERS IN THE COMPARISON GROUP COMPLETED THE SURVEY (43%)

GRIEF AND LOSS

Pathways 2 caregivers scored significantly higher on the post and significantly higher than the comparison group on their understanding of grief and loss. When caregivers fully understood grief and loss, they were able to shift the way they responded to their child.

CHILD BEHAVIOR

SURVEY SESSIONS

After six months, Pathways 2 caregivers reported a **significant decrease in their child's tendency to internalize problems** such as anxiety, depression, social withdrawal, and somatic symptoms.

Pathways 2 had a greater impact on child behavior for relative families.

HIGHER SCORE = MORE BEHAVIOR CHALLENGES

29.7

25.0 Non-relatives

24.7

Relatives 22.6

PRETEST (Before Pathways 2)

POSTTEST (6 months after Pathways 2)

The Behavior Problems Index (BPI) measures the frequency, range, and type of childhood behavior problems that children ages four and older may exhibit.

Six month after attending Pathways 2...

☑ **89%** had a better understanding of attachment

☑ **87%** had a better understanding of child development

☑ **85%** felt more able to respond to their child's needs

RECOMMENDATION

Offer Pathways 2 as a trauma-informed training to help prepare and support families. In terms of outreach, it may be helpful to encourage kinship caregivers, in particular, to attend trainings. Additionally, we found that advertising the provision of free childcare was a helpful incentive. Almost half of the Pathways 2 families said they would not have come without childcare.

The University of Texas at Austin
Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work

JACK, JOSEPH AND MORTON MANDEL SCHOOL OF APPLIED SOCIAL SCIENCES
CASE WESTERN RESERVE UNIVERSITY

This research summary was designed by staff at the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work, in conjunction with the Jack, Joseph and Morton Mandel School of Applied Social Sciences at Case Western Reserve University.

Evaluation questions? Please contact Nancy Rolock at nancy.rolock@case.edu or Rowena Fong at rfong@austin.utexas.edu.

Executive Summary

Overview

Children experience trauma, grief, and loss when they are removed from their families because they cannot safely live at home.The impact of this removal is further compounded by the age of the child at the time of removal, the length of time a child is in care, the number of times a child's placement is changed, and whether or not the rights of the child's parents are terminated. Additionally, in children, the experience of trauma, grief, and loss adversely affects their social, emotional and behavioral wellbeing. Therefore, it is essential that caregivers are prepared and supported to address the increased needs of children who have experienced trauma, grief, and loss. If caregivers receive training and support, these resources will likely have a positive impact on placement stability and permanency outcomes. The National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) has partnered with the Texas Department of Family Protective Services (DFPS) to test an intervention aimed at finding permanent families for children in foster care.

The Theory of Change for this project was that if DFPS identifies families and prepares caregivers to parent children in Texas Permanent Managing Conservatorship (PMC) who have been exposed to trauma, grief, and loss, then:

- More permanent families will be identified;

- Families will be ready and prepared to become parents of these children through adoption or permanent managing conservatorship; and

- The children will be ready for legal permanence.

If all of this happens, then an increased number of children in PMC of DFPS will move to permanence.

Intervention

After thoroughly reviewing evidence-based and promising practices, the Texas DFPS identified Pathways to Permanence 2: Parenting Children Who Have Experienced Trauma and Loss (Pathways 2) © 2012 Kinship Center, a Member of Seneca Family of Agencies as the intervention to help prepare families. Pathways to Permanence 2 was located in the **Develop and Test** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*.

Pathways 2 is a seven session (21-hour) group-delivered interactive series for caregivers that helps caregivers understand the impact of trauma and loss on all aspects of a child's development. The series provides caregivers with opportunities to practice new tools and strategies, which help create a stabilizing and healing environment for children who have experienced trauma and loss. This intervention had not been implemented previously in Texas.

The purpose of this evaluation is to compare the impact that current services and Pathways 2 have on permanency outcomes, time in care, child and family wellbeing, and the behavioral health of children and youth in PMC of Texas DFPS.

Primary Research Question

The primary research question was:

Will children in Permanent Managing Conservatorship (PMC) of Texas DFPS in Region 7 who do not have a finalization hearing scheduled within 60 days of screening (P) experience: increased permanency outcomes; decreased time to finalization/permanence or time in care; increased placement stability; improved child and family wellbeing; and improved behavioral health for children and youth (O) if families are provided with Pathways to Permanency 2 (I) compared to families who receive services as usual in DFPS Region 8 (C)?

The Texas QIC-AG team used a quasi-experimental design to evaluate the effectiveness of Pathways 2. In Region 7, parents were surveyed at two time points, once before participating in Pathways 2 and again six months after completing Pathways 2. In addition, a survey was distributed to families in Region 8 following the same timeline used in Region 7. Region 8 families served as the comparison group.

Key Findings and Discussion

RECRUITMENT AND FIDELITY

Over the course of the recruitment period in Region 7, a total of 671 families were mailed informational flyers inviting them to participate in Pathways 2. Of those, 178 families registered to participate, and 120 families (178 caregivers) participated. At baseline, these families were caring for 230 children, of which 84% were either adopted, in legal conservatorship, foster care, or kinship care.

For this study, we looked at 85 families (110 caregivers) who attended at least five sessions of Pathways 2 and completed the pre and post survey. We used propensity score matching to match these families with 117 comparison group families based on their child's living arrangement (kinship, basic, moderate, therapeutic home settings), the total number of placements, and age at baseline. A total of 79 caregivers in the intervention and comparison were matched on these characteristics.

We used fidelity logs, observations, attendance tracking, and participant evaluations to assess the fidelity of Pathways to Permanence 2 in Texas. Overall, the average percent of content taught as suggested across the seven sessions in a series ranged from 77.25% to 100.0%.

One goal of implementing Pathways 2 was to help caregivers understand the grief, trauma, and loss experienced by children removed from their biological parents. Overall, caregivers who participated in Pathways 2 had a better understanding of grief and loss experienced by children removed from their biological parents compared to the matched caregivers who received services as usual. For example, Pathways 2 caregivers were more likely to **agree** that:

- Loss is a part of life for children who do not live with their birth parents.

- Children lose a part of their identity through adoption and permanence.

- Children have lifelong connections to their birth families and permanent families.

We are cautious in interpreting differences in child, caregiver and family wellbeing measures between the intervention and comparison group. There was likely a selection effect on what motivated caregivers to attend Pathways 2 compared to what motivated caregivers to take a survey. Caregivers who decided to attend Pathways 2 were likely the caregivers who may have been struggling and needing more support. Unfortunately, we were not able to control for differences at baseline in child behavior, caregiver commitment or caregiver strain. As a result, it is difficult to draw conclusions or interpret findings.

Keeping this limitation in mind, we generally found that caregivers in the comparison group reported fewer problematic behaviors, lower levels of strain and higher levels of family functioning and caregiver resilience. While behavior and strain were higher for Pathways 2 families, there were no differences in commitment or permanency outcomes. In fact, as of April 2019, we found that 68% of children in the intervention group were adopted or in PMC of the same caregiver, compared to 64% of children in the comparison group. While not a statistically significant finding at this time, the higher proportion of children in the intervention group is an encouraging sign.

INTERVENTION SPECIFIC OUTCOMES

Within the intervention group, we saw significant improvements in caregiver understanding of grief and loss from pre to post. Additionally, over 80% of Pathways 2 caregivers reported that their understanding of attachment and child development, ability to respond to their child's needs, and confidence in parenting their child had improved since participating in Pathways 2. We've included sample comments taken from the six month post surveys of two participating caregivers below:

> "It has got me to think about how to best parent each of my children and opened me up to more alternative discipline techniques. It has also helped me to understand why it is a slow process."

> "I have new tools to help me parent this child. I understand better what the trauma has done to her and her path in life. I am better at solving problems now."

We also used mixed linear modeling to: 1) look at changes in child behavior problems from pre to post, and 2) determine if changes looked different based on whether or not a caregiver was biologically related to their child. Six months after participating in Pathways 2, we saw a significant decrease in child internalizing behavior problems (anxiety, depression, social withdrawal, and somatic symptoms). When looking at differences between relative and non-relative families, we found that Pathways 2 had a greater impact on child behavior problems for relative families. Relative caregivers reported higher behavior problem scores at pre and lower behavior scores at

post compared to non-relative caregivers. Scores for non-relative caregivers stayed relatively consistent from pre to post.

Changes in family functioning, caregiver strain, and caregiver resilience were not found at this time; however, this result is not particularly surprising. Changing the way a family operates or seeing levels of caregiver strain decrease often takes longer than a period of six months. Ideally, we would have tracked changes over a longer period of time to account for changes that may take longer to achieve. Lastly, we found a small but statistically significant decrease in caregiver commitment from pre to post. When explored further, we noticed that the overall average commitment score was heavily influenced by extremely low scores of just a few caregivers who were no longer parenting their child. The majority of caregivers had commitment scores that either improved or stayed about the same.

Pathways 2 provided caregivers with a foundation to understand trauma, grief, and loss and empowered caregivers with new tools to help them parent their children in a way that addresses impaired-attachments and trauma. When caregivers fully understood grief and loss, there seemed to be a shift in the way they parented and responded to their children. This shift is important for creating a safe and healing home environment and led to a significant decrease in internalizing behavior problems after six months. Moving forward, it may be helpful to:

- **Offer and encourage kinship families to attend Pathways to Permanence 2.** Pathways 2 had a greater impact on child behavior after six months for relative families compared to non-relative families. This findings has significant implications for kinship families, particularly in regions where a high percentage of children are placed in kinship care.

- **Offer Pathways 2 as a trauma-informed training to help prepare and support families.** In Texas, there is a focus on improving and expanding existing trauma-informed care trainings and services throughout the state. Increasing awareness about Pathways 2 and offering this training to families as an additional trauma-informed training option supports this goal. Ideally, any licensed caregiver would also have the opportunity to receive credit-hours that could be used towards their annual training requirements.

- **Provide free childcare during Pathways 2 trainings.** Almost half (45%) of caregivers in this study reported that they would not have attended Pathways 2 had there not been free childcare. Another fourth (25%) were unsure whether or not they could have attended. Having free childcare, among all other factors, seemed to be the most important factor in determining whether or not a family could attend Pathways 2.

- **Develop a Pathways 2 Train the Trainer Model in Texas.** Lastly, to increase the likelihood of sustainability, we suggest that at least two facilitators in Texas receive the Pathways 2 "Train the Trainer" training that would allow them to train future Pathways 2 facilitators in Texas.

Cross-Site Summary

The cross-site evaluation (Chapter 10 of the full report) summarizes overarching themes and analyses found across six QIC-AG sites that focused on addressing issues post permanence: Vermont, Illinois, New Jersey, Catawba County (North Carolina), Wisconsin, and Tennessee. Key findings from the cross-site are summarized below.

Key questions that can help sites identify families who are struggling post permanence. An important aspect of prevention work with adoptive and guardianship families is to be able to identify families who may be the most likely to experience post permanency discontinuity and diminished wellbeing. Through the QIC-AG we asked key questions to better understand issues related to post permanency discontinuity. Our findings show promise for using a set of questions related to familial issues to distinguish families who were struggling and those who seemed to be doing alright. These questions could be administered yearly to all adoptive and guardianship families, with targeted outreach directed at families whose responses suggest they may be at an elevated risk for post permanency discontinuity.

Child welfare jurisdictions interested in targeted outreach to adoptive or guardianship families may consider periodically checking in with families to assess their level of caregiver commitment and familial relationship (e.g., the parent or guardian's assessment of how well they can manage their child's behavior). Based on the responses received from this check-in, jurisdictions could consider targeting outreach to families based on responses to key familial relationship questions piloted with the QIC-AG project.

Maintain connections with families after adoption and guardianship. Connections to services, supports, and resources should begin prior to adoption or guardianship finalization and continue to be maintained after finalization.

Reduce barriers to post adoption service use and empower families to seek services and supports. This process may be made easier by maintaining connections through universal outreach, which includes providing information about availability and eligibility for services after adoption or guardianship finalization so that families know how and where to access supports and services.

Offer support through periodic, targeted outreach to families who exhibit characteristics that suggest they may be at an increased risk for post permanency discontinuity. This could be, for instance, annual check-ins with families to see how they are doing.

Support is important. Families reported that at times what is needed is a friendly voice on the other end of the phone who can listen to struggles regarding birth family contact or provide support for older caregivers. Other times it is helping to get intensive residential treatment services for their child without relinquishing custody. Participants reflected on the important social connections (informal social support) made by attending sessions. Survey respondents reported that they needed formal support from the child welfare and school systems, as well as support in accessing services for their child post-permanence. It is important to understand what *support* means to the family and to find a way to offer it in a timely manner.
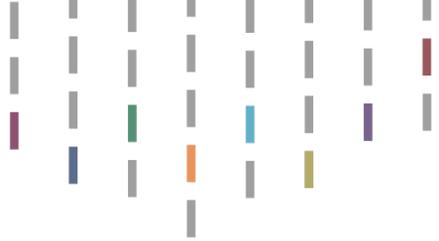
Chapter 1

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QIC-AG Overview

The Children's Bureau, Administration for Children and Families, and Department of Health and Human Service established the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG). In October 2014, the QIC-AG was awarded to Spaulding for Children in partnership with The University of Texas at Austin, The University of Wisconsin at Milwaukee, and The University of North Carolina at Chapel Hill (these entities are referred to as the QIC-AG partners). The QIC-AG was designed to promote permanence when reunification is no longer a goal and improve adoption and guardianship preservation and support. The work of the QIC-AG was guided and supported by a Professional Consortium consisting of experts and leaders in such areas as adoption, guardianship, child safety, permanence, and wellbeing, as well as adult and youth with direct adoption and guardianship experience.

For five years, the QIC-AG team worked with eight sites across the nation, with the purpose to implement evidence-based interventions or develop and test promising practices which, if proven effective, could be replicated or adapted in other child welfare jurisdictions. The project's short-term outcomes varied by site and included, for example, increased level of caregiver commitment, reduced levels of family stress, improved familial relationships, and reduced child behavioral issues. The project had three long-term outcomes: increased post permanency stability, improved behavioral health for children, and improved child and family wellbeing.

Background

In 1984, there were 102,100 children in IV-E funded substitute care and 11,600 children receiving IV-E adoption subsidies (see Figure 1.1). By 2001, nearly equal numbers of children were in IV-E subsidized substitute care and IV-E funded adoptive or guardianship homes. Between 2000 and 2017, while the U.S. substitute care caseload decreased, the number of children in adoptive and guardianship populations doubled. In the United States in 2017, the most current available data, for every 1 child in federally assisted substitute care, there were 3.1 children in IV-E federally assisted adoption or guardianship homes. Estimates for 2018 and 2019 suggest that this trend will continue. In 2019, it is estimated that the number of children in IV-E funded substitute care will be approximately the same as in 2017, but the number of children in IV-E federally assisted adoption or guardianship homes will continue to increase (Committee on Ways and Means of the U.S. House of Representatives, 2018).

Figure 1.1. National Average Monthly IV-E Funded Caseloads
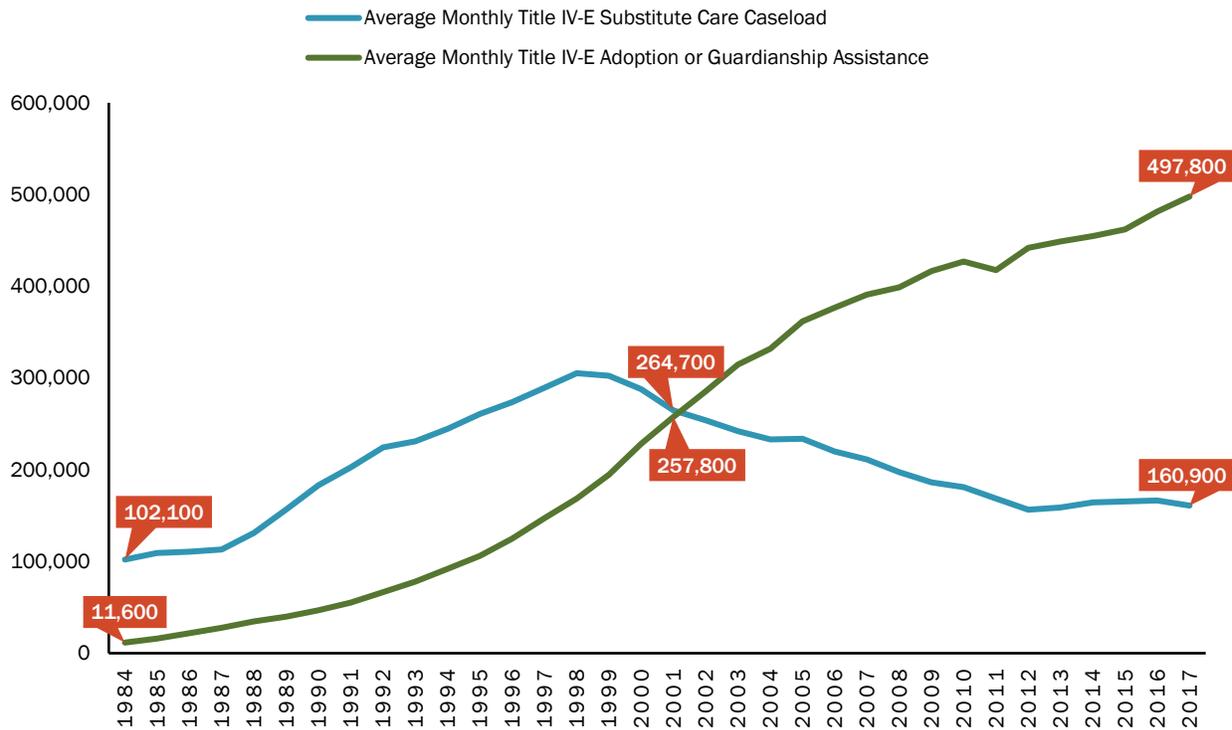
Data sources: The information on federally-funded caseloads are from the Committee on Ways and Means (CWM) of the U.S. House of Representatives and represents the average monthly Title IV-E caseloads.

The dramatic increase in the number of children who have transitioned from substitute care to adoption and guardianship has been accompanied by a heightened awareness of the complex needs that these families may encounter after permanence has been achieved. Research has found that most adoptive parents and guardians provide permanent homes for the children in their care (Rolock, 2015; Rolock & White, 2016; Testa, Snyder, Wu, Rolock & Liao, 2015; White, 2016). However, post permanency instability can occur years after a child has been with an adoptive parent or guardian. Difficulties do not disappear spontaneously once an adoption or guardianship is finalized.

One of the most important challenges confronting the child welfare system in the 21st century is addressing the needs of families formed through adoption or guardianship. The good news in this area is that research has established that most families formed through adoption or guardianship do not experience post permanency discontinuity (PPD). PPD has been estimated somewhere between 5% and 20%, depending on the type of population or sample examined and on how long children and families are observed (Rolock, Pérez, White, & Fong, 2018; Rolock, 2015; White, 2016). PPD may stem from the maltreatment children endured before being placed with their adoptive parent or guardian (Simmel, Barth, & Brooks, 2007). Children who have experienced trauma can demonstrate challenging behaviors at a frequency, intensity, and duration that can stress families beyond their capacity to cope (Barth, Crea, John, Thoburn, & Quinton, 2005; Lloyd & Barth, 2011; Tan & Marn, 2013). Other complex, interrelated factors can also impact post adoption and guardianship stability such as the age or developmental stage of the child (White, 2016), a child who has multiple disabilities and/or needs (Reilly & Platz, 2004), the age of the adoptive parent (Orsi, 2014), a lack of available services for families (Rolock & White, 2016), and weakening relationships or attachments between the child and parent (Nieman & Weiss, 2011).

Few empirical studies have focused on interventions that reduce the risks of post permanency discontinuity. However, best practices indicate proactive measures can be effective in increasing the likelihood of stability, particularly when they occur prior to permanence. Prevention interventions can include: recognizing the strengths, resilience and resources of caregivers (Crumbley, 1997, 2017); having adoption and guardianship competent professionals who are culturally sensitive and trauma-informed (Fong, McRoy, & McGinnis, 2016); developing safety plans in case an alternative placement is needed (Casey Family Programs, 2012); identifying services that best suit the children and family's needs (Testa, Snyder, Wu, Rolock & Liao, 2015); ensuring family input in evaluating outcomes of services; and connecting families with other adoptive or guardianship families (Egbert, 2015).
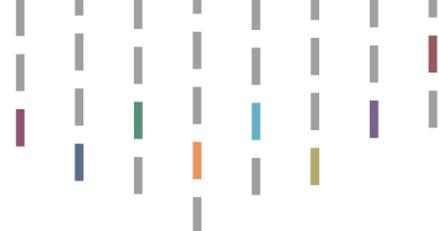
QIC-AG Target Populations

Target Group 1

The QIC-AG project had two target groups. The population in **Target Group 1** was defined as:

Children and youth identified within the selected state, county, or tribal child welfare systems awaiting an adoptive or guardianship placement, or children or youth that are in an identified adoptive or guardianship home but the placement has not resulted in a finalization for a significant period of time due to the challenging mental health, emotional, or behavioral issues of the youth.

PICO RESEARCH QUESTION

The PICO question for Target Group 1 was:

Do foster children and youth in an identified adoptive or guardianship home for a significant period of time **(P)** have increased permanence, wellbeing and stability **(O)** if they receive permanency planning services **(I)** compared with similar foster children/youth who received services as usual **(C)**?

THEORY OF CHANGE

The **Theory of Change** for Target Group 1 was based on the principle that existing child welfare interventions targeting families on the brink of disruption and dissolution do not serve the interests of children, youth, and families. Evidence indicates post permanency services and support should be provided at the earliest signs of trouble, rather than at later stages of weakened family commitment (Testa, Bruhn & Helton, 2009). Ideally, preparation for the possibility of post permanency instability should begin prior to finalization by delivering evidence-supported permanency planning services that equip families with the capacity to weather unexpected difficulties and seek needed services. The best way to ensure families will seek services and supports when they need them after finalization is to prepare them in advance of permanence and check-in with them periodically after adoption or guardianship finalization.

Target Group 2

The population in **Target Group 2** was defined as:

Children and youth and their adoptive or guardianship families who have already finalized the adoption or guardianship and for whom stabilization may be threatened will also be targeted for support and service interventions. The children and youth in this target group may have been adopted through the child welfare system or by private domestic or intercountry private agency involvement.

The PICO question for Target Group 2 was:

Do families with a finalized adoption or guardianship **(P)** have increased post permanency stability and improved wellbeing **(O)** if they receive post permanency services and support **(I)** compared with similar families who receive services as usual **(C)**?

The **Theory of Change** for Target Group 2 suggests that predictors of post permanency instability can include: (1) caregivers' assessment of child or youth behavior problems and (2) caregivers' self-report of their caregiving commitment (Testa, et al, 2015). Site-specific interventions should target families most at risk of post permanency instability. Post permanency stability can be maintained by checking-in with families after finalization to identify needs and assess permanency commitment. By providing post permanency services and support, the capacity of caregivers to address the needs of the children in their care will increase and reduce the needs of these children. Families who are provided with services and support will have increased capacity for post permanency stability and improved wellbeing.

Private Domestic and Intercountry Adoptive Families

The challenges associated with providing a stable, long-term and permanent home are not consigned to adoptions and guardianships that occur through the child welfare system. Private domestic and intercountry adoptive families can also encounter post permanency disruptions and discontinuity. Children and youth adopted intercountry may experience additional challenges not typically found in domestic adoptions such as adapting to an unfamiliar culture and language (Fong, McRoy, & McGinnis, 2016). The QIC-AG project team collaborated with staff from the State Department to obtain information on the process of adopting children via intercountry and preparing and training adoptive families. Consultation with the State Department was an important resource for the QIC-AG team, particularly in determining how intercountry adopted children and youth could be included in sites working with families who had already adopted (Target Group 2). Of the eight sites selected, the six sites working with families after finalization (Illinois, Tennessee, Catawba County (NC), Wisconsin, New Jersey and Vermont) included families who had adopted privately, both domestically and internationally, in their project outreach. This report provides basic characteristics of the intercountry and private domestic adoptive families who participated in the project in those six sites. Vermont outreached to agencies and organizations who served families through private domestic or intercountry adoption and implemented a survey (see survey results in Appendix in Vermont site report). A separate evaluation, conducted by the University of Nebraska – Lincoln, provides additional information on this group of families.

QIC-AG Continuum of Services

Pre Permanence

The QIC-AG developed the *QIC-AG Permanency Continuum of Service* to guide its work with the different sites (see Figure 1.2). The framework is built on the premise that children in adoptive or guardianship families do better when their families are fully prepared and supported to address needs or issues as they arise. The Continuum Framework is arranged as eight intervals, beginning with prior to adoption or guardianship finalization *(Stage Setting, Preparation,* and *Focused Services)*, continuing to post permanence *(Universal, Selective,* and *Indicated prevention efforts)*, and ending with the final two intervals that focus on addressing *Intensive Services* and *Maintenance* of permanence, respectively. The focus of this continuum is children for whom reunification is not a viable option.

Figure 1.2. QIC-AG Permanency Continuum
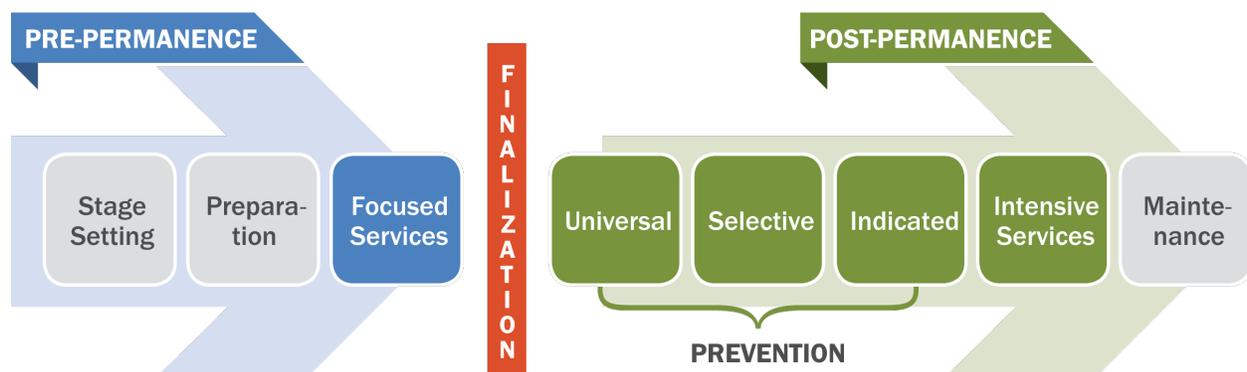
Taken together, the eight intervals serve as an organizing principle that helps guide children within the selected state, county, or tribal child welfare systems transition to adoption or guardianship while supporting families to maintain stability and wellbeing after adoption or guardianship has been achieved. In practice, the intervals overlap, but to ensure clarity the following section will describe each phase of the framework separately. QIC-AG sites did not test interventions in those intervals in gray in Figure 1.2 (stage setting, preparation, and maintenance).

Stage Setting

Setting the stage for permanence focuses on the critical period after a child has entered the child welfare system when information is obtained, decisions are made, and actions take place that will affect the trajectory and ultimately the permanency outcome for the child. The **Stage Setting** interval entails not only concurrent planning but also proactive preparation and training with all stakeholders to minimize both the number of placement transitions and the negative impact of those transitions on the child. Effectively managing transitions involves implementing specific preparations for children and foster parents, improving coordination between service providers responsible for supporting the children, and proactively developing transition plans.

Preparation

Once it is determined that reunification is not an option, specific activities must take place to identify appropriate permanency resources and prepare the children and the families for adoption or guardianship. The **Preparation** interval focuses on the activities that help to identify the resources that will support children and families to make a successful transition from foster care to adoption or guardianship.

Focused Services

Focused Services are designed to meet the needs of children with challenging mental health, emotional, or behavioral issues who are waiting for an adoptive or guardianship placement. **Focused Services** target children in an identified adoptive or guardianship home for whom the placement has not resulted in a finalization for a significant period of time. It is possible that some of these children have experienced a disrupted or dissolved adoption or guardianship, including children who have been adopted via private domestic or intercountry processes. **Focused Services** are intended to prepare families to meet the needs of children in this population and become permanent resources. The two sites that tested **Focused Service** interventions were *Texas* and the *Winnebago Tribe of Nebraska* (see Figure 1.3).

Post Permanence

The first three intervals on the post permanency side of the framework focused on testing prevention efforts at the Universal, Selective and Indicated levels of prevention (see Figure 1.3 for a depiction of the various levels of prevention).

Figure 1.3. Prevention Framework
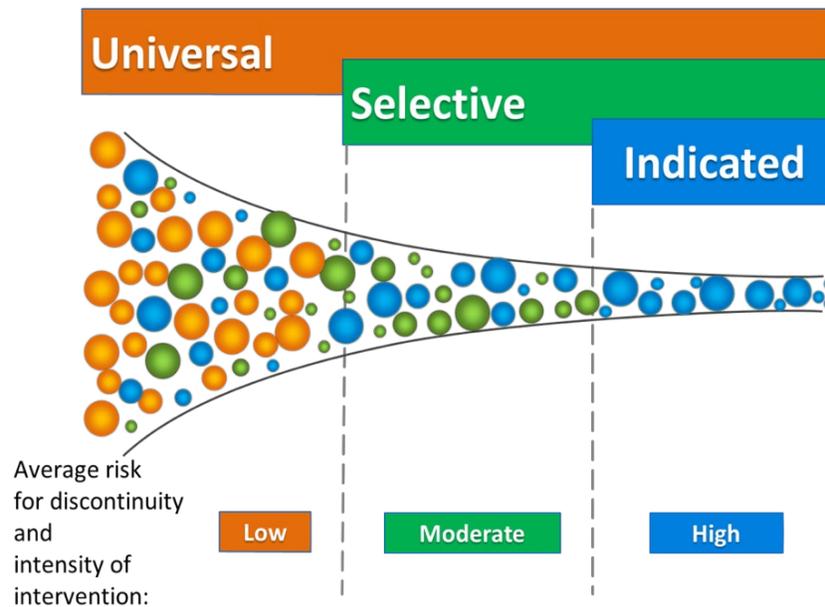
The prevention framework is based on the work of the Institute of Medicine (IOM) prevention planning (Springer & Phillips, 2006).

Universal

Universal prevention is defined as strategies that are delivered to broad populations without consideration of individual differences in risk (Springer and Phillips, 2006).

For the QIC-AG project, **Universal** prevention efforts targeted families after adoption or guardianship had been finalized. **Universal** strategies include outreach efforts and engagement strategies that are intended to: 1) keep families connected with available supports, 2) improve the family's awareness of the services and supports available for current and future needs, and 3) educate families about issues before problems arise. **Universal** prevention strategies can include maintaining regular, periodic outreach to children and families in adoptive or guardianship homes, including families where permanence has recently occurred or for whom it was achieved a few, or several, years ago. *Vermont* tested a post permanence **Universal** prevention intervention.

Selective

In **Selective** prevention efforts, services are offered to sub-groups of individuals identified based on their membership in a group that has an elevated risk for a particular outcome (Offord, 2000; Springer and Phillips, 2006). **Selective** services are preventive and offered proactively, seeking to engage families before a specific need is indicated.

For the QIC-AG project, **Selective** intervention efforts were targeted at families who, based on characteristics known at the time of adoption or guardianship finalization, may be at an elevated risk for post permanency discontinuity. **Selective** services are preventive and offered proactively, seeking to engage families before a specific need is indicated. Child welfare research provides some insight into the characteristics of children and families who are at an elevated risk for post permanency discontinuity, including children who: are older at the time of permanence or have experienced multiple moves. *New Jersey* and *Illinois* tested **Selective** prevention interventions.

Indicated Services

Indicated prevention efforts focus on interventions that seek to address specific risk conditions; participants are identified based on characteristics they themselves have (Offord, 2000; Springer and Phillips, 2006).

For the QIC-AG project, **Indicated** prevention efforts were defined as services that target families who request assistance to address an issue that has arisen after permanence has been achieved, but before the family is in crisis. For instance, when families call an agency with a question about a referral for a service, this might **Indicate** that they are beginning to struggle with issues or may have reached a point where they no longer feel like they can address the issues on their own. *Wisconsin* and *Catawba County (NC)* tested **Indicated** prevention interventions.

Intensive

Intensive services target families who are experiencing difficulties beyond their capacity to manage on their own, and are therefore seeking services. Families may be at imminent risk of experiencing a crisis or may already be in a crisis situation. Services are offered that aim to diminish the impact of the crisis, stabilize and strengthen families who receive services. **Intensive** services are not intended to be preventative in nature. Services include **Intensive** programs designed for intact families who are experiencing a crisis that threatens placement stability and families who have experienced discontinuity. *Tennessee* tested an **Intensive** services intervention.

Maintenance

The aim of **Maintenance** is to achieve the long-term goals of improved stability and increased wellbeing for those who experienced discontinuity or were at serious risk for experiencing discontinuity. For example, children and families who received **Indicated** prevention or **Intensive** services could receive **Maintenance** prevention services in the form of after-care services, monitoring, and booster-sessions.
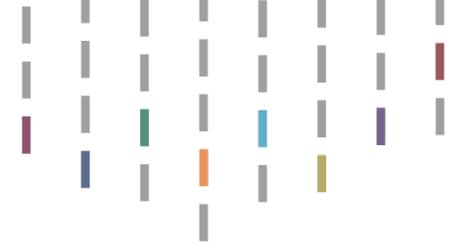
Site Selection

Between October 2014 and March 2015, the QIC-AG team identified sites through preliminary research and a deliberate assessment process. The QIC-AG partners evaluated potential sites using a three-phase assessment process: **Pre Assessment**, **Initial Assessment**, and **Full Assessment**. As the assessment progressed through the phases, the information in each category increased in scope and depth. Each assessment phase was focused on answering a specific question or identifying a specific outcome in relation to six categories: Organizational Demographics, Population, Data Capacity, Continuum of Services/Interventions, Organizational and Evaluation Readiness, and Sustainability. The information gathered during each phase of the process was used by QIC-AG partners to determine which sites would continue to the next phase of assessment and ultimately which sites would be selected as partners.

Pre Assessment

The **Pre Assessment** phase gave the QIC-AG team an opportunity to gather limited, readily available information critical to understanding a site's potential to support the QIC-AG's efforts. From the 29 states, counties, or private agencies that contacted QIC-AG and expressed interest in learning more about the QIC-AG initiative, 18 sites moved on to the **Pre Assessment** phase.

Initial Assessment

The **Initial Assessment** phase was designed to help sites determine their interest, readiness, and capacity to partner with, and support the goals of, the QIC-AG. Meetings were held with the sites to explain the QIC-AG initiative, review and confirm site-specific information collected during the **Pre Assessment** phase, and collect additional detailed information on the six categories. Twelve states and counties had initial assessments that were conducted during an on-site visit. Per the requirements of the QIC-AG cooperative agreement, every attempt was made to ensure sites were diverse in relation to size of the child welfare system, the urban/rural make-up, geographic region, and type of child welfare administrative system. The QIC-AG leadership team developed rating forms to assess the information gathered on the sites and make decisions about which sites would proceed to the **Full Assessment** phase.

The evaluation team had focused discussions at each site regarding the QIC-AG outcomes and the types of data required for tracking children across the continuum. This included discussions about data capacity (access to Adoption and Foster Care Analysis Reporting System (AFCARS), and the ability to link foster and adoption IDs and track children after adoption and guardianship. Furthermore, the benefits of conducting a rigorous evaluation using a randomized controlled trial (RCT) were discussed with each potential site.

Full Assessment

Several states and counties were identified to participate in the **Full Assessment** phase. This process focused on obtaining foundational knowledge of each site's continuum of services and readiness to participate in this initiative. Questions were developed for each site based on review of the information obtained during the **Initial Assessment** phase. In May 2015, the QIC-AG leadership spoke with each site individually to obtain answers to the questions. This information was brought back to the QIC-AG leadership team and ultimately these states or counties were selected: Catawba County (NC), Illinois, New Jersey, Tennessee, Texas, Vermont, and Wisconsin.

Tribal Selection Process

Site selection for a tribal child welfare system followed a similar path but was tailored to tribes. Between March and April 2015, the QIC-AG partners conducted outreach and engaged in preliminary conversations with tribes who expressed an interest to discuss potential collaborations. Tribal experts were consulted and Connie Bear King was hired to lead the outreach and selection process for the project. Connie Bear King followed up individually with the tribes that had expressed interest in the QIC-AG initiative as well as with tribes that had been recommended by other entities as possible candidates for this initiative. As a result of this **Preliminary Assessment,** five tribes expressed interest in being selected as a partner site, and ultimately three tribes moved to the **Initial Assessment** phase. The **Initial and Full Assessment** process was adapted for the tribal selection process. It followed a similar process as the one outlined above. Site visits were conducted, and additional information collected by phone and in person. Ultimately, the Winnebago Tribe of Nebraska was selected in July 2015.

Implementation & Evaluation

Each of the sites had a site-specific team that worked closely with the site (Catawba County (NC), Illinois, New Jersey, Tennessee, Texas, Vermont, Winnebago Tribe, and Wisconsin). Each team consisted of one of the two QIC-AG Principal Investigators (Dr. Nancy Rolock and Dr. Rowena Fong), a site consultant (from Spaulding) and a site implementation manager (typically a member of the public child welfare system). Initially, all sites had two site consultants, but in a couple of the sites this shifted to one site consultant during the latter half of the project. In some sites, the site implementation manager role was split between two people. The core team guided the implementation and evaluation of the project.

In addition to the core project team, the work of the QIC-AG project team in each of the sites was guided by a site-specific Project Management Team (PMT), Stakeholder Advisory Team (SAT), and Implementation Team to help design and implement the project. The PMT included key leaders across multiple systems that provided direction in creating a sustainable assessment, implementation, and evaluation model. The SAT served as an advisory group consisting of key community representatives, including consumers and providers of adoption and guardianship services. Both the PMT and SAT teams had representatives from public, private domestic, and intercountry adoptions; adoptive and guardianship families; and representatives from support agencies, as well as adults and youth with direct adoption or guardianship experience. The Implementation Team was responsible for guiding the overall initiative and attending to key functions of implementation of the evaluable intervention. Some sites had other teams to support the data processes and adaptation of interventions.

Evaluation

Drs. Nancy Rolock and Rowena Fong collaborated with the eight sites to develop site-specific evaluation plans. The most rigorous testing and evaluation methods were used vis-à-vis the sites' selected interventions. Structured, standardized implementation and evaluation tools helped guide their work. While the Institutional Review Board (IRB) of the University of Wisconsin-Milwaukee served as the IRB of record, all 8 sites received IRB approval from either the University of Wisconsin-Milwaukee or the University of Texas at Austin. In addition, some sites were also reviewed by agency, Tribal Council, or local university IRBs.

Three sites conducted **Experimental** design studies (Catawba County (NC), Illinois, and New Jersey). Two used a **Quasi-Experimental** design (Tennessee and Texas) and three were **Descriptive** studies (Wisconsin, Vermont, Winnebago Tribe) (see Table 1.1). Initially Wisconsin, Texas and Winnebago had different evaluation designs, but were changed during the course of the project to adapt to the realities of implementing the evaluable intervention in each site.

Guiding Frameworks

To effectively implement and evaluate the site-specific interventions, the QIC-AG merged two existing frameworks: 1) the Children's Bureau (CB) *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare* (2014) and 2) the National Implementation Research Network (NIRN) Active Implementation Frameworks (2005). Each of these frameworks are summarized below.

Guided by the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare,* each site began with the **Identify and Explore** phase. During this phase each site team worked to identify the problem they sought to address. This included examining current services available across the continuum (from pre permanency to post permanence). Sites selected an **intervention** aimed at serving one of the two QIC-AG target populations (defined earlier). Ultimately this resulted in the development of a specific, well-built **research question** using the Population, Intervention, Comparison Group, Outcome (PICO) framework (Testa & Poertner, 2010). Using the PICO framework, each site narrowed their target population, determined a comparison group, and site-specific outcomes. The PICO was expanded into a **Logic Model** which guided the intervention selection, implementation and evaluation, and a **Theory of Change** that hypothesized how the intervention being tested at their site would bring about the project outcomes.

Each of the eight sites chose an intervention that was embedded in one of four phases of the CB Framework (see Figure 1.4).

Figure 1.4. A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare

Phases of CB Framework

1. **Develop and Test**
2. **Compare and Learn**
3. **Replicate and Adapt**
4. **Apply and Improve**
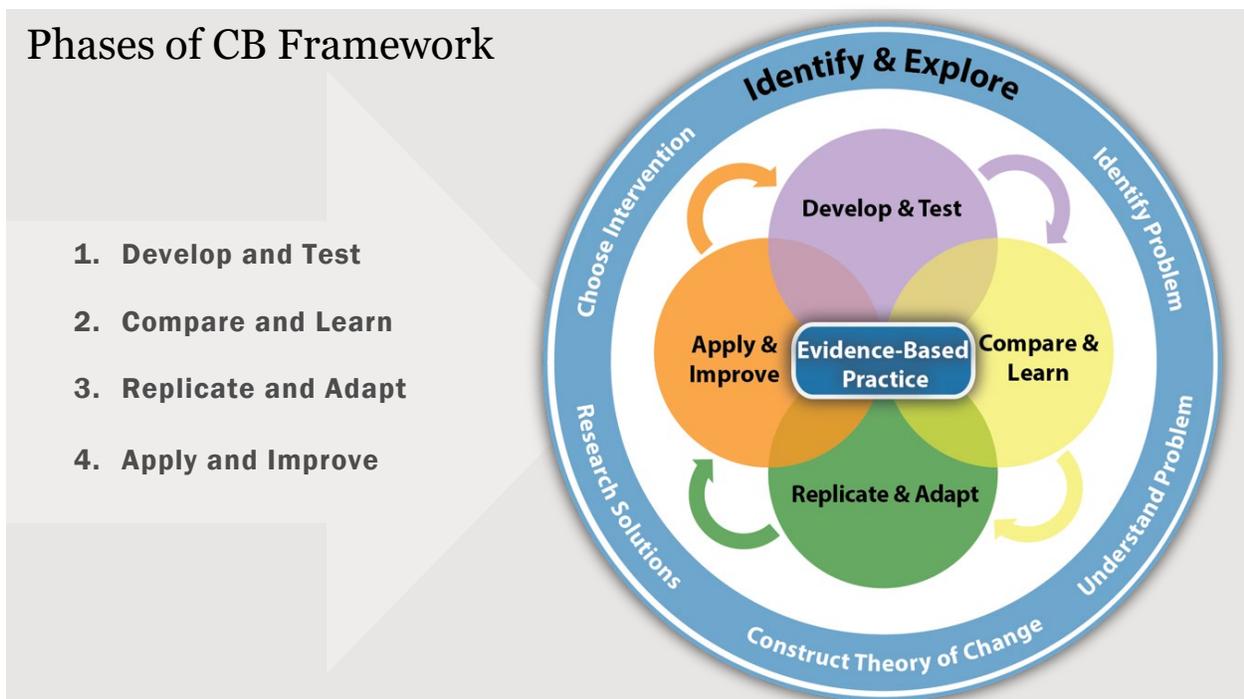
If a site selected an intervention that was well-defined, showed early signs of success, and wanted to compare the intervention's outcome to practice as usual, the site would be in the **Compare and Learn** phase of the CB Framework. An intervention in the **Replicate and Adapt** phase was one that had been evaluated and found more effective than the alternative and consequently was ready to be adapted to serve an alternative population or "rolled-out" on a larger scale. In the QIC-AG project, the interventions tested in Catawba County (NC), Vermont, Texas, and Wisconsin were in the **Develop and Test** phase, Tennessee was in the **Compare and Learn** phase, and the interventions in Illinois, New Jersey, and Winnebago were in the **Replicate and Adapt** phase.

The intervention selection process followed the guidance of the National Implementation Research Network (NIRN) in selecting the intervention. During this process, a search for possible interventions occurred. This resulted in several interventions examined by the PMT and SAT groups, and ultimately a few interventions were examined using the Hexagon Tool (Blase, Kiser & Van Dyke, 2013). The Hexagon Tool (see Figure 1.5) helps the user consider the following items when selecting an intervention:

- Needs of the target population

- Fit with current initiatives

- Availability of resources and supports for training, technology, etc.

- Level of research evidence, and similarities between existing outcomes and project-defined outcomes

- Readiness for replication of the intervention

- Capacity of the site to implement the intervention as intended by the purveyor over time (Blase, Kiser & Van Dyke, 2013).

Figure 1.5. National Implementation Research Network's (NIRN) Hexagon Tool
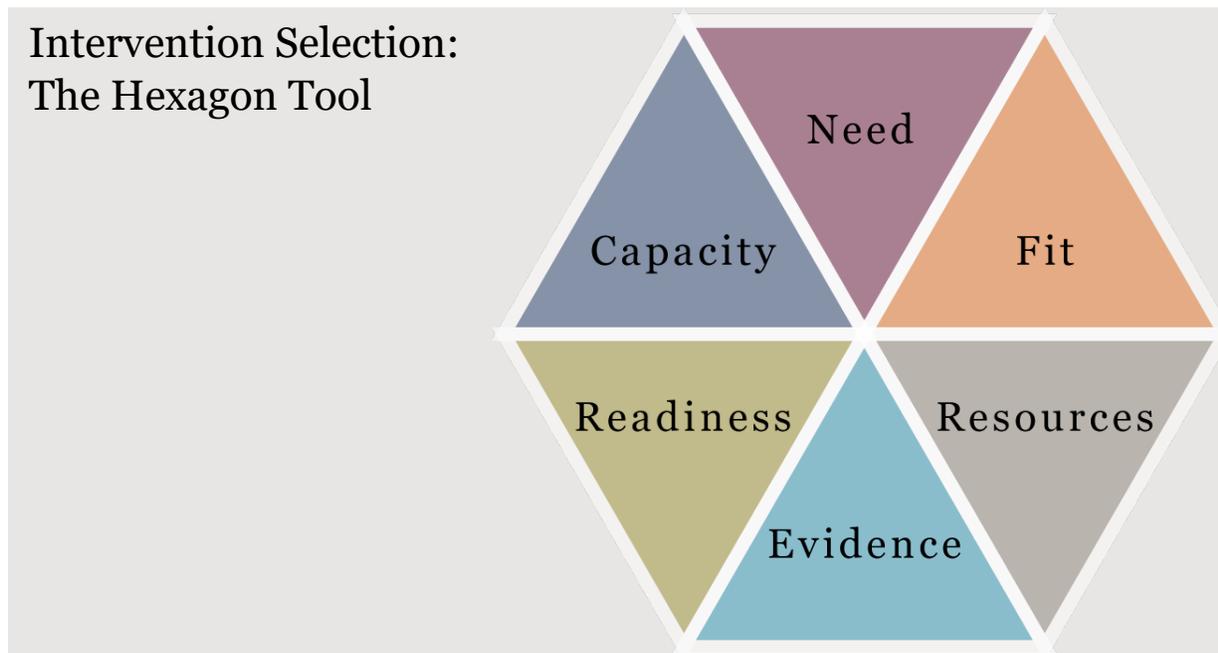
Table 1.1. Site, Target Population, Intervention and Study Design

SITE	INTERVENTION	STUDY DESIGN
TARGET POPULATION: GROUP 1		
WINNEBAGO TRIBE	Family Group Decision Making (FGDM)	Descriptive
TEXAS	Pathways 2 Permanence	Quasi-Experimental
TARGET POPULATION: GROUP 2		
VERMONT	Vermont Permanency Survey	Descriptive
ILLINOIS	Trauma Affect Regulation: Guide for Education & Therapy (TARGET)	Experimental (RCT)
NEW JERSEY	Tuning In To Teens (TINT)	Experimental (RCT)
CATAWBA COUNTY (NC)	Reach for Success	Experimental (RCT)
WISCONSIN	Adoption and Guardianship Enhanced Support (AGES)	Descriptive
TENNESSEE	Neurosequential Model of Therapeutics (NMT)	Quasi-Experimental

Process Evaluations included the following types of information:

- Recruitment procedures

- Intervention participation

- Participant profiles for public adoptive and guardianship families and, when applicable, private domestic and intercountry adoptive families.

- Program outputs

- Results of usability testing

- Fidelity

Previous studies on families formed through adoption or guardianship provided information about specific constructs (e.g., caregiver commitment, child behavior difficulties, and post permanency discontinuity) as well as relationships between those constructs (e.g., risk and protective factors for discontinuity) that were helpful in the QIC-AG evaluation. Caregiver commitment is the extent to which adoptive or guardianship caregivers intend to maintain children in their homes and provide long-term care for them, no matter what challenges, stressors, or negative behaviors may occur (Liao & Testa, 2016; White, Rolock, Testa, Ringeisen, Childs, Johnson, & Diamant-Wilson, 2018). The relationships between caregiver commitment and other post permanency variables, such as placement instability, can be quite complex. Despite these complexities, previous literature generally supports that higher caregiver commitment protects against negative post permanency outcomes, including post adoption and guardianship instability (Child Welfare Information Gateway, 2013; Faulkner, Adkins, Fong, & Rolock, 2017; White et al., 2018). Based on extant literature, the evaluation team sought to incorporate the following types of information in the short-term outcomes portion of the **Outcome Evaluations**, although sites did not all have the same measures: The Behavior Problem Index [BPI] measuring child behavioral issues; the Belonging and Emotional Security Tool [BEST]; and caregiver commitment measures.

Outcomes across Target Group 2 sites are summarized in the final chapter, the **Cross-Site Evaluation**. The QIC-AG evaluation team also conducted a **Cost Evaluation** for each site. These findings are embedded in each site report.
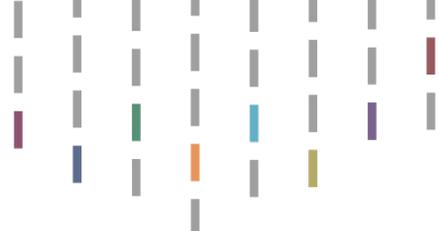
Summary

This chapter described how over five years the QIC-AG selected and collaborated with eight sites (Catawba County (NC), Illinois, New Jersey, Tennessee, Texas, Vermont, Winnebago Tribe, and Wisconsin) with the purpose to implement evidence-based interventions or develop and test promising practices, which if proven effective could be replicated and adapted in other child welfare jurisdictions.

The QIC-AG team guided the eight sites by establishing clear governance and structured programming. Each site was incorporated in the QIC-AG Continuum of Services framework and tested interventions with a site-specific target population. Each site developed their own PICO research question, Logic Model (Circular Model for the Winnebago Tribe of Nebraska), and Theory of Change. Evaluation methods included a number of different study designs depending on the individual sites' program and tailored interventions. Short-term outcomes were individualized for each site, and measures selected based on extant research with adoptive and guardianship families. Long-term outcomes were the same for all sites and set *a priori* in the request for funding.
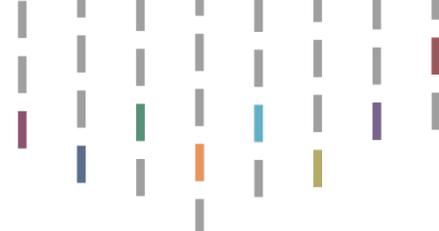
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Chapter 3

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List of Tables and Figures

Site Background

The Texas Department of Family and Protective Services (DFPS) is an independent state-administered system that is divided into 11 geographic regions. The mission of DFPS is to "promote safe and healthy families and protect children and vulnerable adults from abuse, neglect, and exploitation." The Child Protective Services (CPS) program, in particular, investigates reports of child abuse and neglect, provides services to strengthen and reunify families, and works with courts and communities to find permanent homes for children when returning home is no longer an option.

The Texas DFPS CPS Practice Model drives decisions and actions at all levels of the organization. The practice model is guided by the belief that people can change for the better and strives to create opportunities for child safety to occur within families and communities. As part of the CPS Practice Model, Texas has increased its emphasis on ensuring all children have legal and relational permanence: that all children leaving DFPS conservatorship exit into a permanent setting, which involves a legal relationship to a family. Simply put, positive permanence is reunification with a parent or parents, transfer of custody to a relative or extended family member or another suitable individual, or adoption. DFPS staff seek a positive permanency outcome when engaging in permanency planning for all children in DFPS care. If DFPS is unable to achieve positive permanency for a child or youth, then the agency identifies, develops, and supports connections to caring adults who agree to provide life-long support to the youth once he or she ages out of the foster care system.

A fundamental belief in Texas is that all children who are removed from their families are exposed to trauma, grief, and loss. When children are exposed to trauma, grief, and loss, they may experience increased emotional, behavioral and mental health needs that can delay permanence.

National Data: Putting Texas in Context

The data in this section is provided to put the Texas QIC-AG site in context with national data. Through comparing data from Texas to that of the nation we are able to understand if Texas is a site that removes more or fewer children than the national average, and compare the rate of children in foster care in the state and the median lengths of stay of children in foster care in the state to the rest of the U.S. Finally, we compare the per capita rate of children receiving Title IV-E adoption or guardianship assistance. These comparisons are provided over the past five years to give a sense of recent trends.

As displayed in Figure 3.1 between Fiscal Years 2013 and 2017, the rate[1] of children entering foster care in both Texas and the U.S. increased. Between 2013 and 2017, the state's foster care entry rate increased from 24.0 per 10K (16,920 children) to 26.9 per 10K (19, 840 children). This per capita rate was lower than the per capita rates for the U.S. The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. In other words, over the past five years, fewer children, per capita, entered foster care in Texas than in the U.S.

Figure 3.1. Texas Foster Care Entry per Capita Rate (2013-2017)
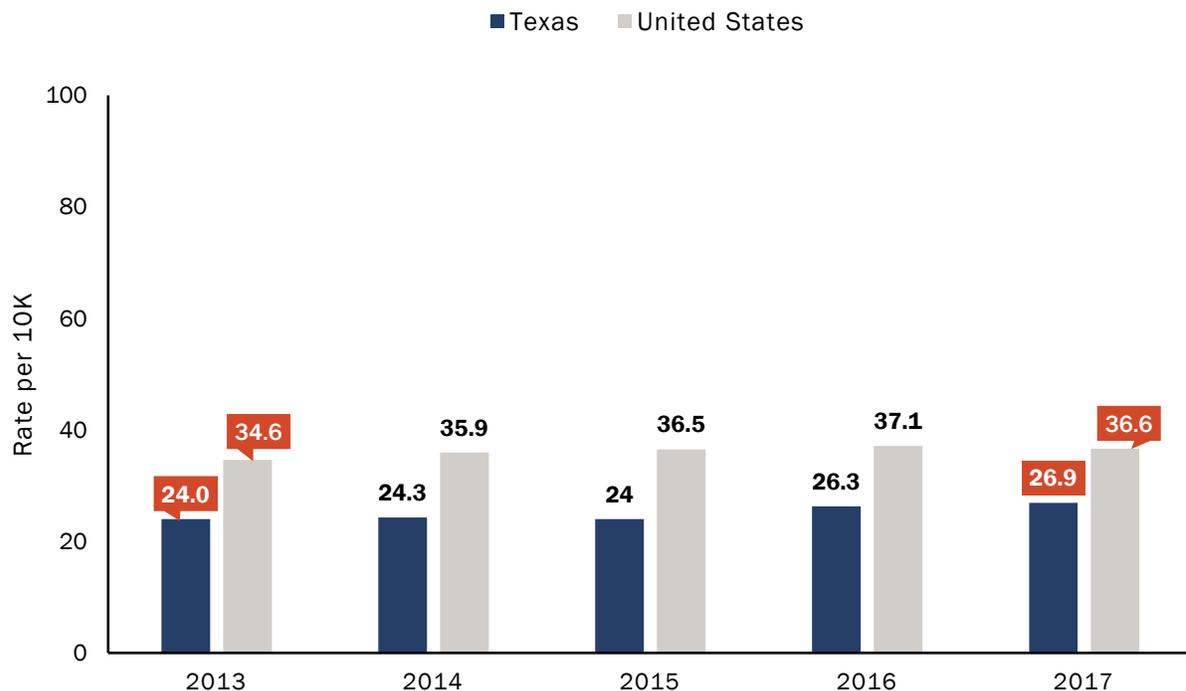
Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

[1] Rates are calculated based on the number of children reported living in the community (e.g., State or US). This provides an idea of the level of child welfare involvement in a specific area. Calculations are derived from Census Bureau estimates (https://www.census.gov).

Between 2013 and 2017, the median length of stay for children in foster care at the end of each year (shown in Figure 3.2) decreased in Texas from 11.7 months in 2013 to 10.6 months in 2017 while in the U.S. it increased slightly from 12.8 months in 2013 to 12.9 months in 2017.

Figure 3.2. Texas Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)
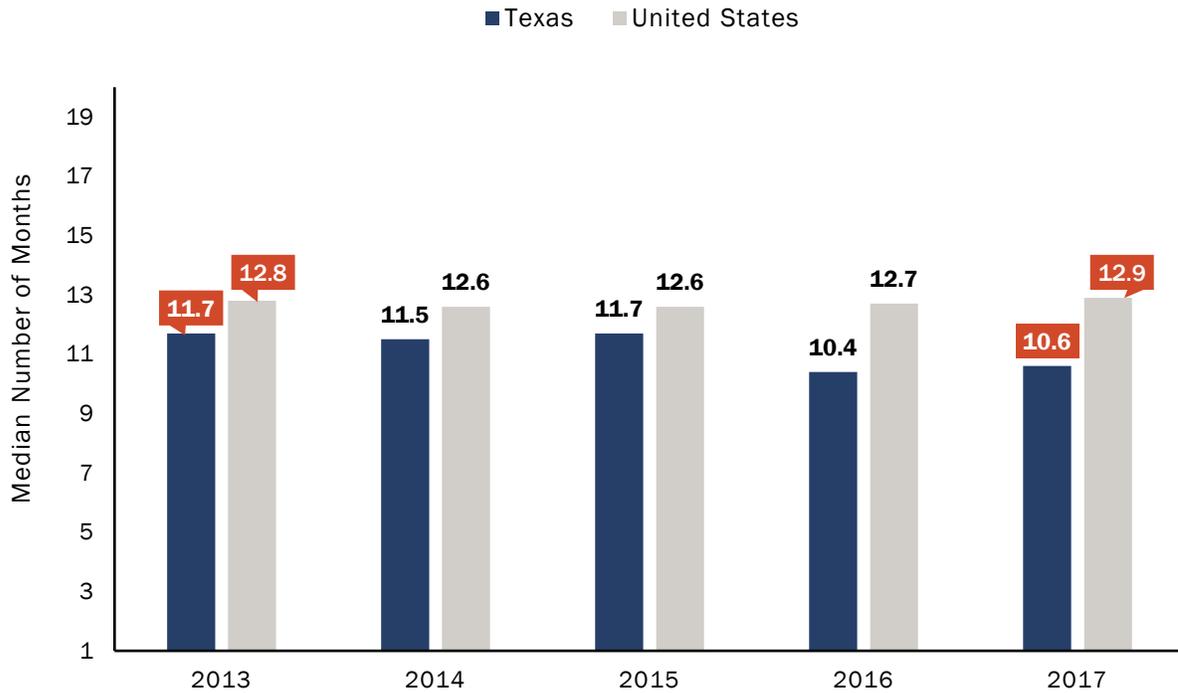
Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

COMPARING IV-E FUNDED SUBSTITUTE CARE CASELOAD TO IV-E FUNDED ADOPTION CASELOAD

Nationally, we have seen a shift in the number and proportion of children living in IV-E supported foster care and IV-E funded adoptive or guardianship homes. As shown in Figure 3.3, the number of children in Texas in IV-E funded foster care and the number of children in IV-E funded adoptive and guardianship homes were approximately the same in 2000 (8,229 and 7123, respectively), yet in 2016 these numbers diverged. In 2016 there were 9,489 children in IV-E funded substitute care and 41,220 children in IV-E funded adoptive and guardianship homes.

Figure 3.3. Texas Caseloads
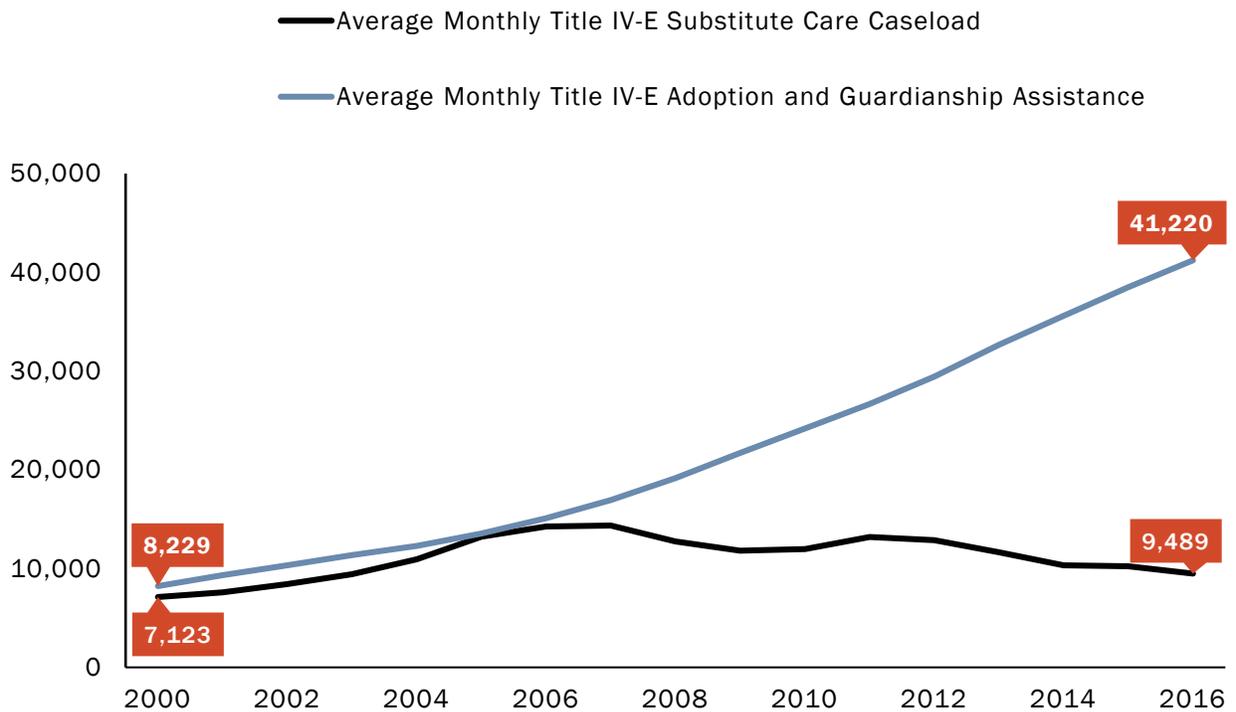
Data sources: Title IV-E numbers: U. S. Department of Health and Human Services / Administration for Children and Families, compiled data from states' Title IV-E Programs Quarterly Financial Reports, Forms IV-E-1 (for years prior to 2011) and CB-496 (for 2011 and later).

QIC-AG Permanency Continuum Interval

Texas implemented an intervention within the **Focused** Interval of the QIC-AG Permanency Continuum Framework. **Focused Services** are designed to meet the needs of children with challenging mental health, emotional or behavioral issues who are waiting for an adoptive or guardianship placement as well as children in an identified adoptive or guardianship home for whom the placement has not resulted in finalization for at least 18 months. It is possible that some of these children have experienced a disrupted or dissolved adoption or guardianship, including children who have been adopted privately or internationally. **Focused Services** are intended to prepare families to meet the needs of children in this population and become permanent resources.
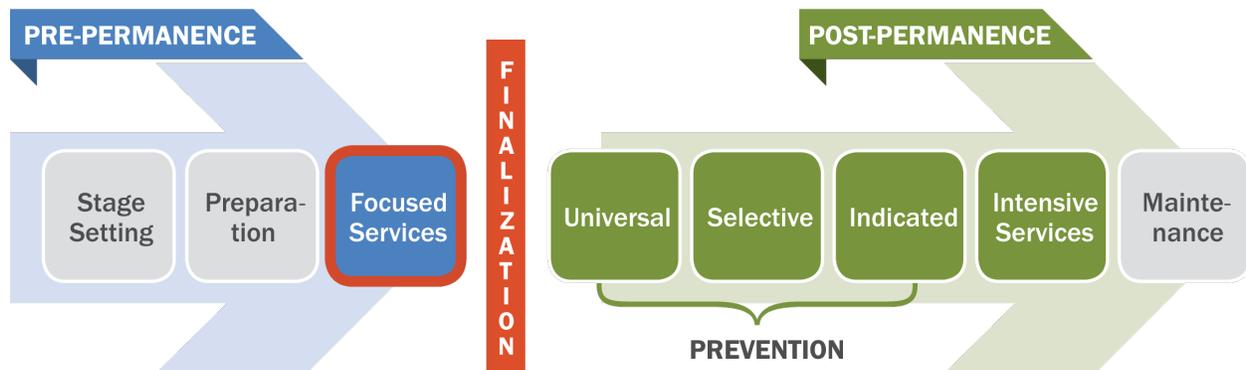
Primary Research Question

The well-built research question using the Population, Intervention, Comparison Group, Outcome (PICO) framework (Richardson, Wilson, Nishikawa & Hayward, 1995; Testa & Poertner, 2010) was:

Did children in Permanent Managing Conservatorship (PMC) of Texas DFPS in Region 7 who do not have a finalization hearing scheduled within 60 days of screening (P) experience: increased permanency outcomes; decreased time to finalization/permanency or time in care; increased placement stability; improved child and family wellbeing; and improved behavioral health for children and youth (O) if families are provided with Pathways to Permanency 2 (I) compared to families who receive services as usual in Region 8 (C)?

Target Population

The target population for the QIC-AG Texas project was identified by DFPS Region 7 Program Administrators and the DFPS Site Implementation Manager (SIM) through the DFPS IMPACT system. The target population included children and youth up to the age of 18 in Permanent Managing Conservatorship (PMC) of Texas in Region 7 and Region 8 provided they didn't meet any of the following exclusion criteria:

- Children with reunification, transfer of PMC, or joint TMC (primary or concurrent) with a biological parent (including Home and Community-Based Services (HCS) placements in which a biological parent was a guardian)

- Children who were on runaway status at the time of screening

- Children who did not have an active caregiver who was willing to have the child(ren) return home if the child was living in an unauthorized placement, residential treatment center, juvenile justice setting, or emergency shelters at the time of screening

- Children placed in agency run group homes where staff rotate care

- Children with a finalization hearing scheduled within 60 days of screening

- Children with caregivers who did not speak English

Intervention

After thoroughly reviewing evidence-based and promising practices, the Texas Department of Family and Protective Services (DFPS) chose to implement Pathways to Permanence 2: Parenting Children Who Have Experienced Trauma and Loss (Pathways 2) © 2012 Kinship Center, A Member of Seneca Family of Agencies. This intervention began in the Develop and Test phase of the Children's Bureau Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare. The Develop and Test phase should result in "a set of specific practices, program components, and intervention guidelines that do not require adjustment, have been defined well enough that others can replicate them, and show an initial improvement in outcomes that can most likely be traced to the intervention" (Framework Workgroup, p. 11).

Pathways 2: Parenting Children Who Have Experienced Trauma and Loss, is a seven-session (21 hour) series designed for foster and adoptive parents, kinship caregivers and guardians, who are parenting children who have experienced trauma and loss as a part of their history. Sessions are three hours and run at least one week apart to allow for time to implement activities; however, there should never be more than four weeks in between each session.

The purpose of Pathways 2 is to provide a foundation based on both science and experience for parents to better understand and help the children in their care while guiding them towards a functional and healthy adult life. It is the intent of the curriculum to assist parents and caregivers to recognize, identify, and address the core issues with new tools given to them during the series. The parents become empowered and have more empathy as their skills increase. By using the information from this curriculum, families could be stabilized and children helped to heal from trauma.

A guiding theme in this curriculum is the belief that parents and caregivers need to develop a greater understanding of themselves in order to better parent their children, a point that becomes particularly critical when parenting children with traumatic histories. This theme is woven throughout the curriculum, with each theoretical framework or concept that is introduced.

ABOUT PATHWAYS 2 SESSIONS

Session 1: Parenting Children with Extra Needs [High Needs]

This session provides an introduction to the curriculum as well as the facilitators and focuses on the impact of societal views on the adoption/permanency experience, the similarities and differences in parenting, and the child's understanding of adoption/permanence. Openness in adoption is discussed, particularly as it relates to children knowing their story. The extra challenges involved in becoming an adoptive/permanent family are explored with an emphasis on identifying strengths in families that can prepare them for the journey ahead.

Session 2: Lifelong Issues in Permanence

This session explores kinship connections for both children and caregivers and introduces the Seven Core Issues in Adoption and Permanence as a theoretical framework for the series. The core issues of Loss, Rejection, Shame & Guilt, Grief, Identity, Intimacy, and Mastery are discussed as they relate to all members of the adoption/permanence constellation.

Session 3: Childhood Development

This session presents the stages of child development as a foundation for understanding what happens when a child's development is impacted by trauma and loss. Emphasis is given to how children may become "stuck" at an earlier stage of development and the importance of caregivers parenting to this stage of development. The difference between a traditional parenting approach and a developmental re-parenting approach is introduced, and techniques for identifying and meeting the needs underlying children's negative behaviors are explored.

Session 4: Creating Positive Attachments, Part 1

This session covers the theory of attachment and its importance in the formation of healthy relationships. Facilitators talk about the critical role of the Arousal-Relaxation Cycle in the attachment relationship between a caregiver and child. The importance of decreasing distress and increasing pleasure for children is discussed, and the emphasis is placed on the importance of doing this over and over again as part of the attachment building process.

Session 5: Creating Positive Attachments, Part 2

This session introduces the science of attachment, and how attachment impacts a child's developing brain. Participants also learn how their own early life experiences have a lasting impact on their relationships, and why it is necessary for caregivers to regulate themselves before responding to their children's behaviors. Attachment-building behaviors that parents/caregivers can do every day with their children are also presented.

Session 6: Parenting the Child of Abuse and Neglect

This session gives an overview of how abuse, neglect, and trauma affect children's histories, behaviors, and needs. Participants have the opportunity to talk about and practice sharing sensitive information about their children's histories using developmentally appropriate language. Facilitators also re-emphasize the role of developmental re-parenting, attachment-based parenting and therapeutic parenting in addressing children's challenging behaviors.

Session 7: Parenting the Child with Drug & Alcohol Exposure

This session provides an overview of the high incidence of parental and alcohol use in child abuse and neglect cases, including children who are exposed to drugs and alcohol. The impact of prenatal exposure on an unborn child's central nervous system and brain development is presented, and the long-term impact of in utero exposure is explored. Lastly, the conclusion of the curriculum provides participants with an opportunity to reflect on what they have learned and what they will carry forward in their parenting.

Prior to this study, the core components, or aspects of the program that are unique/and or essential to Pathways 2 had not previously been defined or measured. The University of Texas at Austin worked with the Kinship Center and the National Quality Improvement Center for Adoption and Guardianship Support and Preservation to develop and operationalize the following Pathways 2 core components (See Appendix A for a full description of each component).

Use of Experienced Facilitators

All facilitators are required to attend a three-day intensive training that provides both the knowledge base and practical experience to facilitate Pathways 2. Ideally, facilitators also attend ACT: An Adoption and Permanency Curriculum for Child Welfare and Mental Health Professionals prior to facilitating their first Pathways 2 session.

All facilitators should have direct experience in working with families and children who have experienced trauma. Facilitators should be knowledgeable and well-versed in the major concepts and content of the curriculum, have a broad understanding of the lifelong impact of adoption and permanency and support the core beliefs and values of the curriculum.

Lastly, facilitators are also expected to be able to establish a safe learning environment, make materials "jurisdiction-relevant," use effective communication and co-facilitation skills, facilitate challenging discussions, and be able to assess their own strengths and areas for growth in permanency-related work.

Pathways 2 Core Beliefs and Values

Permanence in a family is at the center of the core beliefs;

Every child deserves a family;

Children must have permanence to achieve their full potential;

Children and adolescents need families for a lifetime, not just for childhood;

Healthy, functional families can provide a stabilizing and healing environment for previously traumatized and abused children;

Keeping children's previous, positive connections facilitates and deepens the attachment to the new caregivers;

Adoption, foster care and relative caregiving involve complex issues requiring specialized training for the caregivers;

Children and their families must receive interventions that are culturally competent and built on strength-based, family systems models.

Experiential Delivery of Material

The use of activities, sequential ordering of sessions, and class size are essential to the experiential delivery of the material. Facilitators should be comfortable participating in and conducting experiential activities, and should not rush through these experiential opportunities for participants during sessions. Sessions should always be taught in the order designed, and never taught as stand-alone sessions.

Classes with approximately 12-15 participants are considered ideal. The class size should never exceed 20 participants, as smaller class sizes allow for greater participation and sharing. However, facilitators should avoid classes with less than 6 participants because the effectiveness of the series is strengthened by the group processes and dynamics that evolve throughout the course.

Engagement and Participation

Facilitators should have the ability to elicit participant involvement and refer to the Facilitator's Guide as needed for prompts that promote active dialogue from participants. Participants should be encouraged to take an active role in discussions and activities, and facilitators should support and encourage participants to personally reflect and explore issues that may interfere with their ability to engage in an attachment relationship with their child.

Opportunities to Practice and Apply Techniques

It is important to allow sufficient time between sessions for participants to digest information that was learned while conducting sessions close enough together so that content is not lost between sessions of the series. For the Pathways to Permanence 2 series, sessions should not be offered more frequently than weekly, and should not be scheduled more than one month apart.

INTERVENTION ADAPTATIONS

Given that Texas implemented Pathways to Permanence 2 with the intended population for which the program was developed, few adaptions were needed. However, some adaptations were made regarding the preparation of the facilitators. The Texas site team determined that the facilitators needed deeper exposure to the content in order to develop their competency. Therefore, the following training opportunities were added to the facilitator training preparation:

- Technical assistance calls were provided by the developer;

- The developer created timing agendas and a "tip sheet" for each session that supported facilitators in their preparation for delivery of session content; and

- The developer established a Facilitator Videoconference Observation process (non-classroom setting) to assess the capabilities of newly trained facilitators and to provide additional skill development and coaching recommendations.

In addition, the protocol was adapted to include a series of tools used to measure the fidelity in the delivery of the intervention.

Comparison

Families residing in Region 8 caring for a child in the target population served as the comparison group for families in Region 7.

Outcomes

The short-term outcomes for the Texas QIC-AG project were:

- Improved family relationships;

- Increased caregiver resiliency;

- Decreased caregiver strain;

- Increased caregiver knowledge in dealing with childhood trauma, grief, and loss;

- Improved ability for caregivers to respond to challenging behaviors;

- Increased caregiver commitment;

- Increased permanency outcomes; and

- Decreased time to finalization and time in care.

Long-term outcomes, set *a priori* by the project, included:

- Improved placement stability;

- Improved child and family well being; and

- Improved behavioral health for children and youth.

Logic Model

The logic model links the target population, and core interventions, to the intended proximal and distal outcomes. The links illustrate the intervening implementation activities and outputs. By structuring the evaluation process this way, we identified the core programs, services, activities, policies and procedures, as well as contextual variables that may affect their implementation." See Figure 3.4 below.

Figure 3.4. Texas Logic Model

Texas Logic Model

Program Inputs	Implementation	Program Outputs	Short-Term Outcomes	Long-Term Outcomes
Population: Children in Permanent Managing Conservatorship (PMC) of Texas in Region 7 and Region 8 not meeting the following exclusion criteria: • Finalization hearing scheduled within 60 days • Planned reunification, transfer of PMC, or joint PMC with a biological parent including HCS placements in which a biological parent is a guardian • On runaway status • Placed in a group home with rotating staff • Unauthorized placement • No active caregiver **Intervention:** Pathways to Permanence 2 **Comparison:** Services as usual	• Submitted IRB • Developed outreach and recruitment protocols/ materials • Trained caseworkers and staff on recruitment, consent and outreach protocols • Developed core components of Pathways to Permanence 2 • Developed fidelity measures, tracking processes, and pre/post surveys • Trained Pathways to Permanence 2 facilitators • Strengthened foundation for Pathways to Permanence 2 with ACT training for workers and CASA in five counties	**IRB completed** **Finalized materials:** • Outreach, consent and recruitment material • Core components • Fidelity + pre/post measures **Trained staff:** • # of caseworkers trained to do outreach • # of Pathways to Permanence 2 facilitators trained **Families recruited/enrolled:** • # of families recruited, consented, and enrolled • # of pre and post surveys collected **Pathways to Permanence 2:** • # of children served • # of sessions delivered • # and % of participants completing 75% of sessions • % sessions with 75% fidelity	• Improved family relationships • Increased caregiver resiliency • Decreased caregiver strain • Increased caregiver knowledge around child trauma, grief and loss • Improved ability for caregivers to respond to challenging behaviors • Increased caregiver commitment	**Outcomes:** • Increased permanency outcomes • Decreased time to finalization/permanency or decreased time in care • Increased placement stability • Improved child and family wellbeing • Improved behavioral health for children and youth **Unintended consequences:** • Improved ability of caregivers to talk with youth about kinship, adoption, and birth families • Improved ability of staff to support and prepare families • Improved knowledge and ability of staff to assess caregiver readiness • Non-target population children would benefit from caregivers trained in Pathways to Permanence 2

External Conditions	Theory of Change	End Values
• Leadership and staff changes • Simultaneous priorities and initiatives • Ongoing lawsuit • Legislative sessions • Foundation of Pathways to Permanence 2 would be supported by ACT training in five counties	If Texas identifies a model that focuses on identifying families and preparing them to become legal guardians or adoptive parents, with an emphasis on parenting children in Texas Permanent Managing Conservatorship (PMC) who have been exposed to trauma, grief and loss and begins this work immediately, then: • More permanent families will be identified; • Families will be ready and prepared to become adoptive parents/legal guardians of these children; and • The children will be equipped in readiness for legal permanency. If all of this happens, then an increased number of children in PMC will move to permanence.	• Increased Capacity • Stakeholder solidarity • Increased experience with Implementation Science and Evidence-based Practices change management • Collaboration with National Partners

Evaluation Design & Methods

This study was initially designed as a Randomized Controlled Trial (RCT). The RCT design was tested during the initial testing phase of the evaluation. During this phase, participants were randomly assigned to the intervention and comparison groups. However, there was low uptake in participants and unanticipated challenges with the consent and recruitment procedures. Caseworkers found it difficult to track whether families were assigned to the intervention group or comparison group and which forms those families needed to complete. Lastly, caseworkers expressed concern about withholding the intervention from families in the comparison group, particularly when those families were struggling.

In order to address challenges, a quasi-experimental design was employed. In this design, families in Region 7 received Pathways 2 (intervention) while families in Region 8 received services as usual (comparison). Families in Region 7 completed a survey prior to attending Pathways 2 and then again 6 months after Pathways 2 had ended. Region 8 families received one survey, occurring at the same time point at which families in Region 7 received their second survey. This evaluation and protocol design was reviewed by the Institutional Review Board (IRB) at The University of Texas at Austin and approved by DFPS.

Intervention Group - Region 7

Families in Texas DFPS Region 7 who meet eligibility criteria and agree to participate

Comparison Group - Region 8

Families in Texas DFPS Region 8 who meet eligibility criteria and agree to participate

In Region 7, there were 21 series of Pathways 2 implemented over nine cycles. Each cycle took approximately 11 months to complete (from screening to sending the post survey). Within each cycle, between one and four series of Pathways 2 were implemented in different locations and on different days of the week. Implementing Pathways 2 in this way maximized participation and minimized implementation overlap. In Region 8, all families were screened and sent the post survey following the same timeline used in series 14 of cycle 7. An implementation timeline is provided in Table 3B.1 in Appendix B.

Pathways 2 series one (usability) began in October 2016 and was implemented for usability testing. Series two through nine were implemented in 2017 and series 10 through 23 were implemented in 2018. Series four and series 21 were canceled due to low registration numbers. In Region 8, Pathways 2 was not implemented until after the study period had ended. During each implementation cycle, a set list of tasks was completed within a specific timeframe based on the date of the first Pathways 2 session. Tasks included initial screening, secondary screening, recruitment, survey administration, and the implementation of Pathways 2. The implementation cycle tasks and timeframes are displayed by region below in Table 3.1.

Table 3.1. Implementation Cycle Tasks and Timeframes by Region

TASK	TIMEFRAME	REGION 7	REGION 8
BEGIN INITIAL SCREENING (LOCATION, PMC)	70 days out	X	X
SEND "COMING SOON" POSTCARD TO FAMILIES	60 days out	X	
BEGIN SECONDARY SCREENING	60 days out	X	X
SEND FLYER TO ELIGIBLE FAMILIES	45 days out	X	
SEND FLYER/OUTREACH TO CPA'S AND WORKERS	45 days out	X	
BEGIN CAREGIVER REGISTRATION PROCESS	45 days out	X	
BEGIN LOGISTICAL ARRANGEMENTS	15 days out	X	
BEGIN PRE SURVEY PERIOD	15 days out	X	
SEND SURVEY REMINDER	2 days out/as needed	X	
END OF PRE SURVEY PERIOD (GOAL)	1 day out	X	
SERIES START DATE	*Series launch date	X	
SERIES END DATE	60 days post launch	X	
SEND SURVEY OUTREACH MATERIALS REGION 8	195 days post launch		X
6-MONTH POST SURVEY	240 days post launch	X	X

Procedures

USABILITY

A usability test was conducted during the first series of Pathways 2 in October 2016. After implementing this series, the Texas team identified several processes that either did not work or needed improvement. For example, screening and consent processes were centralized and secondary screening sessions were modified to reduce data entry error. The point of randomization also changed after this first series but was later removed when the study design shifted to a quasi-experimental design. The team also recognized that families needed information about the series (location, times, dates) earlier in order to plan attendance. Providing this information so close to the first session made it too difficult for some families to attend. Changes were made and implemented in Series 2 and 3. While series two through five were not a part of usability, we changed the design of the study after implementing these series in order to increase participation in Pathways 2.

The processes for both initial and secondary screening were equivalent for Region 7 and Region 8. For initial screening, the DFPS Site Implementation Manager (SIM) identified a list of all children in permanent managing conservatorship placed in the target area using the most current data from the DFPS IMPACT database (Big Data: CPS Warehouse Report). Children were grouped by household, and in Region 7, sent a "coming soon" postcard (shown below). This process overlapped with the timing of secondary screening.

During secondary screening in Region 7 and 8, the SIM worked with each child's caseworker to determine if a child met any exclusionary criteria or did not have an active caregiver who spoke English. This process generally took two weeks to complete.

Region 7 Recruitment for Pathways 2 (Intervention)

After secondary screening, the SIM sent a recruitment flyer to all eligible families in Region 7. Additional outreach was made to caseworkers and child placing agencies (CPAs) in the target area to inform them about the intervention and ask for their assistance in recruiting families. Flyers provided information about the upcoming series locations, times, and dates as well as the contact information needed to register. The SIM also contacted eligible families directly by phone and/or email to recruit and register families for Pathways 2. During registration, the SIM gathered all contact information for caregivers who planned to attend Pathways 2, determined the number of children who needed childcare and provided general information about the study to families.

Region 8 Recruitment for Survey (Comparison)

In Region 8, the SIM sent an outreach flyer to eligible families one month prior to sending out the post survey. Additional flyers and outreach materials were sent to caseworkers and CPAs in Region 8 to inform them about the survey and ask for their assistance in encouraging families to participate.

An informed consent letter and video were embedded into the beginning of each survey to provide detailed information about what caregivers were being asked to do, the risks and benefits of participation, the voluntary nature of the study, confidentiality, incentives and who to contact with questions. All participating caregivers had to provide consent before starting a survey. In Region 7, participants were asked to review the consent form a second time when they were sent the post survey. All participants had the option to save or print the consent form before completing the pre and post surveys.

In Region 7, all registered caregivers were asked to complete an online pre survey prior to the date of their first Pathways 2 session and a post survey six months after their last Pathways 2 session. If the pre survey was not completed prior to the first class, participants were asked to complete it as soon as possible. The date of completion was tracked by researchers. Reminder emails were sent to non-responders at pre and post to increase response rates. A paper version of the survey was also available for participants who did not have email addresses.

In Region 8, caregivers were emailed and asked to complete a post survey online. This survey is comparable to the post survey in Region 7; however, additional items—including caregiver demographics and caregiver Adverse Childhood Experiences (ACEs)—were incorporated. Questions about Pathways 2 were removed from this version.

CHILDCARE, TRAVEL GIFT CARD, FOOD, AND TRAINING HOURS

In Region 7, free childcare and food were offered during each Pathways 2 session. Additionally, each household received a small stipend for travel ($10.00 per session attended). In order to promote retention, caregivers who attended at least five sessions received an additional $50.00 gift card. Lastly, parents had the option to receive training hours for each session they attended.

INCENTIVES

After participants completed a survey, they received a $25 gift card to Walmart or Target by email. If their email was unavailable, UT researchers mailed a $25 gift card to Walmart through certified mail. All incentives were tracked in an incentive tracking workbook.

FIDELITY

Pathways to Permanence 2 core components were established and defined in order to be able to determine if Pathways 2 was implemented as intended. Observation forms, fidelity logs, and participant evaluations were used to monitor fidelity throughout the project. Evaluators completed at least one observation per series.

Measures

The measures were completed by caregivers privately and submitted online or returned in a pre-addressed, stamped envelope which the caregiver sealed. These measures were chosen based on their established validity and/or use in national surveys.

FIDELITY MEASURES

Table 3.2. Pathways to Permanence 2 Fidelity Measures

FIDELITY TOOLS	PURPOSE	DESCRIPTION
FACILITATOR QUESTIONNAIRE	To record facilitator experience and level of agreement with core beliefs and values.	Facilitators completed this questionnaire once, prior to the first Pathways 2 series they taught.
CORE COMPONENTS OBSERVATION FORM	To determine the extent to which core components are delivered.	Evaluators observed facilitators at least one session per series. Evaluators completed one form per facilitator and shared this form with facilitators.
FIDELITY ASSESSMENT LOG	To determine the extent to which content was delivered as intended.	Facilitators completed a fidelity assessment log following each session. They were asked to self-report if the content was taught as suggested, taught with changes, or not taught.
PARTICIPANT EVALUATION	To gather information about the experience of the participant.	At the end of each session, participants were asked to complete a participant evaluation form about their experience.
PARTICIPANT ATTENDANCE	To gather information about the number of sessions completed by each participant.	Attendance was tracked by the Site Implementation Manager. Evaluators used this info to determine the number/% of participants who completed at least 75% of sessions.

Administrative Data

Researchers used data from four sources (DFPS, the State Automated Child Welfare Information System (SACWIS), and Information management Protecting Adults and Children in Texas (IMPACT)) to help match participants in Regions 7 and 8. Researchers also used this data to assess long-term outcomes and differences between those who participated and those who did not. Some of the information in these reports includes demographic information, the number of placements in the current removal episode, as well as the current placement setting.

Adverse Childhood Experiences (ACEs)

The Adverse Childhood Experiences (Felitti et al., 1998) instrument contains 11 adverse experiences (abuse, neglect, or other potentially traumatic experiences) that may occur in the first 18 years of life. ACEs have been linked to risky health behavior, chronic-health conditions, low-life potential, and early death. A higher ACEs score indicates a higher level of risk for these negative outcomes later in life.

Behavior Problems Index (BPI)

The Behavior Problems Index measures the frequency, range, and type of childhood behavior problems children ages four and older may exhibit (Peterson & Zill, 1986). It is based on responses by the primary caregiver as to whether a set of 28 problem behaviors is not true, sometimes true, or often true. Scores on the BPI range from 0 to 56, where higher scores indicate a child may be exhibiting more behavior. The BPI contains two subscales: the BPI Internalizing Subscale (11 items) and the BPI Externalizing Subscale (19 items) which are used to measure a child's tendency to internalize problems or externalize behaviors.

Belonging and Emotional Security Tool – Adoption and Guardianship (BEST-AG)

The BEST, developed by Casey Family Services (Frey et al., 2008), was originally designed to help social workers guide conversations around emotional and legal commitment with foster parents and youth who are unable to reunify with their family of origin. For this study, the BEST was adapted and used with families in foster care, adoption, and guardianship. The BEST-AG includes two subscales: the Emotional Security Subscale (13 items; measures the shared sense of family belonging) and the Claiming Subscale (7 items: measures the degree to which the caregiver claimed their child either emotionally or legally).

Brief Resilience Scale (BRS)

The Brief Resilience Scale (BRS; Smith et al., 2008) consists of six items designed to evaluate how caregivers respond and cope in times of stress. Mean scores between 1.00 and 2.99 indicate low resilience, scores between 3.00 and 4.30 indicate normal resilience, and scores ranging from 4.31 to 5.00 indicate high resilience (Smith et al., 2013, p.177).

Caregiver Strain Questionnaire – FC/AG22

The Caregiver Strain Questionnaire-Adoption/Guardianship Form (CGSQ-FC/AG22) is an adapted version of the Caregiver Strain Questionnaire (Brannan et al., 1997). This 22-item measure is a self-report measure that assesses the extent to which caregivers experience additional demands, responsibilities, and difficulties as a result of caring for a child who is in foster care, legal guardianship, or who was adopted. The scale includes two subscales that measure objective and subjective strain. Higher scores indicate higher levels of strain.

Education Outcomes

Questions related to a child's education and learning, special education needs, discipline, and extracurricular activities were pulled from the National Survey of Child and Adolescent Wellbeing (NSCAW), the National Survey of Children's Health (NSCH), and the National Survey of Adoptive Parents (NSAP).

Illinois Post Permanency Commitment Items

Several items from the Illinois Post Permanency Surveys were used to evaluate the parent's commitment to their relationship with their child. These questions were originally collected by the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign in two studies, one initiated in 2005 and another in 2008. Both studies were funded by the Illinois Department of Children and Family Services (IDCFS) in order to understand how families formed through adoption or guardianship from foster care fared after legal permanence. Subsequent research related to these studies found that key questions from these surveys related to caregiver commitment played a role in understanding post permanency discontinuity (Liao & Testa, 2016; Liao & White, 2014; Testa, Snyder, Wu, Rolock, & Liao, 2015).

Protective Factors Survey (PFS)

The Protective Factor Survey (PFS; Counts et al., 2010) is traditionally used with caregivers receiving child abuse prevention and family support services such as parent education and home visiting. It can be used once to obtain a snap-shot of how families are doing, but PFS is often used as a pre-post survey to measure changes in protective factors that may occur because of a family participating in an intervention. There are five protective factors included in the survey, of which this study used two: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. The Family Functioning/Resiliency Subscale and the Nurturing and Attachment Subscale were included along with individual items used to measure knowledge on parenting and child development. Higher scores on the Family Functioning/Resilience Subscale indicate more open communication within the family, and a greater ability to persevere or manage problems in times of crisis. On the Nurturing and Attachment Subscale, higher scores indicate a higher level of emotional bonding and positive interaction between the parent and child.

Service Items

Families were asked about the use and helpfulness of various preparation services in the past 6 months.

Missing Data

Missing data imputation was done by replacing any item missing value with the respondent's mean on all observed items, only when more than 75% of the total scale items were responded. The summary scale values (total and subscale scores) were calculated after imputation. When 25% or more items were missing, the summary scale scores were treated missing.

Findings

Sample Frame and Participant Profile

In this section, we first describe the characteristics of children in substitute care in Regions 7 and 8. Then, we compare the characteristics of families in our sample frame who participated and who did not. Lastly, we provide an overview of families in the intervention and comparison groups. Families who lived in Region 7 and participated in Pathways 2 between February 1, 2017, and October 31, 2018, were included in the intervention group[2] for this study. Families in Region 8 who completed the survey in October 2018 were included as the comparison group. Participant outcomes were tracked through May 2019.

DEMOGRAPHICS BY REGION

The target population included children and youth **up to the age of 18 years old in Permanent Managing Conservatorship (PMC) of Texas**

Children in Region 8 Comparison Group: Services as Usual

Children in Region 7 Intervention Group: Pathways to Permanency 2
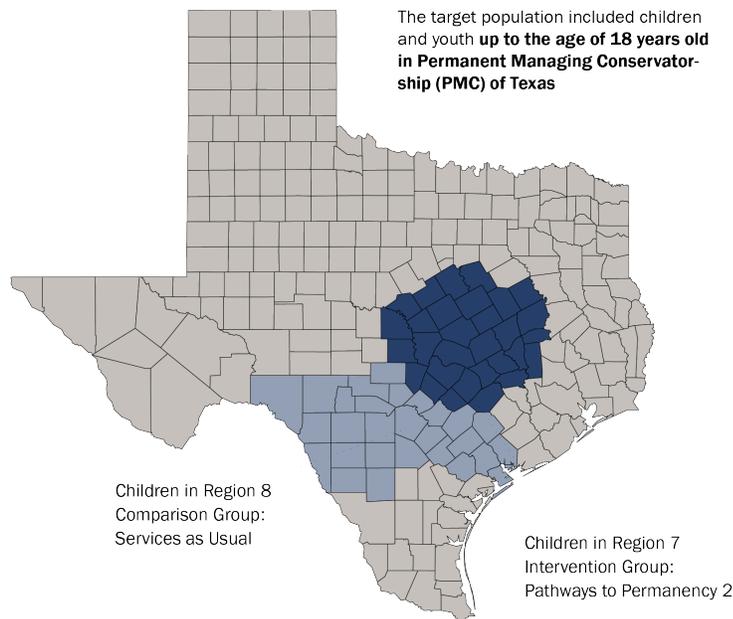
Regional data on the age, sex, ethnicity, service level, and living arrangements of youth in DFPS care in December 2017 were pulled from the DFPS Data Warehouse (2018) to compare the characteristics of children in Regions 7 and 8. This time period reflects the same time period in which the comparison group in Region 8 was identified for this study. It should be noted, however, that this data set represents all children in DFPS care, not just children in PMC. Still, looking for potential differences in the overall characteristics of children in Regions 7 and 8 was important because of the study design. If differences in the two populations existed, they should be considered when evaluating the results of this study.

In December 2017, there were 3,851 children in DFPS conservatorship placed in Region 7 care and 4,733 children placed in Region 8. At this time, there were significant differences in the living arrangements of children in DFPS care. Most notably, the proportion of children placed in private Child Placing Agency homes and independent foster care homes was higher in Region 8 (35%) compared to Region 7 (29%), while the proportion of children in Kinship homes was significantly higher in Region 7 (54%) compared to Region 8 (42%), $\chi2$ (6, N=8,584) = 187.43, p <.001.

Demographic variables including race and ethnicity, age, and gender are only available for children in foster care and not for children living in kinship homes or other substitute care settings. These differences along with differences in living arrangements are presented in Table 3C.1 in Appendix C.

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[2] For this report, the intervention group refers to caregivers who completed a pre, post and attended at least five sessions of Pathways.

CHARACTERISTICS OF THE SAMPLE FRAME

The following table describes the characteristics of the sample frame in Regions 7 and 8. DFPS administrative data from IMPACT, the State Automated Child Welfare Information System (SACWIS), was used to examine regional differences.

Table 3.3. Sample Frame Characteristics by Region

CHILD CHARACTERISTICS BY REGION	SAMPLE FRAME		TESTS COMPARING DIFFERENCES BETWEEN REGIONS		
	REGION 7 N=671	REGION 8 N=274			
	%	%	χ^2	df	p
TYPE OF LIVING ARRANGEMENT			26.32	6	0.000
DFPS FOSTER HOMES	5%	4%			
PRIVATE CPA AND INDEPENDENT HOMES	47%	65%			
RESIDENTIAL TREATMENT	1%	2%			
OTHER RESIDENTIAL OPERATION	0%	0%			
KINSHIP HOMES	43%	28%			
DFPS/PRIVATE ADOPTIVE HOMES	2%	1%			
OTHER SUBSTITUTE CARE SETTING	1%	0%			
IN SIBLING GROUP	51%	62%	8.98	1	0.003
3+ MOVES IN FOSTER CARE	28%	40%	12.87	1	0.000
CHILD'S AGE			9.43	4	0.051
0-2 YEARS OLD	27%	20%			
3-5 YEARS OLD	17%	21%			
6-9 YEARS OLD	18%	14%			
10-13 YEARS OLD	18%	20%			
14-17 YEARS OLD	20%	24%			
	M (SD)	M (SD)	t	df	p
CHILD'S AGE AT REMOVAL	5.36 (4.88)	5.81 (4.75)	1.29	920	0.198
CHILD'S AGE AT START OF PLACEMENT	6.68 (5.53)	7.38 (5.42)	1.73	931	0.084
NUMBER OF MONTHS IN PLACEMENT AT T1	11.21 (10.85)	11.59 (10.78)	0.48	933	0.631
NUMBER OF PRIMARY WORKERS	6.86 (3.53)	6.95 (2.91)	0.38	929	0.703

ABOUT PARTICIPANTS

Participants who lived in Region 7 and participated in Pathways 2 between February 1, 2017, and October 31, 2018, were included in the intervention group for this study. Families in Region 8 who completed the survey in October 2018 were included as the comparison group. Participant outcomes were tracked through May 2019. Overall, 178 caregivers participated in at least one session of Pathways 2 and 135 attended at least five sessions.

In this report, we refer to those caregivers who attended at least five sessions and completed the pre and post surveys as the intervention group. In the intervention group, there were 110 caregivers from 85 family households. These families were caring for 230 children, of which 194 (84%) were either adopted, in legal conservatorship, foster care, or kinship care.

Over the course of the recruitment period in Region 7, a total of 671 families were mailed informational flyers inviting them to participate in Pathways 2. Of those, 178 families registered to participate, and 120 families participated. A total of 56 families did not participate and two families withdrew after starting Pathways 2.

Baseline Differences

Baseline differences between those who participated in Pathways 2 (Region 7) and those who received services as usual (Region 8) were explored (See Table 3D.1 in Appendix D). At the participant level, there was a significant difference in a child's living arrangement. There was a greater proportion of kinship families and basic level foster families among those who participated in Pathways 2. On the other hand, children in the comparison group were more likely to be placed in a contracted therapeutic or higher needs foster family home. In addition to living arrangement, the number of total placements at the time was higher for children in the comparison group.

We used propensity score matching to control for significant differences at baseline between the intervention and comparison groups on the following DFPS IMPACT variables:

- Total placements at baseline
- Living arrangement at baseline
  - o   Kinship home
  - o   Basic-level home
  - o   Moderate-level home
  - o   Therapeutic, Primary Medical Needs, Developmental Disorder
- Current age of the child

A total of 79 of the 81 families (98%) from Pathways 2 and 79 of 117 families (68%) from the comparison group were matched based on these characteristics. After matching, participants did not significantly differ on any of these characteristics. (For additional information on Propensity Score Matching, see Appendix D).

Process Evaluation

A process evaluation determines whether program activities have been implemented as intended and resulted in certain output (Centers for Disease Control and Prevention, 2015). Using fidelity logs, observations, attendance tracking, and participant evaluations, evaluators assessed the fidelity of Pathways to Permanence 2 in Texas. Overall, evaluators found that the facilitators implemented Pathways to Permanence 2 with a high level of fidelity.

FIDELITY LOGS

To assess fidelity to the model, facilitators completed a fidelity assessment log following each session. They were asked to self-report if the content was taught as suggested, taught with changes, or not taught. A session that was "taught as suggested" indicates that facilitators followed the Facilitator's Guide and implemented activities as intended. The content was considered to be "taught with changes" when facilitators made changes to the suggested delivery of material or the content itself. For example, facilitators may have summarized the video content when a video would not play rather than skipping it all together. When a content area was skipped, it was considered "not taught." Content was most often skipped due to time or missing materials (i.e. DVDs, Participant Agreements for Session 1, and additional resource pages for participants).

Overall, the average percent of content that was taught as suggested across the seven sessions in a series ranged from 77.25% to 100.0% for the 20 series (while there were 23, one was for usability testing, and two were canceled due to low numbers). On average,

- **93%** of content was taught as suggested;

- **4%** of content was taught with changes; and

- **3%** of the content was not taught.

Only two series reported a level of less than 80% adherence across all seven sessions.

OBSERVATIONS

Observations were completed by evaluators. At least one session per Pathways series was observed to assess the following four core components of Pathways 2:

1. Use of experienced facilitators;

2. Experiential delivery of material;

3. Engagement and participation; and

4. Provided opportunities to apply and practice.

Core Components

Use of Experienced Facilitators

Facilitators were rated on their knowledge and comfort with the material, appropriate use of the Facilitators Guide, ability to cover all the material within the allotted period, and ability to use a variety of skills to facilitate participants' understanding of the material. The percentage of facilitators who were rated as "needs improvement," "satisfactory," and "good or excellent" on each factor are presented in Figure 3.5.

Figure 3.5. Core Component Ratings: Use of Experienced Facilitators
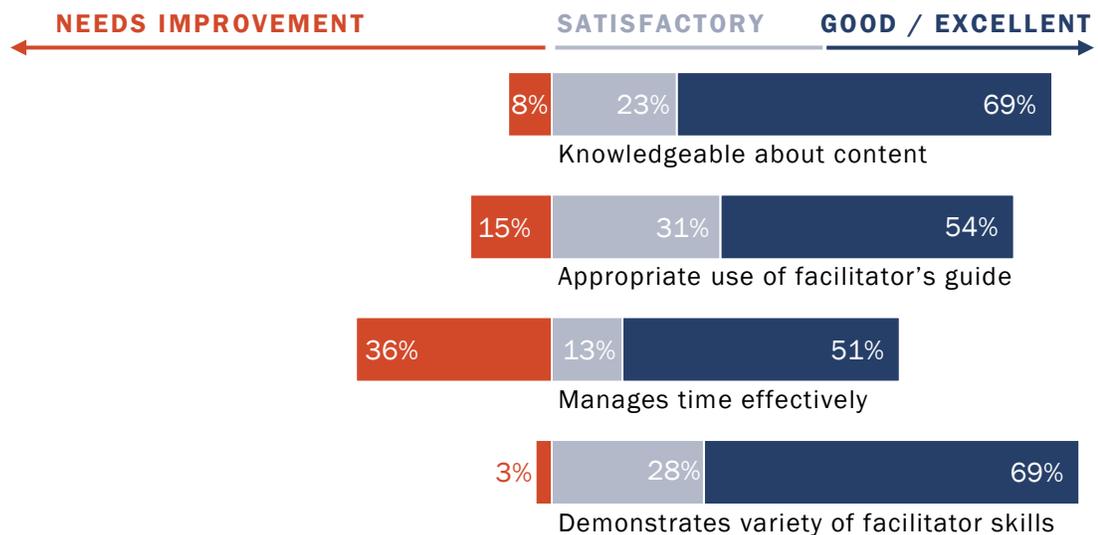
Experiential Delivery of the Material

Facilitators were rated on their use of activities during sessions as "needs improvement," "satisfactory," or "good or excellent." Additionally, evaluators tracked whether or not at least six participants attended each session and whether each session was taught in sequential order.

- **73%** of facilitators were rated as satisfactory or above on their use of activities during observed sessions.

- **63%** of all sessions had at least six participants.

- **100%** of sessions were taught in the correct sequential order.

Engagement and Participation

Facilitators were rated on their ability to encourage participants to take an active role in discussions and attend to participants who apply session material to their own life experiences (see Figure 3.6). Overall, the facilitators were effective in eliciting participation, involving participants in discussions, and facilitating connection among group members. They were supportive, validating, and attuned to participants when they shared. Initially, some facilitators were more didactic in their teaching style, but as they became comfortable with the material, they engaged participants more. There was also an initial tendency for facilitators to want to problem-solve for participants rather than using reflection to support participants in obtaining a deeper understanding of the material.

Figure 3.6. Core Component Ratings: Engagement and Participation

NEEDS IMPROVEMENT   **SATISFACTORY**   **GOOD / EXCELLENT**

3% | 21% | 77%
Elicits participation/involves in discussion

3% | 31% | 67%
Supports personal reflection by participants
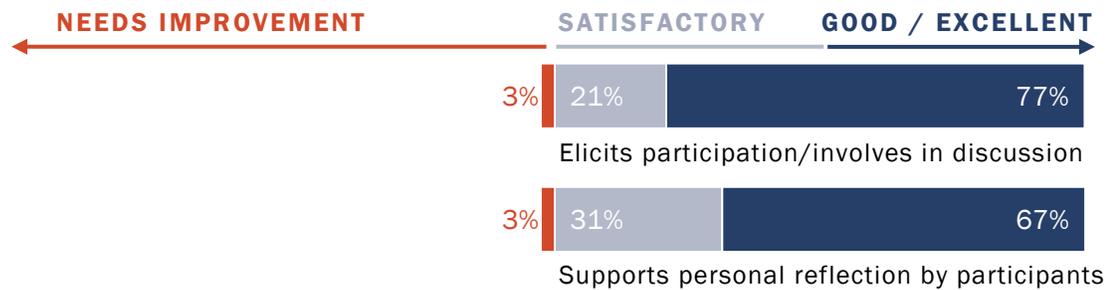
Opportunities to Apply and Practice

Facilitators were rated on their ability to present and encourage completion of homework assignments. The time between sessions was also assessed to ensure that participants had sufficient time to digest information, without having so much time that the learned information was forgotten.

- **78%** of facilitators were rated as satisfactory or above on their ability to review and emphasize homework.

- **100%** of observed sessions were held at least one week apart and no longer than one month apart.

Strengths and Positive Behaviors

The evaluators reported on three strengths or positive observed behaviors of each facilitator during an observation. The three most common strengths and positive behaviors included:

STRENGTH	EXPLANATION
FACILITATION SKILLS	Facilitators were validating, quickly built rapport, and provided a safe space for participants to share their personal experiences.
KNOWLEDGE	Facilitators were confident, knew the material well and were able to explain it in a way that participants understood.
PARTICIPANT ENGAGEMENT	Facilitators were able to elicit participation, involve participants in discussions, and facilitate connection among group members.

Skills to Improve

The evaluators reported on three areas to improve for each facilitator during an observation. The three most commonly reported areas to improve included:

SKILL TO IMPROVE	EXPLANATION
TIME MANAGEMENT	Facilitators had difficulty managing time. Facilitators should review TIP sheets, prioritize and teach material through activities, identify key messages in each section, and determine ways to condense material when needed.
CO-FACILITATOR SKILLS	Facilitators could improve their co-facilitator skills in the following areas: balancing time allocation, increasing communication prior to the session, improving transitions, and working together to manage time effectively.
ENCOURAGING PARTICIPANT REFLECTION	Facilitators missed opportunities to help participants apply the material to their situation. Facilitators should avoid giving advice or problem-solving in these moments, and instead model reflective listening.

Overall, facilitators were knowledgeable about the content and able to demonstrate a variety of facilitator skills. They were validating, quickly built rapport, and provided a safe space for participants to share their personal experiences. Time management was the most difficult challenge for facilitators. Challenges with time management often affected the use of activities and the facilitator's ability to cover homework for the next session. Facilitators reported that some sessions might need to have some content removed.

PARTICIPANT ATTENDANCE

Participant attendance data was used to assess the number of participants who attended at least five out of the seven sessions. The majority of the 178 participants (75%) attended at least five sessions. See Figure 3.7 below.

Figure 3.7. Total Pathways 2 Sessions Attended by Participants (N=178)
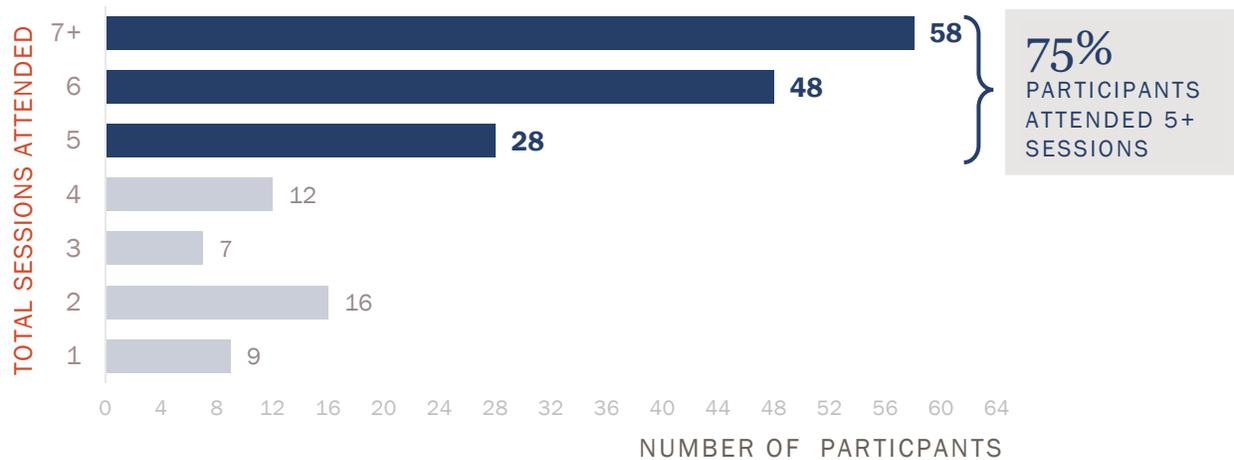
PARTICIPANT EVALUATION DATA

Participants were asked to complete an evaluation after each Pathways 2 session that asked them to rate that session on various criteria (meeting objectives, relevance, interesting delivery, usefulness of material, quality of audiovisual products, time for questions, and encouragement of participation). In total, 960 evaluations were completed across the 20 series. Participants strongly agreed that "facilitators encouraged group discussion" on 90% of the session evaluations. A total of 87% of the session evaluations indicated that participants strongly agreed that the information was relevant and that facilitators took time to answer questions. Participants were also asked to reflect on their experiences and provide suggestions on things that could be improved. Most commonly, participants reported that the quality of the audio/visual products could be improved.

Highlights from Participant Evaluations

"Between the coursework and input from other parents, I have a better understanding of how to parent my children who were exposed to trauma."

"It was excellent! I feel empowered with skills and language to help my children over the obstacles we face."

"Every topic had a component that related in some way to my own situation."

"I am better equipped to perceive and decode my son's behavioral signals of his underlying needs."

In summary, facilitators implemented Pathways 2 with a high level of fidelity. In the future, it will be important to continue to monitor fidelity and seek technical assistant in areas that seem to be more challenging. By continuing to measure fidelity, the program results will likely be replicated.

Outcome Evaluation

In this section, we first compare the primary outcomes for families who completed the pre and post survey and participated in at least five Pathways 2 sessions (Pathways 2 families) with the primary outcomes of families who received services as usual. Next, we summarize changes from pre to post for Pathways 2 families. Lastly, we report on participant experiences, perceived program impact, and participant satisfaction with the program.

<div align="right">

PRIMARY OUTCOMES

</div>

Grief and Loss

One goal of implementing Pathways 2 was to help caregivers understand the grief, trauma, and loss experienced by children removed from their biological parents. Caregivers were asked to rate 20 items about grief and loss from strongly disagree (1) to strongly agree (5). In addition to looking at specific item-level changes, we summed scores for all items to get an overall total score. Items that were significantly different are reported below in Tables 3.4 and 3.5. Findings for all items are reported in Appendix E.

Overall, caregivers who participated in Pathways 2 had a better understanding of grief and loss experienced by children removed from their biological parents compared to the matched caregivers who received services as usual. For example, Pathways 2 caregivers were more likely to **agree** that:

- Loss is a part of life for children who do not live with their birth parents.

- Children lose a part of their identity through adoption and permanence.

- Children have lifelong connections to their birth families and permanent families.

Pathways 2 caregivers had a better understanding of the lifelong impact of trauma, parenting techniques that are effective with children who have experienced grief and loss and the importance of sharing a child's history with them.

Table 3.4. Grief and Loss Items: Intervention vs. Comparison Group (True Statements)

MEASURE/ITEM	N	PATHWAYS 2		COMPARISON		t	df	p
		M	SD	M	SD			
HIGHER SCORES = MORE UNDERSTANDING								
GRIEF AND LOSS TOTAL SCORE – ALL ITEMS	79	71.65	8.89	65.33	8.30	6.32	74	0.000
LOSS IS A PART OF LIFE FOR CHILDREN WHO DO NOT LIVE WITH THEIR BIRTH PARENTS.	79	4.19	1.18	3.75	1.24	2.35	78	0.021
CHILDREN LOSE A PART OF THEIR IDENTITY THROUGH ADOPTION AND PERMANENCY.	79	3.03	1.10	2.43	1.23	3.36	78	0.001
CHILDREN HAVE A LIFELONG CONNECTION TO THEIR BIRTH FAMILIES AND PERMANENT FAMILIES.	79	3.91	0.76	3.45	0.91	3.49	78	0.001

Table 3.5. Grief and Loss Items: Intervention vs. Comparison Group (False Statements)

ITEM	N	PATHWAYS 2		COMPARISON		t	df	p
		M	SD	M	SD			
LOWER SCORES = MORE UNDERSTANDING								
IF CHILDREN ARE JUST LOVED, THEY WILL HEAL.	79	2.63	1.13	3.09	1.15	-2.81	78	0.006
ABUSE AND NEGLECT IMPACT A CHILD MORE THAN LOSS.	79	3.09	1.17	3.82	1.04	-4.59	78	0.000
CAREGIVERS CAN HELP CHILDREN HEAL FROM TRAUMA AND LOSS, BUT MOST OF THE HEALING SHOULD BE DONE IN THERAPY.	79	2.38	0.94	2.86	0.93	-3.11	78	0.003
PARENTING TECHNIQUES LIKE "TIME OUT," BEING SENT TO YOUR ROOM, OR LOSING PRIVILEGES CAN HELP CHILDREN EXPERIENCING LOSS UNDERSTAND RIGHT FROM WRONG.	77	2.88	1.10	3.64	0.99	-4.22	76	0.000
CHILDREN ADOPTED AS INFANTS ARE LESS IMPACTED BY THE LOSS OF THEIR BIRTH PARENTS.	77	2.53	1.24	3.06	1.13	-2.78	76	0.007
THERE ARE SOME DETAILS OF A CHILD'S HISTORY THAT SHOULD NOT BE SHARED WITH THAT CHILD.	77	2.61	0.93	3.30	0.86	-5.01	76	0.000

Child and Family Wellbeing

We are cautious in interpreting differences in child, caregiver and family wellbeing measures between the intervention and comparison groups. There was most likely a selection effect in what motivated caregivers to attend Pathways 2 compared to what motivated caregivers to participate in a survey. It is probable that caregivers who decided to attend Pathways 2 were also the caregivers who may have been struggling and needing more support. Unfortunately, we were not able to control for differences at baseline in child behavior, caregiver commitment or caregiver strain. As a result, it is difficult to draw conclusions or interpret findings.

Keeping this limitation in mind, we generally found that caregivers in the comparison group reported fewer problematic behaviors, lower levels of strain and higher levels of family functioning and caregiver resilience. Interestingly, while behavior and strain were higher for Pathways 2 families, there were no differences in commitment or permanency outcomes. In fact, as of April 2019, we found that 68% of children in the intervention group were adopted or in custody of the same caregiver, compared to 64% of children in the comparison group. While not a statistically significant finding at this time, the higher proportion of children adopted or in permanent custody of the same caregiver is an encouraging sign. Results are reported in Table 3.6.

Table 3.6. Child & Family Wellbeing: Intervention vs. Comparison Group

MEASURE	SCALE RANGE	PATHWAYS 2		COMPARISON		t	df	p
		M	SD	M	SD			
HIGHER SCORES = MORE CONCERN								
BEHAVIOR PROBLEM INDEX (BPI)	0 - 56	24.07	10.88	16.07	11.80	4.03	55	0.000
EXTERNALIZING BEHAVIORS	0 - 38	17.29	7.94	11.48	8.93	3.84	55	0.000
INTERNALIZING BEHAVIORS	0 - 22	8.19	4.51	5.14	4.05	4.20	57	0.000
CAREGIVER STRAIN (CGSQ-FA22)	1 - 5	2.19	0.81	1.83	0.78	3.37	77	0.001
OBJECTIVE STRAIN	1 - 5	2.11	0.88	1.74	0.85	2.92	77	0.005
SUBJECTIVE STRAIN	1 - 5	2.26	0.85	1.90	0.80	3.37	70	0.001
MEASURE	Range	M	SD	M	SD	t	df	p
HIGHER SCORES = LESS CONCERN								
PFS FAMILY FUNCTIONING	1 - 7	5.74	0.80	6.16	0.73	-3.46	78	0.001
PFS NURTURING ATTACHMENT	1 - 7	5.81	0.92	6.21	0.85	-3.92	78	0.000
BEST-AG OVERALL	20 - 100	91.20	10.73	92.66	10.36	-0.94	78	0.349
BEST-AG EMOTIONAL SECURITY	13 - 65	58.38	7.46	59.54	7.46	-1.07	78	0.288
BEST-AG CLAIMING	7 - 35	32.82	3.79	33.12	3.34	-0.55	78	0.586
BRIEF RESILIENCE SCALE	1 - 5	3.78	0.62	3.99	0.58	-2.13	77	0.037

*Caution should be made in the interpretation of these findings. It is likely the intervention and comparison groups were significantly different on variables we were not able to capture for both groups at time 1 (i.e. caregiver strain or child behavior).

Placement Stability and Permanency

The percent of caregivers at the time of the post survey who 1) adopted or obtained permanent managing conservatorship of their child, 2) were caring for their child in foster or kinship care; or 3) were no longer caring for that child in their home are reported below by group assignment in Table 3.7. In both the matched comparison and intervention groups, 86% of children are still living with the same caregiver and 61% were adopted or in that caregiver's PMC.

Table 3.7. Placement Stability and Permanency Status at 6M and in April 2019

	PATHWAYS 2		COMPARISON		t	df	p
PLACED IN CAREGIVERS HOME AT POST	0.86	0.35	0.86	0.35	0.00	78	1.000
ADOPTED OR IN CAREGIVER'S PMC AT POST	0.61	0.49	0.61	0.49	0.00	78	1.000
ADOPTED OR IN PMC AS OF APRIL 2019	0.72	0.45	0.68	0.47	0.60	78	0.552
ADOPTED OR IN PMC OF SAME CAREGIVER AS OF APRIL 2019	0.68	0.47	0.64	0.48	0.60	78	0.552

PATHWAYS 2 PARTICIPANT OUTCOMES AT PRE AND POST

When measuring changes from pre to post in caregiver wellbeing, we reported findings at the caregiver level, using all 110 participants. When evaluating child and family wellbeing, we analyzed the data at the child and family level, using one primary caregiver from each household. We determined the primary caregiver based on the number of Pathways 2 sessions that caregiver completed.

Grief and Loss

Overall, Pathways 2 caregivers significantly increased their understanding of grief and loss from pre to post. More specifically, caregivers were more likely to agree that children experiencing loss often try to gain a sense of control by lying and that children lose a part of their identity through adoption and permanency. They were less likely to see traditional parenting styles as effective, had a greater understanding that loss impacts all children regardless of age, and were more likely to believe that all details of a child's history should be disclosed. Significant changes from pre to post are presented in Tables 3.8 below. All additional findings can be found in Appendix E.

Table 3.8. Grief and Loss Items at Pre and Post

	N	PRE SCORE		POST SCORE		t	df	p
		M	SD	M	SD			
HIGHER SCORES = MORE UNDERSTANDING								
GRIEF AND LOSS TOTAL SCORE – ALL ITEMS	103	4.09	1.13	4.19	1.27	5.66	102	0.000
CHILDREN EXPERIENCING LOSS OFTEN TRY TO GAIN A SENSE OF CONTROL BY LYING.	103	3.42	0,90	3.62	0.89	2.22	102	0.029
LOWER SCORES = MORE UNDERSTANDING								
IF CHILDREN ARE JUST LOVED, THEY WILL HEAL.	103	3.05	1.11	2.68	1.16	-3.20	102	0.002
ABUSE AND NEGLECT IMPACT A CHILD MORE THAN LOSS.	103	3.60	0.97	3.27	1.25	-2.67	102	0.009
PARENTING TECHNIQUES LIKE "TIME OUT," BEING SENT TO YOUR ROOM, OR LOSING PRIVILEGES CAN HELP CHILDREN EXPERIENCING LOSS UNDERSTAND RIGHT FROM WRONG.	103	3.39	0.94	2.83	1.08	-5.79	102	0.000
CHILDREN ADOPTED AS INFANTS ARE LESS IMPACTED BY THE LOSS OF THEIR BIRTH PARENTS.	103	2.95	1.14	2.52	1.26	-3.59	102	0.001
THERE ARE SOME DETAILS OF A CHILD'S HISTORY THAT SHOULD NOT BE SHARED WITH THAT CHILD.	103	2.92	0.96	2.69	1.00	-2.27	102	0.025
WHEN POSSIBLE, CAREGIVERS SHOULD WAIT UNTIL THEIR CHILDREN ARE TEENAGERS BEFORE TALKING TO THEM ABOUT PAINFUL PARTS OF THEIR PAST.	103	2.74	1.01	2.51	1.04	-2.70	102	0.008

> **"I realized that my son and daughter will both be impacted by not being with their birth parents even though they were placed in our home when they were both very young."**
>
> -Participant, 6M Post Survey

Child and Family Wellbeing

To better understand child and family wellbeing, we examined child behavior, family functioning, nurturing and attachment, caregiver strain, commitment, and caregiver resilience measures at pre and post.

Behavior Problems

We evaluated a child's level of behavior problems using the Behavior Problems Index, a measure consisting of two subscales that measure the frequency, range, and type of childhood behavior problems children ages four and older may exhibit (Peterson & Zill, 1986) The Internalizing Subscale (11 items) measures a child's tendency to internalize problems and is characterized by anxiety, depression, social withdrawal, and somatic symptoms while the Externalizing Subscale (19 items) measures a child's tendency to externalize problems and is characterized by acting out, aggression, hostility, hyperactivity and impulsivity. In this study, we used mixed linear modeling to examine whether total BPI scores, Internalizing BPI scores and externalizing BPI scores changed from pre to post. Next, we evaluated whether or not changes looked different for relative and non-relative caregivers. BPI scale and subscale scores for all caregivers, relative caregivers, and non-relative caregivers are reported in Table 3.9 below. More information on the Mixed Linear Models can be found in Appendix F.

Table 3.9. BPI scores for all caregivers, relative caregivers, and non-relative caregivers

MEASURE (SCALE RANGE)	ALL CAREGIVERS (N=59)		NON-RELATIVE CAREGIVERS (N=15)		RELATIVE CAREGIVERS (N=44)	
	PRE M (SD)	POST M (SD)	PRE M (SD)	POST M (SD)	PRE M (SD)	POST M (SD)
BEHAVIOR PROBLEM INDEX (0-56)	26.08 (11.28)	24.17 (11.05)	24.80 (11.21)	24.70 (11.02)	29.67 (11.06)	22.60 (11.36)
MEAN DIFFERENCE (PRE – POST)		-1.91		-0.10		-7.07
BPI EXTERNALIZING BEHAVIORS (0–38)	18.15 (8.49)	17.34 (8.08)	16.90 (8.41)	17.64 (8.18)	21.67 (7.94)	16.47 (7.99)
MEAN DIFFERENCE (PRE – POST)		-0.81		+0.74		-5.20
BPI INTERNALIZING BEHAVIORS (0–22)	9.38 (4.29)	8.25 (4.50)	9.30 (4.41)	8.68 (4.51)	9.60 (4.07)	7.00 (4.38)
MEAN DIFFERENCE (PRE – POST)		-1.13		-0.62		-2.60

Overall, we found a significant decrease in a child's frequency to internalize behaviors from pre to post. Moreover, when we looked at relative status, we found that relative caregivers reported a greater decrease in their child's behavior problems from pre to post compared to non-relative caregivers (See Figure 3.8). Some caution is suggested in interpreting this finding. Only 15 relative caregivers had children over the age of four, and it is not known how representative they are of all kinship families. It would be ideal to explore this relationship further in the future.

Figure 3.8. Changes in Total BPI Scores for Relatives and Non-Relatives

HIGHER SCORE = MORE STRUGGLE WITH CHILD'S BEHAVIOR

The effect of Pathways 2 on BPI scores is different for relative and non-relative caregivers. **Relatives had higher BPI scores at pre, but lower scores at post compared to non-relative caregivers.**

— RELATIVES
— NON-RELATIVES

	PRE	POST
RELATIVES	29.7	22.6
NON-RELATIVES	24.7	25.0
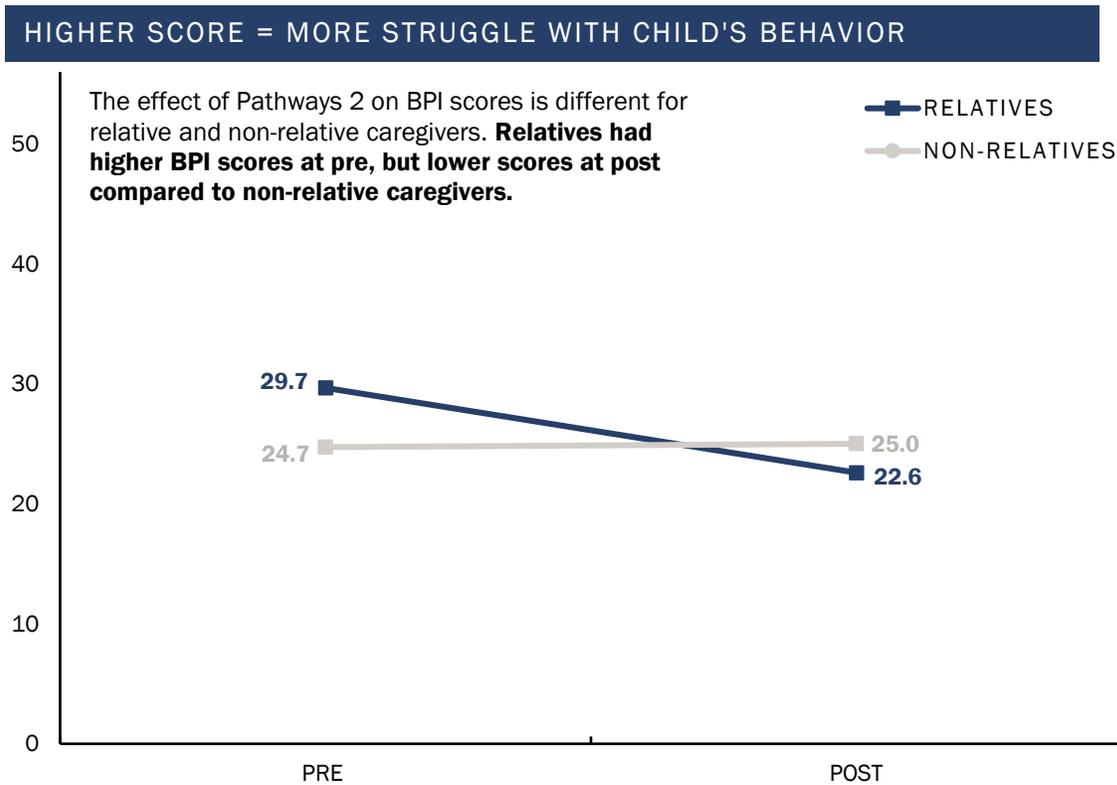
It can often be difficult to see changes in overall behavior and wellbeing until some level of attachment has been established between a child and caregiver. However, kinship or relative caregivers often have formed some level of attachment with their child prior to that child's removal or placement in their home. Thus, when implementing tools and parenting techniques taught in Pathways 2, it's possible that relative caregivers saw greater degrees of change in their children compared to non-relative caregivers as a result of that pre-established relationship.

In Texas, relative and non-relative fictive kin placements differ from other foster care placements in that they are not licensed or required to complete trainings. Therefore, it also makes sense that Pathways 2 might impact kinship families differently when compared to foster parents who have been trained on child development and trauma. Regardless of the reasoning behind these differences, these findings suggest that participating in Pathways 2 may be particularly beneficial for kinship caregivers.

Family Wellbeing, Commitment, and Caregiver Strain

Changes in family functioning, nurturing and attachment, caregiver strain, and caregiver resilience were not found at this time. This result is not particularly surprising, as changing the way a family operates or seeing levels of caregiver strain decrease often takes longer than a period of six months. Ideally, changes would have been tracked over a longer period of time to account for changes that may take longer to achieve.

Overall, we found a significant decrease in caregiver commitment and claiming of their child from pre to post; however, this change was heavily influenced by the small number of caregivers who no longer had their child placed in their home and did not plan on having that child return. When these families were excluded, there was no difference in pre and post scores. All caregiver and family wellbeing outcomes at pre and post are presented in Table 3.10 below.

Table 3.10. Child Wellbeing Indicators at Pre and Post

MEASURE	SCALE	PRE SCORE		POST SCORE		t	df	p
		M	SD	M	SD			
HIGHER SCORES = MORE CONCERN								
CAREGIVER STRAIN (CGSQ-FA22)	1 - 5	2.09	0.71	2.20	0.79	1.83	104	0.070
CGSQ-FA OBJECTIVE STRAIN	1 - 5	2.02	0.80	2.14	0.88	1.66	104	0.100
CGSQ-FA SUBJECTIVE STRAIN	1 - 5	2.16	0.72	2.26	0.82	1.59	104	0.115
measure	SCALE	M	SD	M	SD	t	df	p
HIGHER SCORES = LESS CONCERN								
PFS FAMILY FUNCTIONING	1 - 7	5.72	0.70	5.70	0.82	-0.20	80	0.839
PFS NURTURING ATTACHMENT	1 - 7	5.90	0.81	5.79	0.92	-1.734	80	0.087
BEST-AG OVERALL	20 - 100	92.27	7.11	91.06	10.58	-1.49	104	0.139
BEST-AG EMOTIONAL SECURITY	13 - 65	58.62	5.35	58.29	7.36	-0.58	104	0.560
BEST-AG CLAIMING	7 - 35	33.65	2.26	32.77	3.70	-2.97	104	0.004
BRIEF RESILIENCE SCALE	1 - 5	3.89	0.63	3.87	0.63	-0.25	104	0.801

PATHWAYS 2 PARTICIPANT EXPERIENCES

Program Impact

> "It has got me to think about how to best parent each of my children and opened me up to more alternative discipline techniques. It has also helped me to understand why it is a slow process."
>
> -Participant, 6M Post Survey

Overall, over 80% of participants felt that Pathways 2 positively impacted their understanding of attachment and child development, improved their ability to respond to their child's needs, and increased their confidence in being able to parent their child. See Figure 3.9 below.

Figure 3.9. Perceived Impact of Participating in Pathways 2

SINCE PARTICIPATING IN PATHWAYS 2, HAS EACH OF THE FOLLOWING GOTTEN WORSE, STAYED ABOUT THE SAME, OR GOTTEN BETTER?

UNDERSTANDING OF ATTACHMENT	89%
UNDERSTANDING OF CHILD DEVELOPMENT	87%
ABILITY TO RESPOND TO CHILD'S NEEDS	85%
QUALITY OF RELATIONSHIP WITH CHILD	77%
CONFIDENCE IN PARENTING CHILD	83%

BETTER   SAME   WORSE
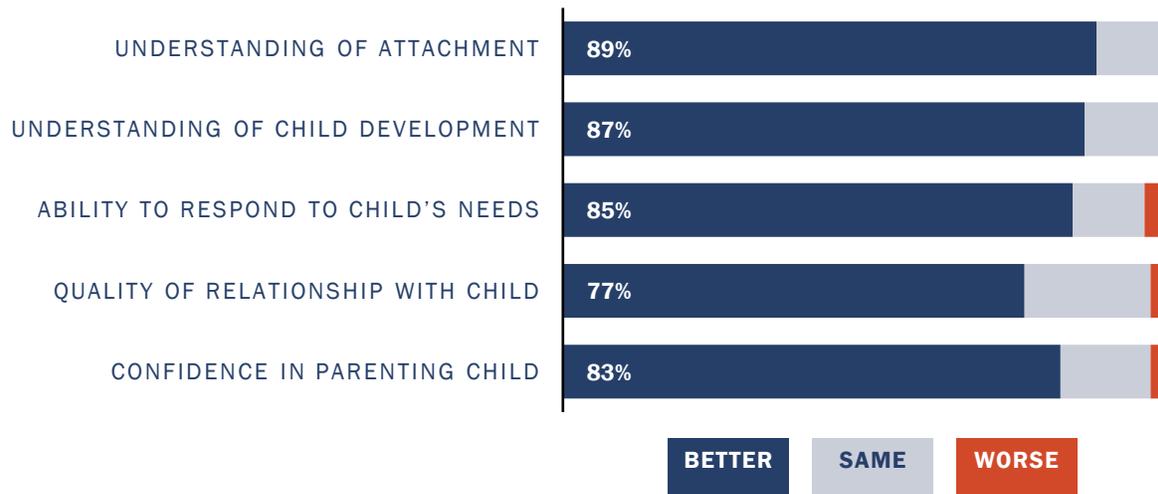
Program Satisfaction

Overall, most caregivers agreed (77%) that the location and meeting times were convenient. The majority of caregivers (70%) indicated the length of sessions (3 hours) was just right. A little over half of the participants (57%) indicated that the length of the program (7 sessions) was just right, while 27% felt it was too long and 16% felt it was too short. Additionally, almost all caregivers agreed that Pathways 2 facilitators were supportive (97%) and knowledgeable (95%). See Figure 3.10 below.

Figure 3.10. Caregiver Satisfaction with Location, Times and Facilitators

HOW MUCH DO YOU **AGREE** OR DISAGREE WITH EACH OF THE FOLLOWING STATEMENTS ABOUT PATHWAYS 2?

THE LOCATION WAS CONVENIENT. **77%**

THE MEETING TIME WAS CONVENIENT. **89%**

FACILITATORS WERE SUPPORTIVE. **97%**

FACILITATORS WERE KNOWLEDGEABLE. **95%**

AGREE | NEUTRAL | DISAGREE
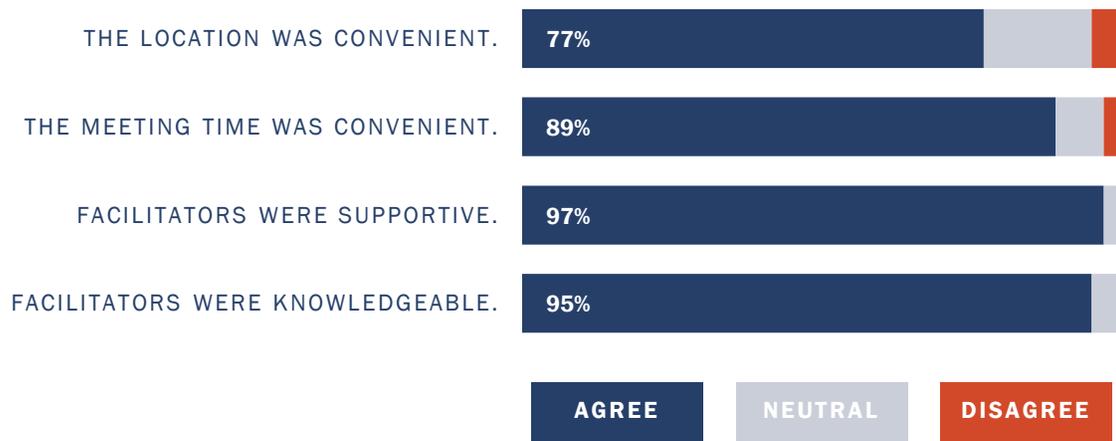
Participant Feedback on Factors That May Impact Participation

Caregivers were asked about factors that may have impacted their decision to attend Pathways 2. The most important factor for caregivers was free childcare. Without free childcare, 45% of caregivers indicated they would not have attended and 22% were unsure. Not having food or travel gift cards would not have prevented the majority of caregivers from attending. (See Table 3.11 below.)

Table 3.11. Would you have attended the program if…?

WOULD YOU HAVE ATTENDED THE PROGRAM IF…	YES	NO	UNSURE
FREE CHILDCARE WAS NOT AVAILABLE?	33%	**45%**	**22%**
CHILDCARE WAS AVAILABLE AT A SMALL COST?	44%	28%	28%
YOU DID NOT RECEIVE HOURS TOWARD TRAINING?	62%	22%	16%
IF FOOD WAS NOT AVAILABLE	86%	7%	7%
YOU DID NOT RECEIVE A GIFT CARD FOR TRAVEL?	86%	6%	8%

Additional Quotes from Caregivers on the Impact of Pathways 2

Lastly, caregivers shared additional feedback on how Pathways 2 impacted their families. We have provided some of their feedback below.

How Pathways to Permanency 2 has impacted my family

"It has helped me to filter out well-intentioned but otherwise inapplicable advice from others, and to prioritize attachment over most anything else. It has also helped me be more understanding of my child's high activity level, knowing that much of it may be out of his control due to potential prenatal exposure."

"By deepening understanding of the development of the traumatized child, how it affects behaviors and beliefs and unveils awareness of self in relation to the content."

"I loved this class! I feel like it has given me some great insights, and put a lot of things in perspective for me. I've put the tools taught in this class to use and talked about them with other family members and friends to help them in dealing with my kids."

"It has provided me with more knowledge in understanding my child. It has taught me new ways to parent him that are more effective. It helped to calm some things down in our home."

"Extremely happy to see that red bucket method actually works. PS don't tell my older kids, but I use it with them too. We sometimes say, "I'm having a red bucket moment." [Name] tantrums are less frequent and of shorter duration."

"I have new tools to help me parent this child. I understand better what the trauma has done to her and her path in life. I am better at solving problems now."

"This was a wonderful experience and we truly wanted to repeat the program. What happened with our foster son would have been much more difficult and painful without this training! His trauma and autism combined with his huge mommy wound, was more than we all could deal with. It became dangerous for him and myself, and it became apparent that he needed a different family dynamic to continue to grow. We grieve his loss but are happy that he is with a wonderful man who loves him."

"The training was by far the most significant of all the trainings I received as a foster parent. I have since forwarded my binder onto my child's adoptive parents."

Limitations

As the original research design of an RCT changed, the decision was made to utilize a separate region as a comparison group. Region 8 was chosen as the comparison group due to its proximity and comparable population. However, we are concerned that families who self-selected to attend Pathways 2 may have been different from the families who self-selected to take a survey (selection bias). For example, the living arrangements and total placements of children in Region 7 and Region 8 were significantly different. We were able to use propensity score matching to control for these known differences, but we did not administer the pre survey in Region 8 and therefore were not able to control for other relevant information such as child behavior, caregiver commitment, caregiver strain and prior trauma training at baseline. If families in the intervention and comparison groups differed at baseline, then these differences would need to be factored into differences at the time of the post survey. For example, Pathways 2 families reported high levels of problematic behavior on the pre survey (BPI = 25.78). This finding suggests that families who attended Pathways 2 were likely the families who may have needed it the most. On the post survey, the level of behavior problems reported by caregivers in the comparison group was significantly lower than the intervention group, but these differences may have been present at baseline. Thus, drawing conclusions about differences between these groups is cautioned.

A second limitation was that our sample size decreased when we 1) used propensity score matching, 2) analyzed outcomes at the child or family level, and 3) used measures that only applied to some participants but not others (age, in-school). With smaller sample sizes, it can be difficult to detect a statistically significant difference, even if it is present. Additionally, the overall mean scores can be largely impacted by a small number of cases with extreme scores. For example, if the majority of caregivers improved a little in one area, but a few cases got drastically worse, the few cases might influence the overall mean. Lastly, smaller sample sizes make it difficult to compare groups of participants. With a larger sample size, we would have liked to further explore the differences in outcomes of relative and non-relative caregivers.

Another limitation for this study was that only a small proportion of the eligible population participated in the research, and 25% of those who attended at least one session of Pathways 2 did not receive the full intervention (5+ sessions). The reasons why caregivers chose not to participate or why some caregivers who attended at least one session did not complete at least five sessions are unknown. As a result, there are limitations and potential biases that threaten the internal and external validity of this study.

Lastly, we were only able to conduct one follow up survey at a single time point (six months). At six months, it may be difficult to see a short-term program impact on overall child and family wellbeing outcomes. Core issues related to trauma, grief, and loss get stirred up for children around changes in legal status, placement, etc. and can slow the progress of change. Ideally, changes would have been tracked over a longer period of time to account for changes that may take longer to achieve.
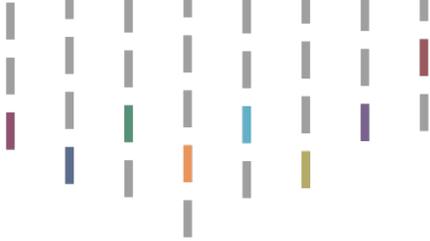
Cost Evaluation

The Texas QIC-AG project implemented and tested the effectiveness of Pathways to Permanence 2 ('Pathways 2'). Pathways 2 is a group intervention for caregivers who are parenting children who have experienced trauma, grief, and loss. The Texas QIC-AG site tested the impact of Pathways on caregivers who had children in long-term foster care to see if Pathways 2 would help move children into permanent placements faster. The project served 100 families in Central Texas. Because families have multiple children, the actual reach of the project was more than 200 children.

Cost Evaluation Approach

The cost-effectiveness research (CER) analysis provides information for policymakers and administrators to help maximize desired outcomes based on the associated cost of achieving them (Meunnig, 2002). CER analysis will be applied to the short-term outcomes identified by Texas as well as the three long-term outcomes targeted by the state of Texas: 1) increased post permanency stability; 2) improved behavioral health among children; 3) improved child and family wellbeing.

Assumptions, Constraints, and Conditions

The first step in this analysis was to identify issues which might impact the validity of our cost analysis findings. CER analyses typically rely on researchers making subjective decisions based on their judgments and perceptions of the available information. Thus, it is important to record assumptions, constraints, and conditions relevant to Texas that may impact the analysis.

ASSUMPTIONS

Assumptions are those factors which will likely impact the program and thus, the accuracy of the cost analysis (Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration, 1993). The primary assumption underlying this cost evaluation is that the time period of implementation is long enough to achieve change in the project sites' outcome measures. We are assuming that the impact of the chosen interventions is achieved or not achieved within the timeframe of the project. However, it is likely that the intervention's true impact will not be seen until after the project period.

We also assume multiple positive outcomes are likely impacted by the QIC-AG site programs. For pre permanency interventions such as Texas, the desired impact of the programs is adoption or guardianship. However, improvement of parent knowledge and/or child behaviors are also positive outcomes. While the Texas site measured outcomes for the selected target child, it is likely that the intervention impacted every child in the home. However, those impacts are not able to be measured.

A final assumption is that the resource allocation captured in costs paid to sites is accurate. It is likely that staff time may be over or under-budgeted depending on the time constraints. For example, at the beginning of an intervention, more staff effort may be needed, but as a program continues, staff effort may be less intense because of the familiarity with the intervention.

Constraints are factors that have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For Texas, constraints included changing political landscapes. During this project, there was a change in many high-level leadership positions at the state agency. However, the Site Implementation Manager (SIM) was able to mitigate impacts to the project. There were also rules put into place with the agency that prohibited workers from managing gift cards due to accountability issues. The SIM was also able to help find solutions for gift card issues.

Conditions are factors that may influence system processes but are not necessarily constraints. A major condition in Texas that impacts cost is the size of the state. The project was limited to one region of the state, but even within that region, there are 30 counties. Most counties are rural counties which meant long drives and overnight trips for group facilitators. That travel added to the project costs, which was an additional condition related to the agency's need to protect caseworker time. In order to minimize burdens to front line workers, both internal and external workers were trained to conduct groups. Workers were provided compensation for their time, which also increased project costs.

Cost Estimation

The next step in this cost analysis is to estimate the costs Texas incurred to implement the intervention. This cost estimation includes actual costs paid to Texas by Spaulding.

To the extent possible, the estimation of costs followed the Calculating the Costs of Child Welfare Services Workgroup's (2013) technical guide, *Cost analysis in program evaluation: A guide for child welfare researchers and services providers*, which identifies five key points to address in cost estimation. Each of these points is addressed below in relation to Texas.

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. The project was managed from the state agency office which had existing infrastructure to provide office space to the SIM. However, the actual engagement of families took place in local communities and space was contracted through community organizations. Thus, costs for facilities/office space are included in this analysis, but office space for the SIM is not. The sites also received substantial technical support from consultants and evaluators during implementation. Although the consultation was crucial to moving sites into implementation, the costs associated with the consultation will only be noted in the conclusion as additional costs for future programs to consider. Evaluation costs are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates.

Perspective refers to the person or group that incurred the costs. The perspective is essentially a filter that helps determine what costs are included. In this cost evaluation, the costs are determined from the perspective of the Texas QICAG site. In other words, if funds were spent by the program, they are considered costs. Participant costs such as travel or lost wages are not included because they were not provided by the program. However, other programs would need to consider those participant costs in relation to the population they intend to serve.

Cost estimation should include the passage of time in order to account for inflation. Given that Texas implemented this intervention for a two year period, costs did not change dramatically. The major cost that would be impacted in this short time frame is staff salary; Texas' yearly incurred direct expenses already account for this change.

Both variable and fixed costs should be captured in a cost estimation. For Texas, fixed costs include salaries, fringe and facility/office space. Variable costs were charged to the project as needed for items such as facilitator travel, supplies, childcare, and gift cards.

Marginal and average costs should be examined in a cost estimation. These calculations are presented in subsequent sections.

COST ESTIMATION STEPS

The steps involved in the cost estimation of this analysis are described below. All QIC-AG sites used a standardized budget form and cost reimbursement form. Costs for Texas were taken from monthly budget forms and summarized into Table 3.12 on the next page.

Collect Data on Resource Costs

In order to collect accurate information, monthly expense forms were used to track actual costs. All QIC-AG sites developed an annual budget. The actual costs billed to QIC-AG were provided to the evaluation team via monthly expense reports. These expense reports contained a year to date summary of expenses. Expenses for each fiscal year were then compiled into Table 3.12.

Collect Data on Resource Allocation

While resource costs are monetary values, resource allocation refers to the percent of time spent on the project. Personnel costs were billed to the project based on the percent of time employees were allocated to the project. The monthly expense reports described above also captured resources allocation.

Estimation of Direct Costs

Descriptions of all direct costs billable to Spaulding were defined by Spaulding. These same descriptions are used in this cost estimation. Multiple direct costs were billable to the project. Each of these is described below.

Personnel

Personnel costs totaled $225,112 for staff time allocated to the project during the implementation phase. The SIM and an administrative assistant provided program support by organizing all aspects of groups, including securing locations, childcare and meals. They also processed documents, managed budgets and/or provided other administrative support. Additionally, personnel time included overtime pay for agency employees to complete trainings and facilitate groups.

Table 3.12. Costs for Texas

	IMPLEMENTATION			TOTAL
	FY 2019*	**FY 2018**	**FY 2017****	
PERSONNEL COSTS				
SITE IMPLEMENTATION MANAGER		$49,075	$65,000	$114,075
ADMINISTRATIVE PERSONNEL		$17,581	$27,759	$45,340
PERSONNEL			$65,698	$65,698
FRINGE		$33,406	$77,985	$111,392
NON-PERSONNEL DIRECT EXPENSES				
CONTRACTED SERVICES: SENECA	$2,840	$12,848	$108,397	$124,084
CONTRACTED SERVICES: LONESTAR		$4,230	$2,707	$6,937
CONTRACTUAL: NON-DFPS COMPENSATION	$6,200	$20,923		$27,123
CONTRACTUAL: CHILDCARE-ANGEL SITTERS	$9,218	$40,103		$49,320
CONTRACTUAL: PIA	$9,075	$1,270		$10,345
PROGRAM SUPPLIES: INTERVENTION MATERIAL		$1,240		$1,240
PROGRAM SUPPLIES: TRAINING MATERIAL		$7,489		$7,489
PROGRAM SUPPLIES		$640	$7,817	$8,458
GIFT CARD INCENTIVES	$1,920	$11,164	$888	$13,972
POSTAGE		$725	$110	$836
PRINTING/DUPLICATION	$142	$96	$4,467	$4,705
FOOD	$3,640	$17,389	$6,579	$27,609
FACILITIES/OFFICE SPACE	$1,714	$10,901	$2,055	$14,670
CHILDCARE SUPPLIES			$2,325	$2,325
TRAVEL	$3,309	$16,861	$27,508	$47,678
NON-PERSONNEL: INDIRECT EXPENSES				
MATERIALS AND SUPPLIES		$1,950	$2,263	$4,213
IT SUPPORT	$707	$2,120	$3,005	$5,832
TOTAL	**$38,764**	**$250,012**	**$404,564**	**$693,340**

*FY2019 thru 3/31/2019 only
**Start date for Fiscal year 2017 was 9/30/16

Fringe

Overall fringe for all employees totaled $111,392. Fringe was calculated based on 32.38% of salary per state agency requirements. In some cases, staff had higher or lower fringe rates based on their length of state service and benefit elections.

Contractual Expenses

Texas contracted for services from five entities.

The Pathways to Permanence 2 curriculum was developed and is owned by Seneca Family Services. Seneca provided training at multiple points in the project and engaged in consultation with the project team throughout the implementation of caregiver classes. Additionally, Texas paid an annual licensing fee for the use of P2P2. Seneca was paid $124,084 during the course of the implementation of the project. Although the costs described here do not include installation costs, we included a $62,591 fee from FY16. This cost is listed in the FY17 column and is combined with the $41,447charge in FY17 (total $108,397).

Lonestar Social Services is a private agency that provides direct childcare staff during the P2P meetings. Lonestar was paid $6,936 over the course of the project.

Individual facilitators who were not employed by the state agency were paid on a contract basis to facilitate groups. Over the course of the implementation, facilitators were paid $27,122.

Angel Sitters is a private agency that provided direct childcare staff to provide childcare during caregiver classes. Angel Sitters was paid $49,320 over the course of the project.

Gift Cards

Gift cards were provided to participants. A total of $13,972 was spent on gift card incentives. Gift card policies changed during the course of the project. In order to incentivize caregivers to attend every session, they were provided a $25 gift card for each session attended.

Materials and Supplies

Over the implementation period, $15,864 was spent on program supplies that were specific to the operation of the intervention. $1,240 was spent on materials for the intervention such as videos. $7,489 was spent on training materials, which were largely printing of facilitator and participant binders which contain substantive files. $7,134 was spent on general supplies.

Travel

Over implementation, $47,678 was paid for travel. A large portion of these funds was used to pay for travel costs for facilitators who have to travel to cities within the region to facilitate groups.

Facilities/Office Space

$14,670 was paid for facility rental fees to secure space for groups. Because childcare was being provided, locations had to include sufficient space to have a caregiver group and one or more spaces for childcare.

Other Direct Charges

Other direct charges include all non-personnel direct costs that do not fit into the categories listed above such as postage ($835); printing ($4,705); food for groups ($27,608); childcare supplies ($2,325).

Estimation of Indirect Costs

Descriptions of all indirect costs billable to Spaulding were defined by Spaulding. These same descriptions are used in this cost estimation. Multiple indirect costs were billable to the project. Each of these is described below.

IT Support

IT support includes all expenses related to IT including computers, contract with a person for IT work, database design, and software. Computer and IT network charges include $6,000 and an additional $5,832 for IT support.

Other

$4,213 was spent on other supplies and equipment not included in the direct costs.

Indirect costs often include facility costs and infrastructure not captured in the above categories. Since this cost evaluation is designed to help other state child welfare policymakers understand the total costs associated with each site program, indirect costs are important to document. Because the state agency was the project lead, the Texas site had a substantial infrastructure. Because the evaluation team assumed that other interested child welfare agencies would also have the infrastructure in place to run programs, we did not attempt to portion out the infrastructure costs that another agency would likely need. Likewise, we assumed that indirect costs will vary greatly by state due to cost of living issues influencing real estate prices and wages and thus, more detailed indirect cost calculations would not be useful to other entities. In order to run a similar program in another area, programs would need building space with heating, air, electricity and water; and some administrative support for contracting and financial management.

Summary of Costs

Total implementation costs for Texas were $693,340 over the course of the implementation of the intervention.

Cost Calculations

For this cost-effectiveness analysis, we conceptualize effectiveness as the short-term outcomes designed to be impacted by the intervention. In Texas, the intervention was expected to result in improved family relationships; increased caregiver resiliency; decreased caregiver strain; increased caregiver knowledge in dealing with childhood trauma, grief and loss; the improved ability for caregivers to respond to challenging behaviors; and increased caregiver commitment. To estimate effectiveness, we first examine change in short term outcomes.

COST PER PARTICIPANT

Cost per participant. Based on the total costs of $693,340 and 178 participants, the cost per participant for this intervention was $3,895.

COST TO EFFECTIVENESS CALCULATION

Pathways 2 significantly increased knowledge of grief and loss for caregivers. The cost-effectiveness ratio (CER) is a simple calculation where effectiveness is represented by E, the cost is represented by C: CER=C÷E. In this case, cost is the total project cost of $693,640 and effectiveness is the 65 caregivers who reported increased knowledge of grief and loss. The cost-effectiveness ratio is $10,667, meaning it takes roughly $10,667 to significantly increase knowledge of grief and loss with this intervention.

COST AVOIDANCE CALCULATION

A long term outcome of this project was to move youth in foster care into permanent placements. In theory, the intervention could result in cost savings to the state. The intervention group had 60 foster youth move out of foster care. The average age of this group was 6 years old. The cost of each youth remaining in foster care is $27.07 per day which equates to $9,528 per year. This cost assumes that youth have a basic level of care, are placed in the least expensive setting and will exit foster care through emancipation. At an average age of 6 years old, youth would have an average of 12 years remaining in long term foster care, which would cost the state $114,336 per child. In comparison, this intervention cost $3,895 per child, yielding a theoretical savings of $110,441 per child.

Sensitivity Analysis

In a sensitivity analysis, assumptions made about various factors assumed in the cost-effectiveness calculation are allowed to vary in a recalculation of the CER. The findings are compared to the initial CER to provide additional context to understanding the real cost of obtaining a particular outcome. Because assumptions and factors will vary for other agencies wanting to implement the intervention, the information provided in the CER analysis can be used to vary budget line items.

In the case of the QIC-AG, sites were provided with a more generous amount of resources than were necessary to run the actual intervention because sites were required to participate in activities specific to the QIC-AG, such as off-site meetings and capacity building activities. Additionally, sites were required to work extensively with a consultant and external evaluator, which required significant staff time. Other child welfare agencies wishing to implement this intervention would not need all of the resources mentioned above.

For this sensitivity analysis, costs that are most likely not needed by other agencies have been removed from the cost calculation. Inclusion or exclusion of costs is subjective in a sensitivity analysis such as this one. Costs were included or excluded depending on whether the expense was critical to the functioning of the intervention. Another agency would want to adjust costs specific to their program needs. For other child welfare entities interested in facilitating this intervention, the Texas site recommends contacting Seneca for an estimate of licensing and training fees; calculating fees for childcare services and meals as these were critical to participant involvement; and training materials. Sites could potentially save funds on personnel by utilizing internal trainers whose salaries are already covered by the agency and seeking in-kind donations.

The following exclusions were made for this sensitivity analysis:

1. The salary and fringe for the Site Implementation Manager were removed. At this site, the Site Implementation Manager was not needed to implement the actual intervention. This position served as a liaison with external entities and managed internal processes. The internal management could, in theory, be provided by one of the Pathways 2 facilitators or administrative staff.

2. Gift cards were removed from the cost calculation. Gift cards were provided to thank people for their time in completing evaluation materials.

3. Program supplies not related to Pathways 2 materials were excluded.

4. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings. Given that Texas is a primarily rural area, costs were incurred for facilitators to travel overnight to locations. Another agency would need to consider potential travel costs if groups will be held at multiple locations.

5. Fees related to renting a meeting space were excluded. The cost of a rental space varies significantly by area and other agencies would need to adjust for their own community and agency needs. With more time, agencies might be able to locate a meeting space that could be donated in-kind.

6. All contracting fees to childcare providers were also removed. Childcare was a critical component of the success of this project. However, agencies may have their own certified childcare staff or they may be able to coordinate care as an in-kind donation.

7. Fees for food were also removed. Meals were an important part of the meetings, but food costs can be mitigated with in-kind donations or deals with local restaurants.

8. Other direct charges were also excluded. These expenses were not necessary for the implementation of the intervention.

9. Indirect charges were also excluded. Indirect costs will vary extensively by different agencies. In some cases, agencies may have no additional indirect costs.

Based on these exclusions, Table 3.13 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $308,900, which amounted to $1,735 per participant.

Table 3.13. Sensitivity Analysis: Adjusted Costs for Texas

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL COSTS				
ADMINISTRATIVE PERSONNEL		$17,581	$27,759	$45,340
PERSONNEL			$65,698	$65,698
FRINGE		$6,279	$31,648	$37,926
NON-PERSONNEL DIRECT EXPENSES				
CONTRACTED SERVICES: SENECA	$2,840	$12,848	$108,397	$124,084
PROGRAM SUPPLIES: INTERVENTION MATERIAL		$1,240		$1,240
PROGRAM SUPPLIES: TRAINING MATERIAL		$7,489		$7,489
TOTAL	**$9,040**	**$66,359**	**$233,501**	**$308,900**

*FY2019 thru 3/30/2019 only
**Start date for Fiscal year 2017 was 9/30/16

Cost Evaluation Summary

The total project cost for Texas was $693,640. The cost-effectiveness ratio is $10,667, meaning it takes roughly $10,667 to significantly increase knowledge of grief and loss with this intervention. However, a sensitivity analysis resulted in an estimated total cost of $308,900 and a cost-effectiveness ratio of $4,752. Given that some youth in the intervention did leave foster care, a cost avoidance calculation suggests that while this intervention cost $3,895 per child, there was a theoretical savings of $110,441 for future foster care costs.
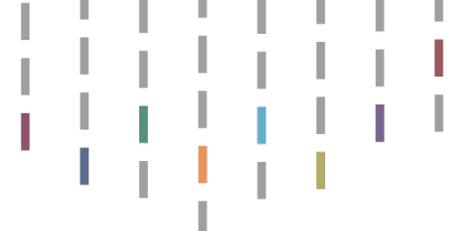
Discussion

The purpose of the Pathways 2 intervention was to help caregivers understand the grief, loss, and trauma experienced by children who are removed from their families and provide parenting techniques and tools to help caregivers support their children in healing. Results from this study found that caregivers who participated in Pathways 2 reported a higher level of understanding of how trauma, grief, and loss impact children. Specifically, compared to caregivers who received their usual services, caregivers who received Pathways 2 were more likely to agree that:

- Loss is a part of life for children who do not live with their birth parents.

- Children lose a part of their identity through adoption and permanence.

- Children have lifelong connections to their birth families and permanent families.

Additionally, internalizing behavior problems decreased significantly from pre to post study. Moreover, when we looked at behavior change from pre to post for relative and non-relative families, we found that Pathways 2 had a greater impact on decreasing child behavior problems for relative families.

While there were limitations to the study design, attrition, and sample size, we believe that by implementing Pathways 2 in Texas, the state has increased its capacity to help prepare and support caregivers to understand and address the needs of their children who have experienced trauma, grief, and loss.

Pathways 2 provided caregivers with a foundation to understand trauma, grief, and loss and empowered caregivers with new tools to help them parent their children in a way that addresses impaired-attachments and trauma. When caregivers fully understood grief and loss, there seemed to be a shift in the way they parented and responded to their children. This shift is important for creating a safe and healing home environment and led to a significant decrease internalizing behavior problems after six months. Moving forward, it may be helpful to:

Offer and encourage kinship families to attend Pathways to Permanence 2. Pathways 2 had a greater impact on child behavior after six months for relative families compared to non-relative families. These findings have significant implications for kinship families, particularly in regions where a high percentage of children are placed in kinship care.

Offer Pathways 2 as a trauma-informed training to help prepare and support families. In Texas, there is a focus on improving and expanding existing trauma-informed care trainings and services throughout the state. Increasing awareness about Pathways 2 and offering this training to families as an additional trauma-informed training option supports this goal. Ideally, any licensed caregiver would also have the opportunity to receive credit-hours that could be used towards their annual training requirements.

Provide free childcare during Pathways 2 trainings. Almost half (45%) of caregivers in this study reported that they would not have attended Pathways 2 had there not been free childcare. Another fourth (25%) were unsure whether or not they could have attended. Having free childcare, among all other factors, seemed to be the most important factor in determining whether or not a family could attend Pathways 2.

Develop a Pathways 2 Train the Trainer Model in Texas. Lastly, to increase the likelihood of sustainability, we suggest that at least two facilitators in Texas receive the Pathways 2 "Train the Trainer" training that would allow them to train future Pathways 2 facilitators in Texas.

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Appendices

Appendix A. Pathways 2 Core Components

CORE COMPONENT #1: USE OF EXPERIENCED FACILITATORS

Facilitator Knowledge

Facilitator knowledge and experience provides a strong foundation to a successful training. "All facilitators should be experienced in working with families that include children who have experienced trauma" (Pathways2 FG p. xxix). A Facilitator should be knowledgeable and "…well versed in the major concepts and content of the curriculum [as this is] essential to the facilitator's ability to manage timing" (Pathways2 FG p. xxix). In addition, a Facilitator should have "…a thorough understanding of the *Seven Core Issues*, developmental re-parenting, attachment, the decoding behaviors exercises." (Pathways2 FG p. xxix). These capabilities will "…enable facilitators to move more fluidly through the content, with use of relevant examples" (Pathways 2 FG p. xxxvi). A facilitator should also have knowledge about the basics of adult learning, have a broad understanding of the lifetime impact of adoption/permanency, have knowledge of normative child development as well as disrupted development and have a strong foundation in cultural competency. Facilitators use a semi-scripted guide to ensure some degree of standardization while using their own knowledge and skills to supplement the content (Pathways2 FG p. xxii). Pathways to Permanence 2 facilitators can benefit from attending the ACT training prior to facilitating a Pathways to Permanence 2 series. The combination of knowledge and experience can vary, but should often draw from education, knowledge, and experience in working with children who have experienced trauma and families' struggles to meet those children's needs. Individually or collectively, the following experiences can contribute to a Facilitator's skill-set:

- Education

- Work History

- Trainer/Facilitator History

- Parent Group Facilitation History

- Social/Therapeutic or Direct Service Delivery History

- Personal experience as a member of the adoption/permanency constellation

Facilitator Skills

Pathways to Permanence 2 facilitators are expected to be able to:

- Establish a safe learning environment;

- Make materials "jurisdiction-relevant";

- Negotiate participant agreements;

- Use effective communication skills;

    o Able to facilitate rather than simply direct discussion,

    o Able to respect differences of opinions and facilitate discussions involving strongly stated opinions,

    o Able to challenge participants to practice and apply techniques to real-life situations;

- Respect the roles and responsibilities of co-facilitators;

- Have a broad understanding of the lifetime impact of adoption/permanency;

- Have knowledge of normative child development as well as disrupted development;

- Be able to facilitate sometimes challenging discussions surrounding cultural competency;

- Have the ability to assess their own personal strengths and areas for growth in permanency-related work.

Each of the skills listed is described in further detail in the Pathways to Permanence 2 *Facilitator Guide, Section 2. Conducting the Training*. In addition, skills in the facilitation of therapeutic group processes are important.

Core Beliefs and Values of Facilitators

Pathways to Permanence 2 facilitators must be able to support the core beliefs of the curriculum (P2P@ FG p. xiv), which are:

- Permanency in a family is at the center of the core beliefs;

- Every child deserves a family;

- Children must have permanency to achieve their full potential;

- Children and adolescents need families for a lifetime, not just for childhood;

- Healthy, functional families can provide a stabilizing and healing environment for previously traumatized and abused children;

- Keeping children's previous, positive connections facilitates and deepens the attachment to the new caregivers;

- Adoption, foster care and relative caregiving involve complex issues requiring specialized training for the caregivers;

- Children and their families must receive interventions that are culturally competent and built on strength-based, family systems models.

CORE COMPONENT #2: EXPERIENTIAL DELIVERY OF MATERIAL

Use of Activities During Sessions

Pathways to Permanence 2 sessions include activities that help participants develop a greater understanding of themselves while exploring the impact of trauma, grief, and loss on all aspects of child development. "…caregivers need to develop a greater understanding of themselves in order to better parent their children, a point that becomes particularly critical when parenting children with traumatic histories" (Pathways2 FG p. xiii). Facilitators should be comfortable participating in and conducting experiential activities, and should not rush through these experiential opportunities for participants during sessions.

Sequential Order of Sessions

Pathways to Permanence 2 is a seven-session series that is designed in such a way that the content from the current session builds upon content covered in preceding sessions. Sessions should always be taught in the order designed, and never taught as stand-alone sessions.

Class Size

Classes with approximately 12-15 participants are considered ideal. Smaller class sizes allow for greater participation and sharing. Facilitators should avoid classes with less than 6 participants for two reasons. First, there are activities used during the series that are most effective when used with pairs or triads. Second, the effectiveness of the series is strengthened by the group processes and dynamics that evolve throughout the course of the seven sessions (supportive peer relationships develop; caregivers are able to learn from one another). For these reasons, more participants should be invited than are ultimately expected, to avoid dropping below 6 participants (keeping in mind as well that some participants enrolled may miss classes during the series due to illness, for example). Class size should not exceed 20 participants. Two facilitators should be considered for larger groups. Using two facilitators allows for more effective management of group dynamics, which will include incorporating the personal experience and knowledge of participants into the discussion to enhance the learning experience. In addition, caregivers connect to different personalities and presentation styles, which is supported by using two facilitators. At least one of the facilitators should be present for all 7 sessions to maintain continuity. It is also ideal if the same second facilitator is present for all 7 sessions, as frequent changes of facilitators can disrupt the trust that is built with the group throughout the series.

CORE COMPONENT #3: ENGAGEMENT AND PARTICIPATION

Facilitators Elicit Participation

Facilitators will "…be able to teach the entire content of the course, and should have experience with participatory training. This includes the ability to elicit participant involvement…" (Pathways2 FG p. xxix). Within the Facilitator's Guide, there are several prompts that can be used to promote active dialogue from participants.

Participant Involvement in Discussions

"Participants will be encouraged to take an active role in discussions and activities. [Facilitators] should elicit agreement from participants that they will take an active role in the classes, as opposed to passively going through the experience…" (Pathways2 FG p. xxxii)

Personal Reflection by Participants

While some participants may be willing and comfortable sharing applications of material to their own life experiences, others will not. Often in evaluations, participants share some of these reflections. Personal reflection will also be enhanced through in-class activities, which are described earlier in this document. The content and process of the Pathways to Permanence 2 series is not intended to provide caregivers with the tools to "fix" the child, but rather to support caregivers in exploring issues that may interfere with their ability to engage in an attachment relationship with the child. It is the attachment relationship that ultimately allows the caregiver to act as the healing agent.

CORE COMPONENT #4: OPPORTUNITIES FOR PARTICIPANTS TO APPLY AND PRACTICE TECHNIQUES

Timing of sessions in the series

It is important to allow sufficient time between sessions for participants to digest information that was learned while conducting sessions close enough together so that content is not lost between sessions of the series. For the Pathways to Permanence 2 series, sessions should not be offered more frequently than weekly, and should not be scheduled more than one month apart.

Participants who are actively parenting

"Adoption/guardianship is a milestone that requires thorough preparation for children and youth, resource families and their community, regardless of the resource families' relation to the children and youth. The content and manner in which this preparation is completed should be adapted to better support and prepare all parties for permanency" (Permanency Support and Preservation Model Guiding Principles, National Resource Center for Adoption, 2014). Pathways to Permanence 2 is unlike some other curricula in that it teaches concepts such as the *Seven Core Issues*, developmental re-parenting, and attachment as the participant is actually parenting the child, as compared with teaching these concepts in "preparation for" parenting. This allows participants to apply concepts learned throughout the series and to get feedback from facilitators to ensure techniques and strategies are being used as intended.

Homework assignments

"It is the intent of the Pathways to Permanence 2 curriculum to assist caregivers to recognize, identify and address the core issues with new tools given to them during the series" (Pathways 2 FG p. xiii). Facilitators are expected to thoroughly describe assignments and allow enough time for questions about assignments from participants. In addition, facilitators should encourage participants to complete assignments and express excitement in anticipation of hearing from participants about their results in the next session.

Appendix B. Implementation Timeline

Table 3B.1. Implementation Timeline by Cycle and Series

REGION	CYCLE	SERIES	SCREENING	PRE SURVEY	PATHWAYS START	PATHWAYS END	POST SURVEY
7	1	1	May/Aug 2016	10/7/2016	10/22/16	12/10/16	06/08/17
	2	2	Oct 2016	2/3/2017	02/18/17	04/08/17	10/05/17
	2	3	Oct 2016	2/1/2017	02/16/17	04/06/17	10/03/17
	3	4*	Dec 2016	3/17/2017	04/01/17	Cancelled	Cancelled
	3	5	Dec 2016	3/20/2017	04/04/17	05/16/17	11/12/17
	4	6	Apr 2017	7/24/2017	08/08/17	09/19/17	03/18/18
	4	7	Apr 2017	7/28/2017	08/12/17	10/07/17	04/05/18
	5	8	May 2017	8/28/2017	09/12/17	10/24/17	04/22/18
	5	9	May 2017	9/1/2017	09/16/17	10/28/17	04/26/18
	6	10	Sept 2017	12/27/2017	01/11/18	02/22/18	08/21/18
	6	11	Sept 2017	1/17/2018	02/01/18	03/22/18	09/18/18
	6	12	Sept 2017	1/19/2018	02/03/18	03/24/18	09/20/18
	6	13	Sept 2017	3/5/2018	03/20/18	05/01/18	10/28/18
8	0	0	Dec 2017	NA	NA	NA	11/13/18
7	7	14	Dec 2017	3/21/2018	04/05/18	05/17/18	11/13/18
	7	15	Dec 2017	3/23/2018	04/07/18	05/19/18	11/15/18
	7	16	Dec 2017	4/16/2018	05/01/18	06/12/18	12/09/18
	7	17	Dec 2017	4/18/2018	05/03/18	06/14/18	12/11/18
	8	18	Mar 2018	5/23/2018	06/07/18	07/26/18	01/22/19
	8	19	Mar 2018	5/18/2018	06/02/18	07/14/18	01/10/19
	8	20	Mar 2018	6/25/2018	07/10/18	08/21/18	02/17/19
	8	21*	Mar 2018	7/20/2018	08/04/18	Cancelled	Cancelled
	9	22	May 2019	8/24/2018	09/08/18	10/20/18	04/18/19
	9	23	May 2018	8/24/2018	09/08/18	10/20/18	04/18/19

Appendix C. Characteristics of Children in Substitute Care by Region

Table 3C.1. Characteristics of Children in Substitute Care by Region

CHILDREN IN DFPS CARE: CHILD CHARACTERISTICS BY REGION	REGION 7 N=3851	REGION 8 N=4733	TESTS COMPARING DIFFERENCES BETWEEN REGIONS		
			χ^2	df	p
ALL SUBSTITUTE care					
TYPE OF LIVING ARRANGEMENT			187.43	6	0.000
DFPS FOSTER HOMES	4%	3%			
PRIVATE CPA AND INDEPENDENT HOMES	29%	35%			
RESIDENTIAL TREATMENT	6%	7%			
OTHER RESIDENTIAL OPERATION	4%	10%			
KINSHIP HOMES	54%	42%			
DFPS/PRIVATE ADOPTIVE HOMES	1%	1%			
OTHER SUBSTITUTE CARE SETTING	2%	2%			
FOSTER CARE ONLY*					
CHILD RACE			534.39	3	0.000
BLACK	20%	9%			
HISPANIC	33%	69%			
WHITE	38%	18%			
OTHER RACE OR UNKNOWN	8%	4%			
CHILD IS FEMALE	47%	50%	2.44	1	0.118
CHILD'S AGE			19.25	4	0.001
0-2 YEARS OLD	30%	25%			
3-5 YEARS OLD	17%	16%			
6-9 YEARS OLD	18%	20%			
10-13 YEARS OLD	14%	18%			
14-17 YEARS OLD	21%	22%			
HAS SIBLING	19%	11%	49.59	1	0.000
SERVICE LEVEL			7.80	5	0.167
BASIC	64%	64%			
MODERATE	11%	13%			
SPECIALIZED	14%	14%			
INTENSE	4%	4%			
PSYCHIATRIC TRANSITION	0%	0%			
BLANK OR END DATED	6%	5%			

Data Source: Texas DFPS Data Warehouse - SubAdopt Data Mart (2018). Regional Statistics about Children in DFPS Care [Data file]. Available from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

Appendix D. Propensity Score Matching Results

We used propensity score matching to determine and control for significant differences at baseline between the intervention and comparison groups on the following DFPS IMPACT variables:

- Total placements at baseline
- Living Arrangement at baseline
    - Kinship home
    - Basic-level home
    - Moderate-level home
    - Therapeutic, Primary Medical Needs, Developmental Disorder
- The current age of child

We matched the intervention and comparison groups on the variables listed above using a nearest neighbor matching estimator with replacement and imposing a tolerance level of .01. The first table below compares the intervention and comparison groups on the characteristics listed above prior to matching. The next table compares the intervention and comparison groups on these same characteristics after matching has occurred.

Table 3D.1. Participant Characteristics by Group Assignment: Not Matched

| CHILD CHARACTERISTICS BY REGION	UNMATCHED PARTICIPANTS		TESTS Comparing differences between groups		
	PATHWAYS 2 N=81*	COMPARISON N=117			
	%	%	$\chi2$	df	p
TYPE OF LIVING ARRANGEMENT			10.51	4	0.033
KINSHIP HOME	35%	21%			
BASIC AGENCY/CPA HOME	36%	26%			
MODERATE AGENCY/CPA HOME	10%	16%			
THERAPEUTIC/HIGH NEEDS HOME	17%	33%			
RESIDENTIAL TREATMENT	2%	3%			
	M (SD)	M (SD)	t	df	p
CHILD'S AGE AT BASELINE	7.23 (4.97)	8.26 (5.39)	-1.36	196	0.177
TOTAL NUMBER OF PLACEMENTS	2.86 (2.08)	3.70 (2.58)	-2.41	194	0.017

*There were four caregivers who served as alternate caregivers in the Pathways 2 group. These caregivers were not caring for a child in their home, but rather supporting a family who did. For this reason, we excluded them in this analysis and used the remaining 81 caregivers.

Table 3D.2. Participant Characteristics by Group Assignment: Matched

CHILD CHARACTERISTICS BY REGION	MATCHED PARTICIPANTS		TESTS COMPARING DIFFERENCES BETWEEN GROUPS		
	PATHWAYS 2 N=79	COMPARISON N=79			
	%	%	χ2	df	p
TYPE OF LIVING ARRANGEMENT			1.132	4	0.889
KINSHIP HOME	34%	33%			
BASIC AGENCY/CPA HOME	37%	35%			
MODERATE AGENCY/CPA HOME	10%	11%			
THERAPEUTIC/HIGH NEEDS HOME	18%	16%			
RESIDENTIAL TREATMENT	1%	4%			
	M (SD)	M (SD)	t	df	p
CHILD'S AGE AT BASELINE	7.24 (4.99)	7.01 (5.50)	0.27	156	0.785
TOTAL NUMBER OF PLACEMENTS	2.86 (2.08)	2.66 (1.81)	0.65	156	0.515

A total of 79 of the 81 families (98%) from Pathways 2 and 79 of 117 families (68%) from the comparison group were matched based on these characteristics. After matching, participants did not significantly differ on any of these characteristics.

Figure 3.11. Living Arrangements of Child Before and After Matching
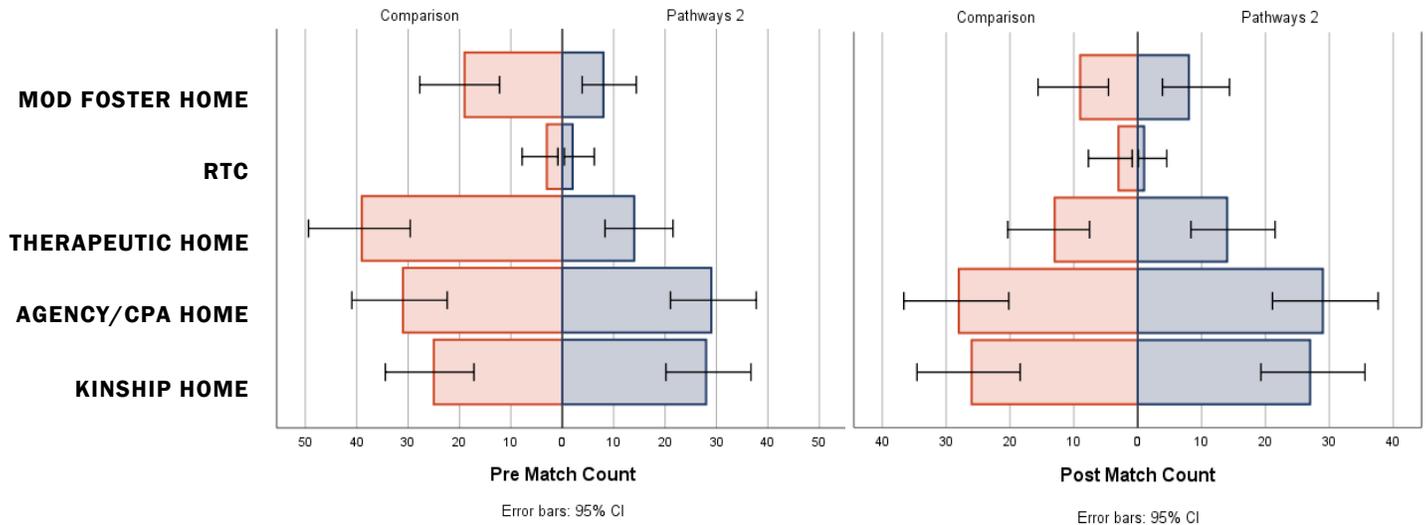
INTERVENTION VS MATCHED COMPARISON GROUP

Table 3E.1. Grief and Loss Items: Intervention vs. Comparison Group

	N	PATHWAYS 2		COMPARISON		t	df	p
		M	SD	M	SD			
					HIGHER SCORES = MORE UNDERSTANDING			
GRIEF AND LOSS TOTAL SCORE – ALL ITEMS	79	71.65	8.89	65.33	8.30	6.32	74	0.000
A CHILD'S CAREGIVERS SHOULD BE INCLUDED IN THEIR CHILD'S THERAPY.	79	4.10	1.30	4.19	1.22	-0.47	78	0.641
LOSS IS A PART OF LIFE FOR CHILDREN WHO DO NOT LIVE WITH THEIR BIRTH PARENTS.	79	4.19	1.18	3.75	1.24	2.35	78	0.021
IT IS IMPORTANT FOR A CHILD TO BE CLAIMED BY A FAMILY.	79	4.38	1.11	4.38	1.05	0.00	78	1.000
CHILDREN WHO DO NOT LIVE WITH THEIR BIRTH PARENTS OFTEN ACT OUT USING EXTREME BEHAVIORS.	79	3.51	0.88	3.35	1.12	0.97	78	0.337
ACTING OUT IS A WAY FOR A CHILD TO TRY TO CREATE A SENSE OF BELONGING.	79	3.37	0.91	3.24	0.96	0.88	78	0.380
CHILDREN EXPERIENCING LOSS OFTEN TRY TO GAIN A SENSE OF CONTROL BY LYING.	79	3.59	0.81	3.34	1.11	1.74	78	0.086
CHILDREN LOSE A PART OF THEIR IDENTITY THROUGH ADOPTION AND PERMANENCY.	79	3.03	1.10	2.43	1.23	3.36	78	0.001
WHEN CHILDREN ACT OUT, THERE ARE OFTEN UNDERLYING NEEDS BEING MET THROUGH THAT BEHAVIOR.	77	3.95	0.93	3.69	0.91	1.80	76	0.077
CAREGIVERS' OWN EXPERIENCES OF GRIEF AND LOSS OFTEN MAKE IT HARDER TO PARENT A CHILD WHO HAS EXPERIENCED LOSS.	77	2.91	1.21	2.57	1.07	1.88	76	0.064
CHILDREN HAVE A LIFELONG CONNECTION TO THEIR BIRTH FAMILIES AND PERMANENT FAMILIES.	77	3.91	0.76	3.45	0.91	3.49	76	0.001
CHILDREN'S FEELINGS OF GRIEF OFTEN LOOK LIKE PHYSICAL SICKNESS AND/OR ANGRY BEHAVIORS.	77	3.87	0.88	3.71	0.78	1.15	76	0.255
CAREGIVERS SHOULD PRIORITIZE THEIR RELATIONSHIP WITH THEIR CHILD OVER DISCIPLINING THEIR CHILD WHEN THEIR CHILD ACTS OUT.	77	3.52	0.93	3.55	0.91	-0.18	76	0.861

Table 3E.2. Grief and Loss Items: Intervention vs. Comparison Group Cont.

	N	PATHWAYS 2		COMPARISON		t	df	p
		M	SD	M	SD			
LOWER SCORES = MORE UNDERSTANDING								
IF CHILDREN ARE JUST LOVED, THEY WILL HEAL.	79	2.63	1.13	3.09	1.15	-2.81	78	0.006
ABUSE AND NEGLECT IMPACT A CHILD MORE THAN LOSS.	79	3.09	1.17	3.82	1.04	-4.59	78	0.000
CAREGIVERS CAN HELP CHILDREN HEAL FROM TRAUMA AND LOSS, BUT MOST OF THE HEALING SHOULD BE DONE IN THERAPY.	79	2.38	0.94	2.86	0.93	-3.11	78	0.003
PARENTING TECHNIQUES LIKE "TIME OUT," BEING SENT TO YOUR ROOM, OR LOSING PRIVILEGES CAN HELP CHILDREN EXPERIENCING LOSS UNDERSTAND RIGHT FROM WRONG.	77	2.88	1.10	3.64	0.99	-4.22	76	0.000
CHILDREN UNDER THE AGE OF SIX ARE TOO YOUNG TO FEEL GRIEF.	77	1.55	0.74	1.70	1.05	-1.23	76	0.222
CHILDREN ADOPTED AS INFANTS ARE LESS IMPACTED BY THE LOSS OF THEIR BIRTH PARENTS.	77	2.53	1.24	3.06	1.13	-2.78	76	0.007
THERE ARE SOME DETAILS OF A CHILD'S HISTORY THAT SHOULD NOT BE SHARED WITH THAT CHILD.	77	2.61	0.93	3.30	0.86	-5.01	76	0.000
WHEN POSSIBLE, CAREGIVERS SHOULD WAIT UNTIL THEIR CHILDREN ARE TEENAGERS BEFORE TALKING TO THEM ABOUT PAINFUL PARTS OF THEIR PAST.	77	2.58	1.04	2.91	1.10	-1.88	76	0.064

Table 3E.3. Post Grief and Loss Items: Intervention Group Pre to Post

	N	PATHWAYS 2		COMPARISON		t	df	p
		M	SD	M	SD			
							HIGHER SCORES = MORE UNDERSTANDING	
GRIEF AND LOSS TOTAL SCORE – ALL ITEMS	103	4.09	1.13	4.19	1.27	5.66	102	0.000
A CHILD'S CAREGIVERS SHOULD BE INCLUDED IN THEIR CHILD'S THERAPY.	103	4.09	1.13	4.19	1.27	-0.65	102	0.519
LOSS IS A PART OF LIFE FOR CHILDREN WHO DO NOT LIVE WITH THEIR BIRTH PARENTS.	103	4.10	1.08	4.26	1.08	-1.22	102	0.225
IT IS IMPORTANT FOR A CHILD TO BE CLAIMED BY A FAMILY.	103	4.59	0.77	4.46	1.02	1.07	102	0.288
CHILDREN WHO DO NOT LIVE WITH THEIR BIRTH PARENTS OFTEN ACT OUT USING EXTREME BEHAVIORS.	103	3.44	1.04	3.52	0.95	-0.86	102	0.391
ACTING OUT IS A WAY FOR A CHILD TO TRY TO CREATE A SENSE OF BELONGING.	103	3.45	0.98	3.50	0.90	-0.46	102	0.65
CHILDREN EXPERIENCING LOSS OFTEN TRY TO GAIN A SENSE OF CONTROL BY LYING.	103	3.42	0.90	3.62	0.89	-2.22	102	0.029
CHILDREN LOSE A PART OF THEIR IDENTITY THROUGH ADOPTION AND PERMANENCY.	103	2.83	1.12	3.04	1.11	-1.72	102	0.088
WHEN CHILDREN ACT OUT, THERE ARE OFTEN UNDERLYING NEEDS BEING MET THROUGH THAT BEHAVIOR.	103	3.89	0.74	4.00	0.89	-1.08	102	0.281
CAREGIVERS' OWN EXPERIENCES OF GRIEF AND LOSS OFTEN MAKE IT HARDER TO PARENT A CHILD WHO HAS EXPERIENCED LOSS.	103	2.80	1.08	2.93	1.20	-1.07	102	0.285
CHILDREN HAVE A LIFELONG CONNECTION TO THEIR BIRTH FAMILIES AND PERMANENT FAMILIES.	103	3.86	0.75	3.91	0.72	-0.61	102	0.545
CHILDREN'S FEELINGS OF GRIEF OFTEN LOOK LIKE PHYSICAL SICKNESS AND/OR ANGRY BEHAVIORS.	103	3.85	0.80	3.88	0.82	-0.35	102	0.727
CAREGIVERS SHOULD PRIORITIZE THEIR RELATIONSHIP WITH THEIR CHILD OVER DISCIPLINING THEIR CHILD WHEN THEIR CHILD ACTS OUT.	103	3.40	0.95	3.50	0.95	-0.97	102	0.333

Table 3E.4. Grief and Loss Items at Pre and Post Cont.

	N	PRE SCORE		POST SCORE		t	df	p
		M	SD	M	SD			
LOWER SCORES = MORE UNDERSTANDING								
IF CHILDREN ARE JUST LOVED, THEY WILL HEAL.	103	3.05	1.11	2.68	1.16	-3.20	102	0.002
ABUSE AND NEGLECT IMPACT A CHILD MORE THAN LOSS.	103	3.60	0.97	3.27	1.25	-2.67	102	0.009
CAREGIVERS CAN HELP CHILDREN HEAL FROM TRAUMA AND LOSS, BUT MOST OF THE HEALING SHOULD BE DONE IN THERAPY.	103	2.59	1.03	2.49	1.04	1.07	102	0.285
PARENTING TECHNIQUES LIKE "TIME OUT," BEING SENT TO YOUR ROOM, OR LOSING PRIVILEGES CAN HELP CHILDREN EXPERIENCING LOSS UNDERSTAND RIGHT FROM WRONG.	103	3.39	0.94	2.83	1.08	-5.79	102	0.000
CHILDREN UNDER THE AGE OF SIX ARE TOO YOUNG TO FEEL GRIEF.	103	1.46	0.65	1.45	0.68	0.15	102	0.884
CHILDREN ADOPTED AS INFANTS ARE LESS IMPACTED BY THE LOSS OF THEIR BIRTH PARENTS.	103	2.95	1.14	2.52	1.26	-3.59	102	0.001
THERE ARE SOME DETAILS OF A CHILD'S HISTORY THAT SHOULD NOT BE SHARED WITH THAT CHILD.	103	2.92	0.96	2.69	1.00	-2.27	102	0.025
WHEN POSSIBLE, CAREGIVERS SHOULD WAIT UNTIL THEIR CHILDREN ARE TEENAGERS BEFORE TALKING TO THEM ABOUT PAINFUL PARTS OF THEIR PAST.	103	2.74	1.01	2.51	1.04	-2.70	102	0.008

Appendix F. Mixed Linear Models

The following two tables show the results of two linear mixed effect models. The first looks at the impact of time (pre to post) on the Internalizing Subscale of the BPI. The second looks at the Total BPI score over time for relative and not relative caregivers.

Table 3F.1. Results of Linear Mixed-Effects Model: Comparing Internalizing BPI at Pre and Post

RESULTS OF LINEAR MIXED EFFECTS MODEL OUTCOME: INTERNALIZING CHILD BEHAVIOR PROBLEMS							
FIXED-EFFECTS	**COEFFICIENT**	**SE**	*t*	*df*	*p*	**95% CI**	
TIME: PRE POST	1.01	0.50	2.04	56.34	0.046	0.02	2.01
CONSTANT	8.34	0.57	14.63	83.20	0.000	7.20	9.47
RANDOM-EFFECTS	**ESTIMATE**	**SE**	**WALD Z**		**SIG**	**95% CI**	
CS DIAGONAL OFFSET	7.00	1.33	5.25		0.000	4.82	10.16
CS COVARIANCE	12.31	3.02	4.07		0.000	6.38	18.23

The fixed predictor in the first model was time (pretest or posttest). The variable for individual effects was modeled as a random variable. The estimate for the fixed effect was significant: $t(56.34)=1.01$, $p=0.046$. The BPI Internalizing subscale score was on average 1.01 points higher on the pre than the post. Also, the Wald Z was statistically significant, supporting that the parameters in the linear mixed model were not all zero and should be included in the model (UCLA Statistical Consulting Group, 2019).

Table 3F.2. Results of Linear Mixed-Effects Model: Comparing Total BPI Scores at Pre and Post Among Relative and Non-Relative Caregivers

RESULTS OF LINEAR MIXED EFFECTS MODEL OUTCOME: Total Child Behavior Problems by relative status							
FIXED-EFFECTS	COEFFICIENT	SE	t	df	p	95% CI	
RELATIVE (NON-RELATIVE AS REFERENCE)	-2.41	3.32	-0.73	74.51	0.470	-9.02	4.23
TIME: PRE POST	-0.28	1.26	-0.23	55.44	0.823	-2.80	2.23
INTERACTION: RELATIVE X TIME	7.34	2.44	3.02	54.56	0.004	2.47	12.23
CONSTANT	25.01	1.67	15.01	75.32	<0.000	21.69	28.32
RANDOM-EFFECTS	ESTIMATE	SE		WALD Z	SIG	95% CI	
CS DIAGONAL OFFSET	32.70	6.28		5.21	0.00	22.44	47.64
CS COVARIANCE	90.93	20.32		4.47	0.00	51.10	130.77

The fixed predictors in the second model were relative status (whether caregiver was related to their child or not), time (pretest or posttest), and then an interaction term for these two variables. Also, the variable for individual effects was modeled as a random variable. The estimate for the interaction term, the key result of interest for this model, showed a significant interaction between time and relative status was present; $t(54.56)$ = 3.02; p = .004, suggesting that relatives had an additional decrease sover time on this outcome variable of about 7.34 points from pre to post, as compared to non-relatives. Also, the model Wald Z test was statistically significant, supporting that the parameters in the linear mixed model were not all zero and should be included in the model (UCLA Statistical Consulting Group, 2019).

Chapter 10

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Tables and Figures

Overview

The cross-site evaluation summarizes the overarching themes and analyses found across six QIC-AG sites: Vermont, Illinois, New Jersey, Catawba County (North Carolina), Wisconsin, and Tennessee. These sites tested six different interventions (see Table 10.1) that served families after adoption or guardianship finalization (Target Group 2). We did not include findings from Texas and the Winnebago Tribe of Nebraska in this evaluation because these sites focused on interventions serving families pre-permanence (Target Group 1). This cross-site evaluation is intended to be a summary chapter that is appended to individual site-specific reports rather than a stand-alone document. For background information regarding the QIC-AG project, please refer to the Program Background chapter. For site-specific information, please refer to individual site reports.

Table 10.1. QIC-AG Target Group 2 Sites and Interventions

SITE	INTERVENTION
VERMONT	Vermont Permanency Survey
ILLINOIS	Trauma Affect Regulation: Guide for Education & Therapy (TARGET)
NEW JERSEY	Tuning in to Teens (TINT)
CATAWBA COUNTY, NC	Reach for Success
WISCONSIN	Adoption and Guardianship Enhanced Support (AGES)
TENNESSEE	Neurosequential Model of Therapeutics (NMT)

As discussed in more detail below, individual site reports found trends suggesting that, in many sites, the interventions tested may have produced stronger effects if more time was available to observe families who had received the intervention. However, during the observation period, we did not find strong intervention effects on long-term child and family wellbeing outcomes. Regarding post permanency discontinuity, based on record reviews and an examination of administrative data in these sites, only a small number of children (approximately 1% of all children involved with the project from the intervention and comparison groups) reentered foster care during the project period, not enough to draw conclusions or inferences regarding post permanency discontinuity.

Distal, or long-term, outcomes of increased post permanency stability and improved wellbeing take time to observe, more time than what the project period covered. However, research has found proximal, or short-term, outcomes, such as caregiver commitment and child behavior challenges, are predictors of these distal outcomes. Proximal outcomes were observed during the study period and are examined in this chapter. This chapter also summarizes findings related to engagement in services; survey participation; service needs and use; outcomes; and suggestions for next steps. Where applicable and relevant, results across sites are combined. In other places, results are kept separate but compared due to similarities (e.g., results of population-based surveys in Vermont and Catawba County [NC] are combined).
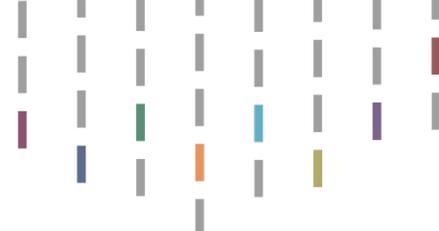
Cross-Site Results

This section synthesizes findings and limitations related to recruitment, intervention participation, service needs, and outcomes for families whose adoption or guardianship was finalized through the public child welfare system. Findings from the private domestic and intercountry adoptive families engaged through the project are summarized in Appendix A.

Engagement with Adoptive and Guardianships Families

Not all child welfare jurisdictions consider outreach to families after legal finalization of adoption and guardianship as the responsibility of a child welfare system. Yet, families who have adopted or assumed guardianship of children, particularly children who have experienced trauma and maltreatment, report continuing to need support and services long after adoption or guardianship finalization (White et al., 2018). The QIC-AG project conducted a variety of outreach procedures and protocols to reach families. In some sites, a Universal approach was used where the site attempted to contact all families formed through adoption or guardianship in the jurisdiction. In other sites, a more targeted, purposeful outreach process occurred directed at families who had increased risk of post permanency discontinuity. In addition, some sites served families who self-referred or were referred for services.

This section examines engagement with the target population in each site. First, we examine families who were targeted because they had a characteristic that suggested they might be at increased risk for post permanency discontinuity (Selective prevention). We then explore engagement with families who were served in sites where families self-referred, or were referred, to a service provider (Indicated prevention). Finally, we examine service needs and usage, as reported on surveys administered to all adoptive or guardianship families (Universal prevention). A summary of engagement with families who adopted through private or intercountry processes is included in the Appendix.

SERVICE ENGAGEMENT FOR SELECTIVE PREVENTION SITES

In Illinois and New Jersey, the QIC-AG project targeted adoptive and guardianship families who had characteristics that, based on extant research, suggested they may be at increased risk for post permanency discontinuity. The primary group characteristic in these two sites was that the families had children who were pre-teens or teens. The different research designs and interventions being offered concurrently in each site make direct comparisons difficult and is the reason Cook County is excluded from the summary below. However, the Central Region of Illinois site and New Jersey used the same research design, and had similar rates of contact and participation:

- In the Central Region of Illinois, of the 557 families assigned to the intervention group, staff were able to successfully make contact with 53% of families, and ultimately 12% of those families targeted for outreach participated in the intervention.

- In New Jersey, of the 769 families assigned to the intervention group, staff were able to successfully make contact with 57% of families, and ultimately 12% of those families targeted for outreach participated in the intervention.

CENTRAL REGION, IL

577 families assigned to the intervention group

53% successfully contacted

12% participated in the intervention

NEW JERSEY

769 families assigned to the intervention group

57% successfully contacted

12% participated in the intervention

In both sites, a variety of outreach methods were used to make contact with families and increase uptake. For example, at the suggestion of the stakeholders in Illinois, the project staff made additional follow-up calls to families who initially said they wanted to participate in the project but later declined. Concerned that outreach materials sent through the mail might be overlooked, staff also redesigned outreach letters several times, including addressing envelopes with different colored ink and reformatting a letter so it looked similar to one sent from another site. These additional efforts did not increase uptake. In New Jersey, approximately two weeks before a session started, staff added a phone call to their recruitment process asking families who had registered what they would like for dinner. Dubbed the "turkey sandwich call," the purpose was to increase follow-through for registered families and to provide the team with a more accurate accounting of who intended to participate. The "turkey sandwich call" did not increase attendance rates. However, it did provide an opportunity for families to inform staff that they were not going to attend, resulting in a more accurate number of expected participants.

Due to the relatively low proportion of families who participated in the interventions, the research team sought to understand differences between families who participated in the interventions and families who did not. To accomplish this, in Illinois and New Jersey a short questionnaire was sent to families prior to the initial outreach (before services were offered). This questionnaire asked parents and guardians about their relationship with their child (e.g., How confident are you that you can meet your child's needs? How often have you or your significant other struggled to effectively manage your child's behavior in the last 30 days?). The data were then analyzed, comparing the responses of intervention participants with those of families who did not participate in the intervention. This analysis found that families who engaged in services profiled as struggling more than families who did not engage in services. Specifically, compared to families who did not participate in services, families who engaged in services were, on average:

- Less confident that they could meet the needs of their child

- More likely to struggle to effectively manage their child's behavior

- More likely to struggle to appropriately respond to their child

In other words, families who engaged in services reported that they were struggling more than families who did not engage in services. In one of the Illinois sites it was reported that over half of the intervention participants went on to receive services-as-usual after receiving intervention services (TARGET). This suggests that families were needing services, but perhaps the specific intervention offered was not the right fit, or perhaps it was needed in conjunction with other types of services.

Another important note regarding engagement is that most adoptive and guardianship families did not engage in services. Therefore, child welfare systems can rest assured that if they provide post permanency services, only a proportionally small number of families will accept those services. In addition, there are certain characteristics (described in the bullets above), that may indicate families who are willing to engage in services. Future sites may want to consider conducting targeted prevention outreach to families who express the characteristics described in the bullet points above.

CATAWBA COUNTY (NC)

240 families were sent surveys

128 (53%) took the survey

94 designated for outreach

41% successfully contacted

3 participated in Success Coach services

In Catawba County, the working hypothesis was that there were families in need of post adoption services who either did not know about the services or were unable to access the services. During the project period, 240 families in Catawba County were sent surveys. Of those 240 families, 53% (128) completed and returned surveys. Of the 128 families who returned surveys, 94 were designated for outreach. Of the 94 families designated for outreach, 41% (39) parents were subsequently successfully contacted by Catawba County staff to assess their interest in Success Coach services. A total of 3 families signed service agreements and participated in Success Coach services. Families who were contacted through outreach but declined services largely reported they did not need extra support.

In Wisconsin, at the Indicated level of prevention where services were provided to families who reached out to a contact point, there was some concern about announcing the project widely to families. In what was referred to as "the floodgates opening," the Wisconsin project staff worried they would be overwhelmed with requests for services and might not be able to serve all of the families. This concern was based on the interactions staff had with adoptive and guardianship families in the past and the difficulties the families had conveyed, and a feeling that many adoptive and guardianship families would engage in services. The program initially relied on referrals to AGES after families contacted one of the points of entry. This did not yield the number of program participants that the project expected. As a result, the agency sent letters to eligible families alerting them of the AGES program. At no point in the program did staff feel that they were flooded with requests for services.

Survey Response Rates

Surveys were sent to families in Vermont, Catawba County (NC), Illinois and New Jersey[1]. In Vermont, the survey could be completed electronically or by pen and paper. In all the other sites, the surveys were pen and paper only. In Catawba, Illinois, and New Jersey a pre-paid cash incentive was also included. A variety of methods were used to encourage participants to return the surveys: sites sent emails, made phone calls, and followed up with non-responders in a series of assertive outreach efforts. The sites also engaged a look-up service to acquire the most recent contact information for families. Surveys were sent to adoptive parents and guardians who were asked to respond to the survey focusing on one target child per family. Surveys assessed caregiver's experiences related to adoption or guardianship (for example, respondents completed standardized measures, such as the Caregiver Strain scale, the Behavior Problem Index, and questions related to caregiver commitment, familial relationships, and service needs and use).

- In Vermont, 1,470 families were sent surveys and 809 (55%) responded.

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[1] The survey responses from Illinois and New Jersey discussed in this section are from the primary outcome surveys only.

In Catawba County (NC), surveys were mailed to families, with follow-up calls and mailings after the initial survey was sent. In Catawba, the survey was sent by the county agency, and contact information was the latest information the county had for families currently receiving an adoption subsidy.

- In Catawba County, 240 families were sent surveys and 128 (53%) responded.

In Illinois and New Jersey, surveys were also mailed to families, with follow-up calls and mailings after the initial survey was sent. The surveys were sent by a university-based research center based in Illinois. Prior to making contact, the research team used a look-up service to obtain the most recent contact information for families. The surveys in Illinois and New Jersey were used to collect short-term outcome data and were sent to all families assigned to the intervention and comparison groups after participants had completed the intervention. As such, response rates for intervention participants and comparison groups are also provided.

- In Illinois, 2,731 families were sent surveys and 1,293 (47%) responded.
    - Intervention participants: 105 were sent surveys, 81 (77%) responded
    - Comparison group: 596 were sent surveys, 327 (55%) responded
- In New Jersey, 1,212 families were sent surveys and 514 (42%) responded.
    - Intervention participants: 94 were sent surveys, 62 (66%) responded
    - Comparison group: 443 were sent surveys, 187 (42%) responded
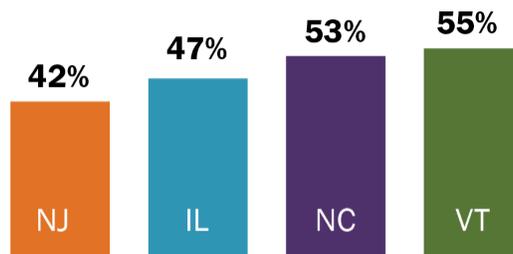
Overall Response Rates

In sum, after all the various attempts to reach families who have adopted or assumed guardianship of children in foster care were completed, about half of all surveyed responded. Future projects intended to reach adoptive or guardianship families should take this into consideration. The variation in overall response rates (from 42% in New Jersey to 55% in Vermont) may be related to several factors that have nothing to do with the family's desire to provide information. For instance, it could be that families in New Jersey were hesitant to respond to a survey that came from a university that was out of state, or that there were unmeasured characteristics about families from one state or another that influenced the response rates.

The somewhat higher response rate from families in Catawba may be related to the resource-rich nature of service provision in that county (many families identified as being in need of service through the survey were already engaged in services and did not accept Success Coach services), or the state mandate to provide post adoption services. The higher overall response rate in Vermont could be related to the extra effort and assertive outreach provided by that site. Thus, differences in response rates across sites could have something to do with the specific site itself, as the jurisdictions in the QIC-AG varied widely in terms of urban-rural settings and the prior experiences families have engaging with the agency.

Finally, response rate variation may be due to the nature of the target populations in each area. Vermont and Catawba County reached out to all families, while Illinois and New Jersey focused in on families who, research suggested, had characteristics that placed them at increased risk for post permanency discontinuity. Future research should explore these differences.

SERVICE ENGAGEMENT SUMMARY

Across multiple sites, there were similar concerns that services offered post permanence would open the "floodgates" with families clamoring for services and overwhelming the public child welfare system and staff with increased demand. This was not the case in the QIC-AG sites. Other child welfare jurisdictions and other projects may run into difficulty estimating how many families to expect to serve when offering post permanency services and supports. One difficulty in estimating potential service uptake with families formed through adoption or guardianship is that many child welfare jurisdictions do not have a long history of engaging families in post permanency services. In addition, to understand how frequently services are requested by adoptive and guardianship families, a good tracking system, one that is linked to child welfare administrative data systems, is lacking in most jurisdictions. Linking to adminsitrative data would allow systems to understand the percentage of families who seek services. Our best estimates come from Illinois and New Jersey. Findings from these two sites would suggest that if service providers estimate a 12% uptake rate (both sites saw 12% of families engage in services), they should be adequately staffed to serve the families who engage in services.

Service Needs and Use

Service needs and use described in this section are summarized from the following sources:

- Surveys from Vermont and Catawba County (NC)
- Interviews with families in Wisconsin
- Surveys from New Jersey and Illinois

SURVEYS IN VERMONT AND CATAWBA COUNTY (NC)

Two QIC-AG sites, Vermont and Catawba County (NC), implemented surveys with questions that assessed post adoption service needs and use. By examining the results of these survey questions across the two sites (Tables 10.2 and 10.3), one conclusion is that the most needed and used services were those related to mental health support. In particular, individual counseling for children was a need for a significant proportion of families (e.g., almost 50% in Vermont). Thus, post permanency services should be designed to support the mental health needs of children and families.

Families in Vermont also reported high use of routine medical care (79%). Families used a wide variety of post adoption services, but service usage rates across all types of services were less than 50%. Indeed, some services received very little use. For instance, no respondents in Catawba reported using respite care or adoption support groups since their adoption was finalized. However, it is important to note that these survey results were based on populations in the state of Vermont and one county in North Carolina, and thus, they may not generalize to other locations or cultures.

Table 10.2. Vermont Service Use in Past 6 Months

OF THE 796 FAMILIES SURVEYED IN VERMONT:	NUMBER OF FAMILIES WHO USED SERVICES IN THE PAST 6 MONTHS	PERCENT OF FAMILIES WHO USED SERVICES IN THE PAST 6 MONTHS
FAMILY SUPPORT SERVICES		
FAMILY COUNSELING	213	27%
CASE MANAGEMENT SERVICE COORDINATION	99	12%
DCF SOCIAL WORK SERVICES	85	11%
SCHOOL/CHILD CARE SERVICES		
REGULAR CHILD CARE SERVICES	178	22%
AFTERSCHOOL PROGRAM	159	20%
SCHOOL-BASED CLINICIAN	152	19%
BEHAVIOR SUPPORT SERVICES	139	18%
MEDICAL SERVICES FOR CHILD		
ROUTINE MEDICAL CARE	626	79%
MEDICATION MANAGEMENT	199	25%
SPEECH OR OCCUPATIONAL THERAPY	124	16%
MENTAL HEALTH SERVICES		
INDIVIDUAL COUNSELING FOR CHILD	336	42%
INDIVIDUAL COUNSELING FOR CAREGIVER	177	22%
PSYCHOLOGICAL ASSESSMENT FOR CHILD	129	16%
PSYCHIATRIC MEDICATION FOR CHILD	126	16%
CARE COORDINATION/CASE MANAGEMENT FOR CHILD	78	10%

Table 10.3. Catawba County (NC) Service Needs and Use after Adoption Finalization

SERVICES MOST FAMILIES REPORTED NEEDING	% OF FAMILIES WHO RESPONDED TO SURVEY AND REPORTED THAT THEY NEEDED	OF THOSE FAMILIES THAT TRIED TO OBTAIN, % THAT WERE SUCCESSFUL	OF THOSE FAMILIES THAT OBTAINED SERVICES, % THAT WERE "EXTREMELY" OR "QUITE" HAPPY WITH THE SERVICES
MENTAL HEALTH SERVICES	35%	97%	74%
SPECIALIZED MEDICAL OR DENTAL CARE SERVICES	27%	89%	80%
EDUCATIONAL SUPPORT SERVICES	24%	83%	71%
CHILD DEVELOPMENTAL SERVICES	23%	100%	68%

Adoptive parents and guardians reported that they do not always feel that the child welfare system provides them with support after finalization. They suggested periodic outreach by the agency to ensure families are aware of the services available to them, and to inform them of 'warning signs' of what to expect when parenting a child who has experienced trauma and loss:

> "DCF was very involved, while we were working up to the adoption…once it was final…they disappeared! A lot of adoptive parents feel…once we sign the papers…we're crossed off a list. No calls. No help. Nothing!"

> "Once I gained legal guardianship it seemed as though all resources disappeared."

> "Finding available psychiatric care for [our adopted daughter] was very difficult…But once we found it, it made a world of a difference for her. Please try to find a way to make these services more accessible for these kids."

> "I have been advocating for both of my boys for 18 years. I have never heard or been exposed to [agency name] counselors. Why? Based on your questions, this is a resource available for school-age children…Why isn't this a routine survey that could be issued yearly to address needs and recommend resources for families?"

> "I wish I had been warned of signs to look for so maybe I would've gotten help for my child sooner. I also wish I knew who would provide mental health/counseling services for DCFS adopted kids."

In interviews with the research team, adoptive parents and guardians in Wisconsin reported difficulty in accessing services prior to their AGES involvement. Prior to AGES, many families had searched for appropriate services and supports, often for many years. Adoptive parents and guardians said that they needed support earlier and wished that services were available when they first started to struggle. The participants repeatedly stated that services and resources provided earlier in the adoption and guardianship process might prevent (or could have prevented) problems. They also reported that finding appropriate, timely, and effective adoption and guardianship-competent services was difficult. Some examples of the issues in Wisconsin:

> "I couldn't get help because [my adopted son's issues are] not bad enough…Why should he have to get so bad and then we have to take years to get him back, where if I had that help literally you know when I started seeing stuff when he was two or three I think we'd be seeing a different ten-and-a-half year old."

> "I mean, [the AGES worker] literally saved our family. Which was great because I don't know that I could've gotten my point across without her putting it in another perspective for the principal and the guidance counselor. She also has trauma information. She knows how to go about talking to the school about the things that could come up because of their trauma. For whatever reasons, they're less likely to just listen to you but somehow [the AGES worker] legitimizes our issues."

Families reported the need for service providers with direct experience working with families formed through adoption and guardianship, as in this example:

> "If they [service providers] don't have any experience in adoption, they just don't get it…The trauma that babies from other countries can experience after one day of abandonment is

> tremendous…Finding somebody that can understand that adoptive piece of the puzzle and understands children is difficult."

The QIC-AG project tested a wide variety of outreach activities and types of outreach, but the proportion of families who engaged in services did not overwhelm the service providers. This is good news, suggesting that not all families need services and supports in addition to what they are currently receiving. In fact, what families told us about their adoption and guardianship experiences confirms this:

> "We have experienced difficulties we had not anticipated because of the severe amount of childhood trauma and neglect our son went through. We are extremely lucky to have found a therapist who specializes in his diagnosis. She has worked wonders with him and has been a tremendous support and resource for us: both at home and how to work with the schools and daycare. Our post permanency worker is also another asset that we could not live without. She has lived through the same type of situation we have, and her knowledge, compassion, and understanding are extremely helpful and supportive. She has provided a ton of resources we would not have known about."

> "My experience in guardianship with this child has been positive and the way I expected from the beginning. Raising a child is not an easy task, but I am sure it was the right choice. We are family."

> "I am grateful to the adoption agency for taking care of making sure my adoption experience was great and also for making sure my nephew stayed with family."

> "Before you adopt, make sure you have everything you need as far as services for your child. My case manager made sure all his services were in place before the adoption and it was put into the adoption. So, I get whatever I need to help him get the help he needs."

SERVICE NEEDS AND USE SUMMARY

In sum, most families were doing well with the supports and services they currently have in place. However, they also suggested that the child welfare system may want to focus on making a wider variety of post permanency services available and accessible. Even in locations where services are provided, families reported not knowing how to access the services. If they did access services, they reported that the services were not always appropriate, timely, or helpful. Parents and guardians suggested that effective adoption and guardianship-competent services are needed. Specifically, they reported being told by service providers that what they were experiencing was 'not that bad', was 'typical of youth that age', or that they just needed to 'try harder'. However, when a professional advocated for them, it legitimatized their experiences, resulting in better services for their family. Parents and guardians suggested that service providers, including school personnel, need to be better informed about the problems faced by children and youth in adoptive and guardianship families. Service providers need to be trauma-informed and familiar with issues related to families formed through adoption and guardianship.

Outcomes

Distal (long-term) project outcomes were: increased post permanency stability, improved behavioral health for children, and improved child and family wellbeing. As detailed in the site-specific reports, sites did not have enough time to see the effects of the intervention. This is a common quandary for intervention research, where follow-up periods in research studies can be insufficient. The QIC-AG Permanency Continuum highlights the importance of prevention, but long-term, complex behaviors (e.g., child externalizing behaviors) are hard to address in a single intervention and over a relatively short period. As many participants in this study reported, having continuous, long-term supports and services are important. Coupled with lessons learned in other sites, each site has a firmer foundation for understanding the experiences, characteristics, needs, and strengths of families who have experienced adoption or guardianship. While this report provides a rich set of information learned in each site, a few key messages or lessons from each site are highlighted below. This is not a comprehensive list, rather highlights of key findings by site. Additional details are provided in the site-specific reports.

- In Vermont, the project was able to provide a robust assessment of the needs, characteristics, and strengths of families formed through adoption and guardianship. The Vermont site developed an understanding of families who are struggling and those who seem to be doing well. Caregivers who would definitely adopt or assume guardianship of their child again had higher levels of resilience, open communication, perseverance in times of crisis, and more positive parent-child interaction compared to caregivers who indicated they were uncertain or definitely would not adopt or assume guardianship again. The "definitely adopt or assume guardianship again" group had less strain attributed to parenting their child and more confidence in knowing how to meet their child's needs. Additionally, they felt more prepared at the time of their child's finalization and used fewer services in the past six months than those who expressed hesitancy to adopt or assume guardianship again.

- In Illinois, intervention participants were struggling more than families who did not participate in the intervention. Yet, this study did not find that TARGET participants fared better than children in the comparison group on the outcomes measured (e.g., child behavioral issues and wellbeing measures). It is possible that no intervention effects were observed due to the limited observation window of about 6 months post intervention. With additional time, perhaps differences between the intervention participants and families assigned to the comparison group will emerge. It is also possible that families in Illinois needed something different than TARGET. Additional research is needed to develop next steps in Illinois.

- In New Jersey, no statistically significant differences were found between the TINT intervention participants and the overall comparison group and between the TINT participants and a sample of the matched comparison group on the key measures of child and family wellbeing. However, promising trends suggest that with additional time, statistically significant differences may emerge. Specifically, caregivers who participated in the intervention tended to feel better able to manage their child's behavior, which is a key factor related to post permanency stability and family wellbeing. An extended observation period in New Jersey would enhance our understanding of these issues.

- In Wisconsin, parents and guardians reported that service providers often did not listen to them or believe how bad it could be at home. Results indicated that families felt supported when the AGES workers made home visits, listened to families' concerns, and provided support and advocacy with other service providers or systems. The AGES workers were

flexible, which was critical to supporting families in need. The workers served as family advocates, amplifying the family's voice so that professionals would both listen and hear. Bringing AGES to scale, with a larger number of families and longer observation period would be a good next step.

- In Catawba County (NC), families who needed post adoption services and supports were largely already engaged in services through the existing outreach methods and service delivery systems. Few additional families requested Success Coach services as a result of Reach for Success. However, through the outreach survey sent to adoptive families, a profile of family characteristics, services sought and received, and responses to key measures related to post adoption stability provided valuable information to the child welfare agency to design future post adoption and guardianship interventions and supports.

- In Tennessee, compared to neuro-typical children their age, children and youth who participated in the intervention saw an increase, over baseline, of their functioning on key domains measured through the NMT Metrics. Importantly, a decrease in BPI scores from pretest to posttest, stronger for the intervention group compared to the comparison group, was observed. Trends found in this study are promising, but more research using a larger sample and a longer observation window is needed. Post adoption services should be designed to help children and families cope with prior experiences of trauma and placement instability.

Based on record reviews and an examination of administrative data in these sites, only a small number of children reentered foster care during the project period. Specifically, approximately 1% of all children involved with the project (from the intervention and comparison groups) reentered foster care during the project period. This is not enough to draw conclusions or inferences regarding the outcome of post permanency discontinuity.

Limitations

The interventions tested in the QIC-AG sites varied in several ways that preclude the use of a uniform multi-site design. First, the interventions selected in different sites had varying levels of evidence-support. Thus, a variety of evaluation designs were used, based on how well-supported the intervention was, results of usability testing, and the number of study participants. For example, some sites used an experimental design, yet the randomization methods varied (i.e., a traditional Randomized Control Trial or a randomized consent design [Zelen, 1979, 1990]). In other sites, a quasi-experimental design was used, and some sites used descriptive analyses. Furthermore, each site tested a different intervention, and thus, had different definitions for subject inclusion, different short-term outcomes, and a variety of external conditions that impacted implementation.

Another cross-site limitation is that previous research suggests the primary long-term outcome of interest (post-permanence stability) in the QIC-AG research study requires an extended observation period. For example, as noted above, research from Illinois has found that approximately 2% of adoptions or guardianships have experienced instability two years after finalization; 6% after five years; and 12% ten years after achieving legal permanence (Rolock & White, 2016). This is problematic for effective evaluations that have a shorter follow-up period. Given the low rate of instability and short window for follow-up, the evaluation focused on more proximal indicators that are predictive of long-term permanency outcomes (e.g., BPI scores and caregiver commitment scale). However, even the ability to observe a significant change in the relatively short follow-up period was limited.
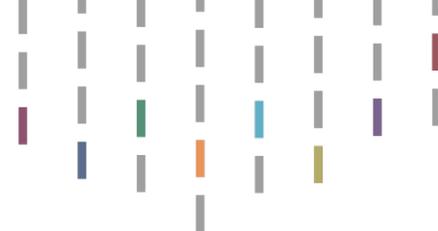
Examining Post Permanency Discontinuity

The QIC-AG was designed to promote permanence when reunification is no longer a goal and improve adoption and guardianship preservation and support. Promoting permanence often requires the examination of factors that would jeopardize that goal and might lead to discontinuity. This section examined mechanisms for assessing risk for post permanency discontinuity, using existing administrative data and through the collection of primary data (e.g., surveys or questionnaires). Post permanency discontinuity, defined as foster care reentry after an adoption or guardianship finalization, was examined using data from four sites (Vermont, New Jersey, Tennessee, and Illinois). These data were not available from Catawba County or Wisconsin. Several Multivariate Cox survival models were estimated with administrative data to examine predictors of time-to-foster care reentry.

Separate models were run for each state and one with all four sites combined. Children were tracked using administrative data starting in the year 2000 and then ending in years 2015, 2016, or 2017 (depending on data available for each state), and the dependent variable was the time-to-reentry, with several predictor variables included in models. Multivariate Cox regression is a useful statistical model to examine the impact that several predictors have on a time-to-event outcome, such as post permanency discontinuity, while also accounting for information provided by censored cases or those cases that do not experience post permanency discontinuity by the end of the study period (Guo & Fraser 2010).

Prior research found strong evidence for using two predictors of post permanency discontinuity: 1) the caregiver's assessment of the child problem behaviors using the Behavior Problem Index (BPI); and 2) caregiver commitment to the adoption or guardianship, e.g., a caregiver's self-report of the frequency with which they think of ending the permanency relationship (Testa, Snyder, Wu, Rolock, & Liao, 2015). Based on these findings, the evaluation team used these and other measures and constructs from prior studies, conducted with families formed through adoption and guardianship, in the site-specific evaluations.

In sites that used BPI and caregiver commitment measures, families were compared across the continuum to see if there were differences in the families targeted for outreach. Specifically, it was hypothesized that families targeted for outreach at the Universal level would, on average, have low-risk scores on the key measures. In contrast, families targeted for outreach at the Selective or Intensive intervals would be expected to exhibit higher risk scores, and those where the intervention was at the Intensive level would have the highest risk scores (because Intensive interventions are designed to support those who have the highest needs).

Post Permanency Discontinuity

In this section, available administrative data was used to help understand what characteristics, known at the time of adoption or guardianship finalization, were associated with post permanency discontinuity. Prior research has established that the following experiences of children while in foster care were helpful in understanding who was most at risk for post permanency discontinuity: a child's age at the time of adoption or guardianship, the number of moves the child had in foster care prior to adoption or guardianship, and the length of time the child spent in foster care prior to permanence (Rolock, & White, 2016; Rolock, & White, 2017; White, 2016; White et al., 2018). Using data from Vermont, New Jersey, Tennessee, and Illinois, we ran multivariate survival analyses to examine these relationships. Detailed results by state are in the Appendix (Table 10.6) and summarized in Figure 10.1. In sum, this analysis found that:

- Children aged six or older at the time of finalization were 2.9 times more likely to reenter foster care compared to children whose adoption or guardianship was finalized prior to the age of six.

- Children who had three or more moves in foster care were 66% more likely to reenter foster care, compared to children who had less than three moves while in foster care.

- Children of color (compared to White children) were 6% more likely to reenter foster care.

Figure 10.1. Characteristics of Children Most Likely to Reenter Foster Care after Adoption or Guardianship
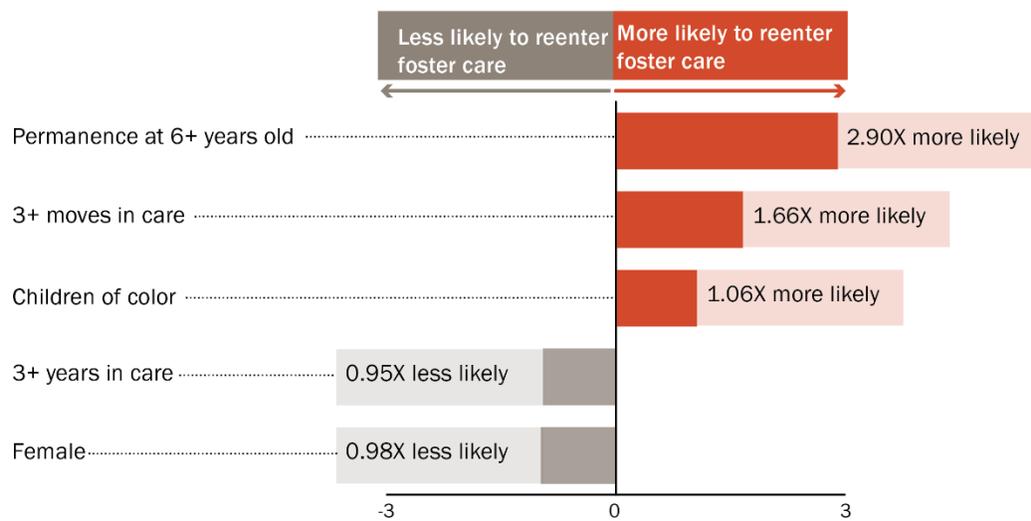
Note: The graph above shows hazard ratios. They are plotted on a logarithmic scale for ease of interpretation. Hazard ratios less than 1.0 represent decreased odds relative to the comparison group, while values greater than 1.0 represent increased odds relative to the comparison group. In this graph, for instance, the strongest predictor of foster care reentry after adoption of guardianship is the child's age at the time of permanence. The interpretation is: children aged six or older at the time of finalization are 2.9 times more likely to reenter foster care, compared to children whose adoption or guardianship is finalized prior to the age of six.

These findings largely support by prior research in that the age of the child at the time of finalization and the experience of instability while in foster care are strong predictors of post permanency discontinuity.

Analysis Along the Prevention Continuum

The QIC-AG developed the *QIC-AG Permanency Continuum of Service* to guide its work with the different sites (described in Chapter 1, Figure 1.3). The Continuum serves as an organizing framework that helps guide child welfare systems in moving children to adoption or guardianship while supporting families to maintain stability and wellbeing after adoption or guardianship has been achieved. The analysis in this section focuses on the post permanency portion of the Continuum where prevention services were offered.

Based on previous research that established associations between caregiver commitment and caregiver assessment of child behavior difficulties to post permanency discontinuity, the QIC-AG evaluation team examined these constructs across different sites. Prior research suggests these constructs are proximal outcomes associated with post permanency discontinuity. The QIC-AG targeted different groups of families formed through adoption or guardianship along the QIC-AG continuum based on the level of risk for post permanency discontinuity, theorizing that as the average risk for post permanency discontinuity increased, so would the intensity of the intervention needed. The purpose of the following analysis is to provide a preliminary test of possible screening questions that could be used to identify families who may be at risk of experiencing post permanency discontinuity.

In their QIC-AG survey responses and through initial assessments, families responded to questions and completed measures related to child and family wellbeing and behavioral health. This analysis asks the question: do family responses provide us with information that helps us differentiate between families at risk for post permanency discontinuity and those who are unlikely to experience discontinuity? Some caveats about the data analyses presented below:

- For this section of the report, Vermont and Catawba County (NC) are classified as Universal outreach. Although the Catawba intervention (Reach for Success) was an Indicated intervention, the initial survey sent to all adoptive families in the county who had not been previously engaged in post adoption services was a Universal outreach effort. This section grouped Vermont and Catawba results to examine Universal outreach data.

- For the analysis of data from Illinois and New Jersey, intervention participants were removed because we did not want to confound these findings with the effect of the intervention. In other words, for this section we are analyzing the characteristics of families identified in the Selective interval, not describing the impact of the intervention.

- In Wisconsin data were collected at **intake**, prior to participation in the intervention. This baseline data was used to understand the profile of families who indicate that they may be having some difficulty, and to compare their outcomes to families who responded to surveys in the other sites.

- The number of respondents varied by site. There is greater confidence in the results of sites where there are more respondents. In particular, caution should be exercised in the interpretation of the Wisconsin findings, given the lower number of respondents and the wide variety of types of adoptions or guardianships served in that site (please see the Wisconsin report for additional information).

- Not all sites collected the same information; therefore, some sites will not be represented in the graphs showing site-specific results.

Table 10.4. Number of Survey Respondents by Site, by Measure

MEASURES	PREVENTION: UNIVERSAL		PREVENTION: SELECTIVE		PREVENTION: INDICATED
	VT	NC	IL	NJ	WI
BPI	722	122	1,186	449	71
STRAIN	802	128	1,173	450	71
BEST-AG	N/A	126	1,209	448	71

The analysis in this section that shows data across sites does not compare how well each site did, or the outcomes for each site. Rather this analysis is intended to show how at-risk the population was in each site before contact with child welfare agencies. For example, it would be expected that participants in Wisconsin would have worse scores on scales of wellbeing at the point of contact because Wisconsin was an indicated site, and it would be expected that Catawba County would have better scores on scales of wellbeing at the point of contact because the Catawba County survey was a universal intervention.

Behavioral Problem Index (BPI)

The overall hypothesis was that the higher the sites were along the continuum from Universal to Intensive levels of intervention, the overall BPI scores would increase, suggesting more difficult child behaviors. For example, Universal sites (Vermont and Catawba County [NC][2]) gathered BPI scores for all children and youth adopted, and Vermont also included youth placed into guardianship (North Carolina did not have a guardianship assistance program until 2017; guardianship cases were not included in the Catawba study). It would be reasonable to assume that average BPI scores would be lower in these sites than BPI scores in the indicated site (Wisconsin) where the scores were gathered for children who were at higher risk for post permanency discontinuity. As shown in Figure 10.2, that trend did not hold true for all of the QIC-AG sites. Specifically, results from Vermont did not follow the expected trend.

While the average score in Vermont was lower than the scores of families who were at the Indicated level (Wisconsin), they were higher than the scores of respondents in the Selective prevention sites (Illinois and New Jersey). Aside from Vermont, the mean BPI scores in the remainder of the sites followed the expected pattern. An important message to note from this analysis is that, while BPI scores may be helpful in identifying families in need of additional support and services, having a high BPI score is not in and of itself an indicator that a family is at

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[2] Note that the overall intervention in Catawba County (NC) was at the indicated level. The Universal component was the fact that the project surveyed all adoptive families in the county who had not engaged with Success Coach services.

risk. For example, Testa, et al., (2015) found that the relationship between elevated BPI scores and post permanency discontinuity was mediated by the level of caregiver commitment. Familial relationships are a complex and nuanced area that needs further understanding, particularly for families formed through adoption or guardianship.

Figure 10.2. Overall Behavioral Problem Index (BPI) Scores by Site
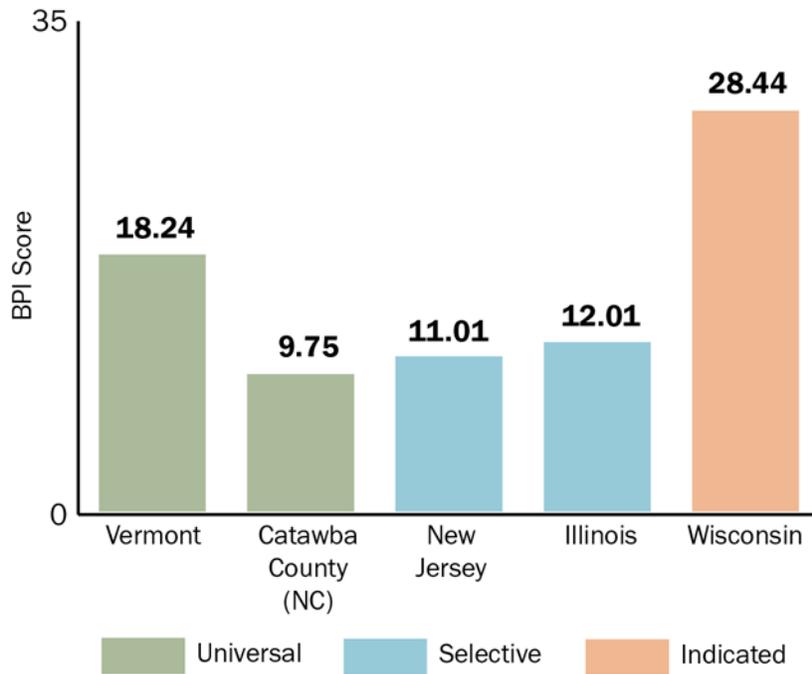

Figure 10.2 note: It should be noted that we expect to see higher levels of behavior problems in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are experiencing difficulties that result in them being in contact with a service provider, and thus, these two sites were serving families that were at higher risk for post permanency difficulties than families in the other QIC-AG sites.

Caregiver Strain

Similar to the hypothesis for BPI, the hypothesis regarding Caregiver Strain was that as sites were placed higher along the continuum, the overall Strain scores would also increase, suggesting more caregiver strain. With the exception of Wisconsin, similar mean scores were observed in most sites (Figure 10.3) that collected this information. However, the Wisconsin mean was based on only 71 children, and the other sites had between 1,173 respondents in Illinois and 128 in Catawba County. In addition, there was less overall variation in this measure than others, such as the BPI, because the total score was an average of individual scores on questions.

Figure 10.3. Mean Caregiver Strain Scores by Site
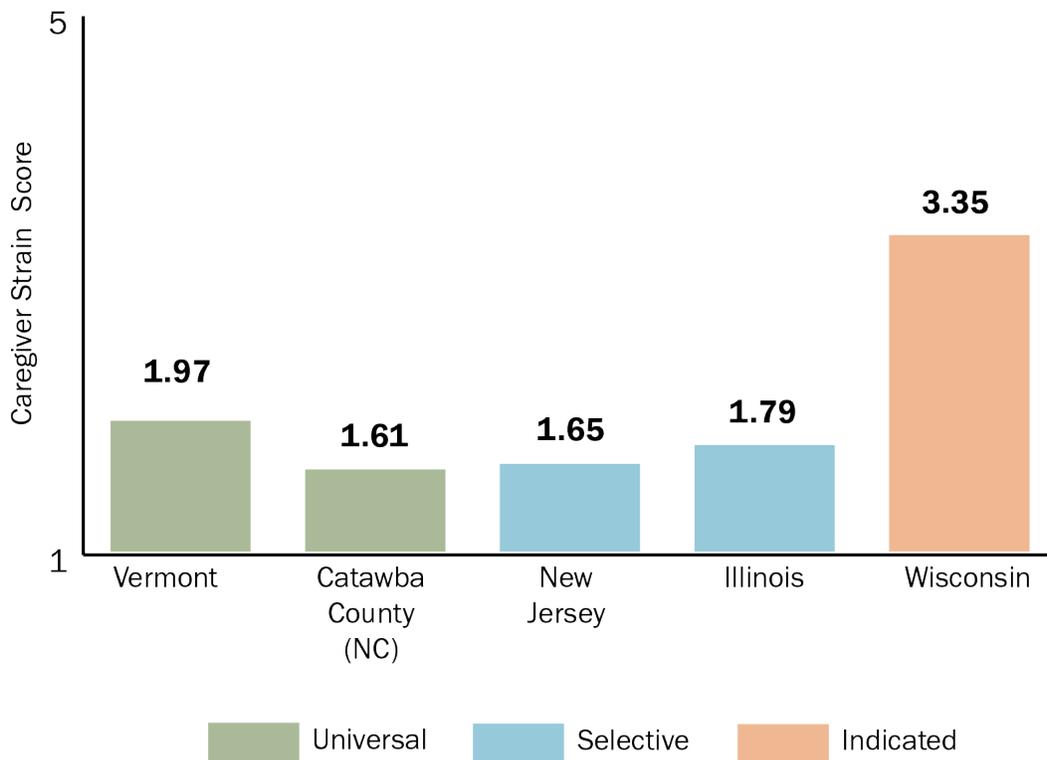
Figure 10.3 note: It should be noted that we expect to see higher levels of caregvier strain in the site that is serving families who reach out to request assistance (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are experiencing difficulties that result in them being in contact with a service provider, and thus, this site was serving families that were at higher risk for post permanency difficulties than families in the other QIC-AG sites.

Belonging and Emotional Security Tool – Adoption and Guardianship (BEST-AG)

The hypothesis associated with the BEST-AG was the opposite of the prior two measures. We hypothesized that as sites were placed higher along the QIC-AG Permanency Continuum, there would be a decrease in the level of belonging and emotional security that the caregiver had for the child or youth. Results (Figure 10.4) found similar mean scores in Catawba County (NC) (Universal), Illinois and New Jersey (Selective). The average BEST-AG scores in Wisconsin were lower; this site was also where families made contact with the system, rather than the project proactively reaching out to the family. In other words, the families in Wisconsin were experiencing some level of difficulty that resulted in their contact with the project.

Figure 10.4. Overall Belonging and Emotional Security Tool – Adoption and Guardianship (BEST-AG) Scores by Site
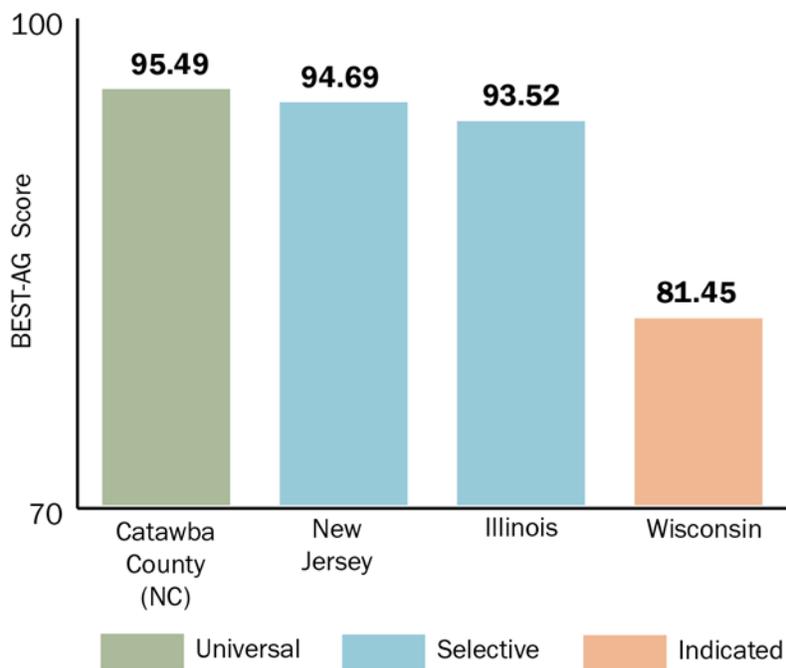

Figure 10.4 note: It should be noted that we expect to see lower levels of belonging and emotional security in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are experiencing difficulties that result in them being in contact with a service provider, and thus, thissite was serving families that were at higher risk for post permanency difficulties than families in the other QIC-AG sites.

Impact of Caregiver Commitment on Key Measures

Caregiver commitment is the extent to which adoptive parents or guardians intend to maintain children in their homes and provide long-term care for them, no matter what challenges, stressors, or negative behaviors may occur (Liao & Testa, 2016; White, Rolock, Testa, Ringeisen, Childs, Johnson, & Diamant-Wilson, 2018). Previous research studies have conceptualized caregiver commitment in two ways. First, caregiver commitment has been examined as a potential indicator, or predictor, of other long-term post permanency outcomes of interest, such as placement instability (Mariscal, Akin, Lieberman, & Washington, 2015; White et al., 2018). Second, caregiver commitment has been investigated as an intermediate or "proximal" adoption or guardianship outcome that results from the characteristics, relationships, and actions of children, caregivers, family members, social supports, and service systems (Nalavany, Ryan, Howard, & Smith, 2008; White, 2016; White et al., 2018). For example, researchers have examined how negative child behaviors, child-caregiver kinship, and even the availability of services may be associated with caregiver commitment to adoptions and guardianships (Mariscal et al., 2015; Rolock & Pérez, 2015; Testa et al., 2015; White et al., 2018).

The relationships between caregiver commitment and other post permanency variables, such as placement instability, can be quite complex. As one example, Testa and colleagues (2015) surveyed adoptive parents and guardians and assessed child behavior problems using the Behavior Problems Index (BPI) and caregiver commitment by asking caregivers about their thoughts of ending the adoption or guardianship. They found that the relationship between negative child behaviors and placement instability was mediated by caregiver commitment. Further, this mediated the relationship between child behaviors and instability and was moderated by other characteristics, such as the degree of kinship between caregiver and child.

Keeping in mind the significant role caregiver commitment has played in understanding post permanency discontinuity and other challenges in prior studies (Liao & Testa, 2016; Testa et al., 2015; White et al., 2018), a series of commitment questions were asked of parents and guardians involved with this study. One of the commitment questions asked parents and guardians to think about what they know now and respond to a question that asked if they would adopt or assume guardianship again. (*If you knew everything about your child before the adoption or guardianship that you now know, do you think you would still have adopted or assumed guardianship of him or her?*) Responses were on a 5-point scale, from 'definitely would have' to 'definitely would not have'. To analyze this, first, a dichotomous variable was created, where 'definitely would have' was coded as 'definitely would,' and 'probably would have', 'might or might not have', 'probably would not have' and 'definitely would not have' were coded as 'hesitant'.

IF YOU KNEW EVERYTHING ABOUT YOUR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT YOU NOW KNOW, DO YOU THINK YOU WOULD STILL HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM OR HER?

Definitely would have		Probably would have	Might or might not have	Probably would not have	Definitely would not have

Definitely would			Hesitant		

Results (depicted in Figure 10.5), show that between 19% and 24% of respondents from the prevention-related sites (Vermont, New Jersey and Illinois) expressed some level of hesitancy to adopt or assume guardianship again[3]:

- In Vermont, where outreach was Universal, 22% of families expressed hesitancy to adopt or assume guardianship again.

- In New Jersey, 19% of families expressed hesitancy to adopt or assume guardianship again.

- In Illinois, 24% of families expressed hesitancy to adopt or assume guardianship again.

Figure 10.5. Percent of Caregivers who Expressed Hesitancy to Adopt or Assume Guardianship Again
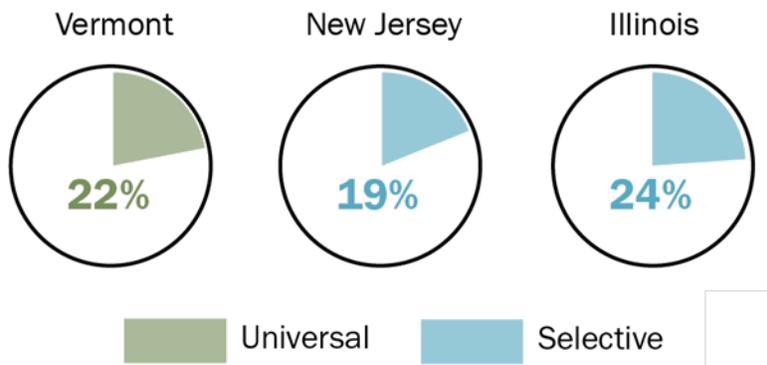
These results do not align exactly with the theory behind the continuum. Through this theory, one would expect a lower proportion of families to express hesitancy in Vermont (Universal) than in New Jersey or Illinois (Selective). It is possible that external factors (e.g., level and type of post permanency services available) play a role, or that some unmeasured factors are at play.

Keeping in mind the proportion of families in each category (hesitant to adopt or assume guardianship again, or not hesitant), the next step in this analysis examined responses **within each of these two groups.** Results (summarized in Table 10.4 in the Appendix, and in Figures 10.6 – 10.8).

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[3] Please note that the number of respondents from Wisconsin was too small to include that site in these analyses.

The following annotation of Figure 10.6 is provided to guide the reader in understanding Figures 10.5 – 10.8:

1. **Responses were sorted into two groups (see Figure 10.5):**

- Families who were hesitant to adopt or assume guardianship again.

- Families who expressed no hesitancy (definitely would adopt or assume guardianship again).

2. **In Figure 10.6, the bars and the numbers above the bars are the mean BPI scores for each group.**

Using Vermont as an example, the following information is reported in Figure 10.4: The group who expressed hesitancy or reported that they would not adopt or assume guardianship again (only 22% of all families) had an average BPI score of 26.45. The average score for families who reported that they definitely would adopt or assume guardianship again was 14.95. In other words, families who were hesitant to adopt or assume guardianship again scored much higher – more behavioral issues – than families who reported that they definitely would adopt or assume guardianship again. This is a statistically significant difference, as indicated by the three stars next to 14.95.

This analysis revealed some interesting trends that are examined along the continuum and across three key measures: The Behavioral Problem Index (BPI), Caregiver Strain (CS), and the Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG).

Figure 10.6. Behavior Problem Index (BPI) by Inclination to Adopt or Assume Guardianship Again
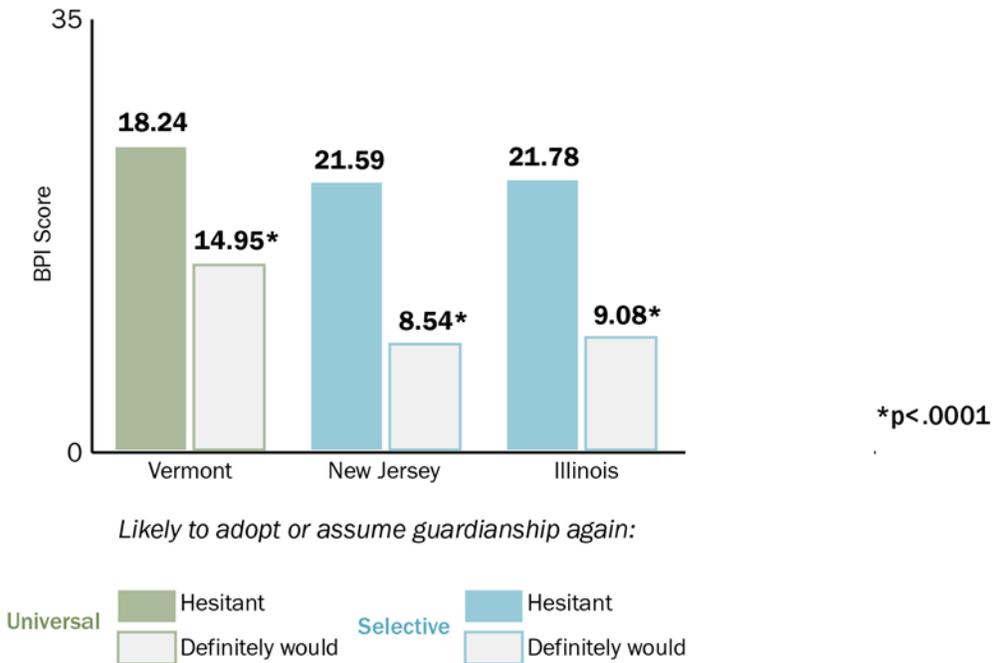
The BPI was selected as a standardized measure of child behavior problems based on previous research with adoptive and guardianship families (Liao & Testa, 2016; Testa et al., 2015; White, 2016). Higher scores on the BPI mean more behavioral issues. As shown in Figure 10.6, there is a statistically significant difference in the BPI for children whose parents or guardians expressed hesitancy to adopt or assume guardianship again and parents or guardians who *do not* express hesitancy to adopt or assume guardianship again, with those who expressed hesitancy scoring higher on the BPI.

Figure 10.7. Caregiver Strain by Inclination to Adopt or Assume Guardianship Again
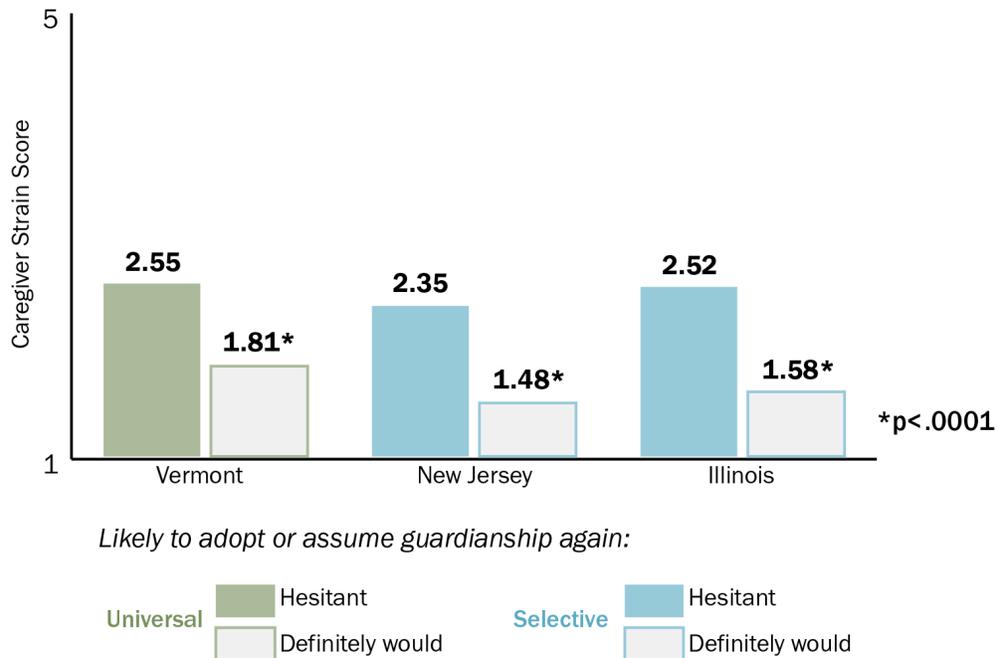

The Caregiver Strain Questionnaire-Adoption/Guardianship (CGSQ-AG) used in this project is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger, & Brickman, 1997), a measure to assesses the extent to which caregivers experience additional demands, responsibilities, and difficulties as a result of caring for a specific child. Caregiver strain, similar to parenting stress or burden, has been found in the previous literature to be associated with lower child and family satisfaction and wellbeing after adoption or guardianship (White et al., 2018). The same analysis was conducted with the caregiver strain measure (see Figure 10.7), and similar patterns emerged. Again, keeping in mind that this analysis focused on the differences highlighted in Figure 10.5 (that 22% of families in Vermont, 19% in New Jersey, 24% in Illinois expressed hesitancy to adopt or assume guardianship again).

With the Caregiver Strain measure, higher scores mean higher levels of strain. Results found a statistically significant difference in the level of strain reported by caregivers who expressed hesitancy to adopt or assume guardianship again in all three sites where data was available. These families also reported much higher rates on caregiver strain than families who were not hesitant to adopt or assume guardianship again.

Figure 10.8. Belongingand Emotional Security Tool (BEST-AG) by Inclination to Adopt or Assume Guardianship Again
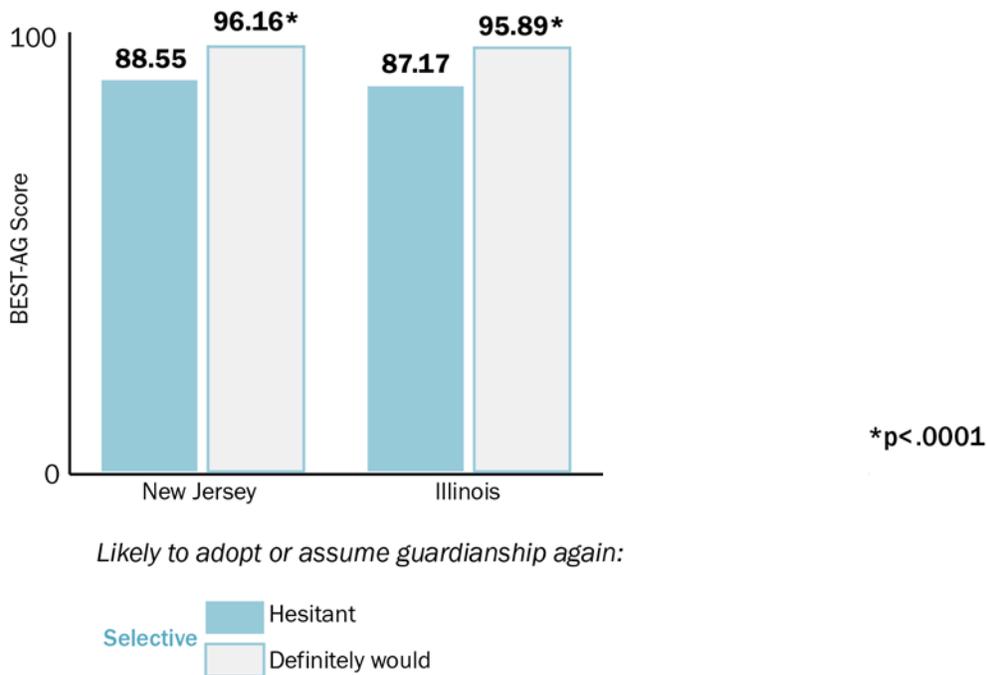
The BEST-AG, developed by Casey Family Services (Frey, Cushing, Freundlich, & Brenner, 2008), was originally designed to help social workers frame conversations about emotional and legal commitment with foster parent and youth who are unable to reunify with their family of origin. For this study, the BEST-AG was adapted and used with families formed through adoption and guardianship because previous research has shown that lower caregiver commitment is related to increased levels of post permanency discontinuity (Testa et al., 2015; White et al., 2018).

This analysis was repeated with the BEST-AG. However, note that with the BEST-AG, higher scores mean *an increased level of belonging and emotional security*. Results (depicted in Figure 10.8) found a statistically significant difference in the BEST-AG for children whose parents or guardians expressed hesitancy to adopt or assume guardianship again. Specifically, families who express hesitancy to adopt or assume guardianship again are not doing as well as families who do not express hesitancy. There is a statistically significant difference between the two groups.

Taken together, these findings suggest that the target populations along the continuum varied in interesting and unexpected ways. For instance, in Vermont, Universal outreach would be expected to find a population with less risk for post permanency discontinuity than a population that was targeted based on specific risk factors (New Jersey and Illinois), but this was not the case. In all three prevention sites (Vermont, New Jersey, and Illinois), approximately 20% (19% to 24%) of the families who responded to surveys had much higher BPI scores, more strain, and less of a sense of belonging and emotional security. In addition, Universal and Selective prevention sites were much more similar than expected.

These findings suggest that in addition to the administrative data that can be used to assess risk for post permanency discontinuity, the question related to hesitancy to adopt or assume guardianship provides an opportunity for a more nuanced assessment of risk for post permanency discontinuity. In addition to this one question, there are other questions related to caregiver commitment and familial relationships that should be examined related to assessment for risk for post permanency discontinuity. Child welfare jurisdictions interested in targeted outreach to families formed through adoption or guardianship may consider periodically checking in with families to assess their level of caregiver commitment and familial relationship (e.g., the parent or guardian's assessment of how well they can manage their child's behavior). Based on the responses received from this check-in, jurisdictions could consider targeting limited resources to families who express hesitancy to adopt or assume guardianship again or results from additional caregiver commitment or familial relationship questions piloted with the QIC-AG project. Additional analysis of other questions related to familial relationships and caregiver commitment may also be worth exploring.

Discussion

This section summarizes several takeaways from the QIC-AG project when looking at the results of the studies across sites working with families formed through adoption or guardianship. It is important to note that discussing key themes in this way risks glossing over substantive differences across sites and the importance of site-specific considerations in service needs and intervention design. However, despite the considerable variation among these sites in populations, outreach methods, and interventions implemented, some crosscutting themes emerged across sites and may be helpful to those who plan outreach and services to families formed through adoption and guardianship.

FAMILIES KNOW WHAT THEY NEED; FAMILIES WHO WANT SERVICES ENGAGE IN SERVICES

There was a significant amount of effort by the QIC-AG aimed at understanding how to reach families, and anticipating how families would respond to outreach from the project. These findings suggest that families are quite capable of self-assessment. In short, families know what they need. This is evident in the data collected; families who participated in services had more intense struggles than those who did not engage in services. Families who engaged in services tended to be families who reported that they were struggling to effectively manage their child's behavior or respond appropriately to their child. Conversely, families who did not engage in services tended to be families who reported they were adjusting fine. In other words, future projects can worry less about the specific type of outreach (e.g., mailings addressed with a specific color of ink or pictures) and more about offering services and supports to families formed through adoption or guardianship.

SERVICE UPTAKE DID NOT OVERWHELM POST PERMANENCY SERVICE PROVIDERS

There was a concern in several sites that if post adoption or guardianship services were made available to families, too many caregivers would want them and then overwhelm the capacity of the child welfare system to respond. It was difficult to plan for group sessions or numbers of facilitators because project staff did not know how many families to anticipate participating. Jurisdictions concerned about their capacity to offer post permanency supports and services should not expect being overwhelmed with requests. Most families do well with the supports and services currently in place, and will not be interested in additional services, if offered. Furthermore, for those families who need additional services or support, they are often desperate for assistance, and the offer of additional support can be life-changing for the families involved.

ONGOING SERVICE NEEDS

Similar to other research with families formed through adoption and guardianship, families involved in this study reported that they were doing well with the supports and services they currently have in place. However, just because the level of need did not overwhelm the system does not mean that services are not needed. Families suggested that the child welfare system may want to focus on making a wider variety of post permanency services available and accessible. A primary task for child welfare service providers is to ensure that families who are struggling can easily access the services they need. In the survey responses and in interviews with families formed through adoption or guardianship, parents and guardians reported not knowing where or

how to access services, or reported trying to access services but finding them inadequate. In other words, project findings suggest that families know when they are struggling, yet helpful services remain elusive. This is further complicated by the fact that many child welfare agencies do not have a robust system of services targeted at families formed through adoption or guardianship.

Some parents and guardians reported that the supports and services available to them as foster parents disappear after finalization, yet they were still in need of those services. In addition, for adoptive parents and guardians whose needs change after finalization, services and supports can become more difficult to access. Finally, being connected with providers who understand the unique circumstances of families formed through adoption and guardianship is important to families in need. Parents and guardians reported struggling to be heard and believed. Service providers did not always believe that the situation at home was as bad as it was. For instance, Wisconsin caregivers reported that when they told a provider that they had already tried an idea, they were not believed, but when they said the same thing to an AGES worker, they were heard and believed.

Finally, the use of the word *support* is important. Families in Wisconsin reported that it is not always another intervention that is needed. Sometimes what is most needed is just a friendly voice on the other end of the phone, who can listen to struggles regarding birth family contact or provide support for older caregivers. Other times it is helping to get intensive residential treatment services for their child without relinquishing custody. TINT participants in New Jersey reflected on the important social connections (informal social support) made by attending TINT sessions. Survey respondents in New Jersey and Illinois reported that they needed formal support from the child welfare and school systems, as well as support in accessing services for their child post-permanence. It is important to understand what *support* means to the family and to find a way to offer it in a timely manner.

In sum, some suggestions moving forward:

- Maintain connections with families after adoption and guardianship. Connections to services, supports, and resources should begin prior to adoption or guardianship finalization and continue to be maintained after finalization.

- Reduce barriers to post adoption service use and empower families to seek services and supports. This process may be made easier by maintaining connections through universal outreach, which includes providing information about availability and eligibility for services after adoption or guardianship finalization so that families know how and where to access supports and services.

- Offer support through periodic, targeted outreach to families who exhibit characteristics that suggest they may be at an increased risk for post permanency discontinuity. This could be, for instance, annual check-ins with families to see how they are doing.

- Encourage child welfare jurisdictions to develop systems to track and update families' addresses and contact information so that families receive the information that agencies send.

- Increase the availability of service providers experienced in working with families formed through adoption or guardianship, particularly for child and family mental health support.

Caregivers shared additional thoughts through surveys, and the majority of those responses included something positive about the adoption or guardianship experience. In many comments,

the caregivers described a deep love and appreciation for the children they had adopted or assumed guardianship of. However, for some parents and guardians, their child also presented unanticipated challenges, including attachment issues from past trauma experienced, problems at school, and identity concerns. Additionally, challenges often did not occur until children were older, years after legal finalization of the adoption or guradianship. Difficulties interacting with birth families were problematic for some families, suggesting the need for support navigating a child's other relationships. Therefore, culturally sensitive, developmentally-appropriate, trauma-informed services that take into consideration the unique experiences of adoptive and guardianhsip families, and are requested and delivered in a timely fashion have the potential to help avert difficulties that adoptive families experience after legal permanence.

POST PERMANENCY CONTACT BY A CHILD WELFARE AGENCY IS WELCOME AND APPRECIATED

The project successfully contacted a large percentage of the families they attempted to reach. It is important to note that response rates close to, or even well below, 50% are not unusual for post adoption surveys described in the previous literature, and that response rates in previous studies vary widely (White, 2016). Furthermore, families appreciated being contacted. It is noteworthy that the project heard from many families who expressed gratitude for the opportunity to tell their story. In work with families who have exited the foster care system to adoption or guardianship, there is sometimes a question about whether and how families experience a request for engagement by the formal child welfare system. The responses provided by families suggest that they both appreciate and need outreach from the system and are interested in the results:

> **"If you ever need me to answer any questions again please let us know. We adopted three kids all [with] special needs and one that is dual diagnosis mental health and developmental disabilities and she has been the challenge! I most certainly could tell the good, the bad, the ugly, of all of it! I still would do it all over again."**

In summary, agencies should assume that families would welcome outreach post permanency. This may be contrary to the perception that adoptive and guardianship families wanted to be left alone by state agencies. Adoptive parents and guardians are often parenting children that have experienced significant trauma and struggle to receive the appropriate services without public agency support.

IDENTIFYING FAMILIES AT RISK FOR POST PERMANENCY DISCONTINUITY

Results from previous studies of post permanency discontinuity indicate that a small proportion of children who exit foster care to adoption or guardianship experience post permanency discontinuity, or reentry into foster care after finalization, as captured by administrative child welfare data systems (White et al., 2018). Yet, for families who experience discontinuity, the process can be very difficult, and result in additional trauma, loss and diminished wellbeing for all involved.

Research from other studies (extant research) has found that caregiver commitment, while strong at the time of finalization, may diminish over time and that a diminished level of caregiver commitment is associated with increased risk of post permanency discontinuity (Testa et al., 2015; White et al., 2018). However, this extant research, and the relationships they examine, are complicated. One key finding from the extant research is that child behavior problems and caregiver strain have been identified as a risk factors for post permanency discontinuity (Newton, Litrownik, & Landsverk, 2000; Liao & White, 2014). In other words, children with elevated BPI scores, and caregivers with elevated levels of strain, are at greater risk for post permanency discontinuity.

Results from this project found that there are statistically significant differences on key measures (BPI, BEST-AG, Caregiver Strain) between parents and guardians who express hesitancy to adopt or assume guardianship again and families who do not express hesitancy to adopt or assume guardianship again (one measure of caregiver commitment). Results from this project also found that families who report that they are less confident that they can meet the needs of their child, or were more likely to report that they struggle to effectively manage their child's behavior (familial relationship measures), were more likely to engage in services.

An important aspect of prevention work with adoptive and guardianship families is to be able to identify families who may be the most likely to experience post permanency discontinuity and diminished wellbeing. Through the research conducted with the QIC-AG, we asked key questions to better understand the relationship between caregiver commitment, familial relationship, and post permanency discontinuity. We found the responses show promise for use as a tool to distinguish families who were struggling and those who seemed to be doing alright. Next steps for this line of research would be to test these questions as a tool to identify families most at risk for post permanency discontinuity. These questions could be administered yearly to all adoptive and guardianship families, with targeted outreach directed at families whose responses suggest they may be at an elevated risk for post permanency discontinuity.

MULTI-PRONG APPROACH TO OFFERING SUPPORT AND SERVICES

These results found that families are capable of self-assessment for engagement in post permanency services. Universal, broad outreach efforts should occur with families formed through adoption or guardianship on a regular basis, to remind them of available services and how to access services and supports. From the experiences of this project, this should not overwhelm systems, and the relatively small proportion of families who are interested in engaging in services are likely to participate.

In addition, child welfare agencies interested in understanding which families are at increased risk for post permanency discontinuity may want to consider asking some key questions related to caregiver commitment and familial relationships at regular intervals post-finalization. Results can then be used to let families who may be struggling and at-risk for post permanency discontinuity to know more about available services. Agencies can also deliberately ask families most at risk for post permanency discontinuity about what services and supports are needed so that a robust array of supports and services can be delivered. Families experiencing stressful events are not always capable of unraveling the complex public and private service and educational systems. Families involved in this study reported that the support they received to navigate and advocate for services made all the difference in their family's wellbeing.

Finally, agencies should offer services and supports that address immediate concerns as part of their service array. In at least one of the sites, families who engaged in the intervention later engaged in services-as-usual. This suggests that they had additional needs that were not addressed through the specific intervention. A wider array of services may be needed by the adoptive parents and guardians. In addition, through the relatively small number of families who participated in the AGES program, the project has learned that some families will have issues where they are in urgent need of services. Other families will have long-term issues. These are issues that were concerning to the families and they wanted to address or better understand, but were generally not overwhelming them at that moment. Service providers need to be prepared to offer an array of services and supports to families who contact an agency or provider looking for assistance. Adoptive and guardianship families struggle like other families, but there is a uniqueness to their struggles. Services and supports need to be put into place to address these unique needs.

ADOPTIVE PARENTS AND GUARDIANS REPORT ON THEIR POST PERMANENCY EXPERIENCES

Throughout the project, the teams have listened to families formed through adoption and guardianship. Site-specific Theories of Change, membership on Stakeholder Advisory Groups (SAT) and insight from parents and guardians guided the project development and implementation. We conclude with some thoughts from parents and guardians. Several of the QIC-AG sites asked parents and guardians for additional thoughts about their experiences with adoption or guardianship. Some common themes emerged from caregiver responses across sites. First, most comments from caregivers expressed their deep love and concern for their children and showed that they were committed to their children for life. Caregivers' comments also expressed joy and delight over being able to bring their adopted or guardianship child into the home. For example:

> "It has been a life-changing experience. It has been harder than I thought it would be, but I am always thankful that we adopted our daughter, I love her with all my heart, and I can't imagine our family without her."

> "It's been a great experience watching my child grow into a young respectful young man. I wouldn't trade him for the world. Had him since he was three weeks old now he is 18 years old. Best 18 years."

> "My adoption has given me fulfillment and purpose and an opportunity to pour into the life of my granddaughter. As we are going through her teen years we have run into many challenges, as she is developing, maturing and finding her own way. Yet this has been rewarding."

Second, despite their commitment to children, some caregivers noted frustrations, especially regarding inconsistency and availability of services and supports. For example, caregivers reported difficulties with school-related issues, interactions with birth families, accessing mental health services, and finding help from social workers when needed. For example:

> "Sometimes [he] can be a joy to have but when the school calls and say he's acting up at school it reflects back to me. Is there something different I can do to change his perspective on learning? He is a smart little boy but when he gets around some of his friends at school he seems to act up."

> "We were not aware of the depth of our daughter's disabilities. Schooling is hard for her, there is really no place she fits in, regardless of all the IEPs in place and all the hard work that has been put into it. She has many disabilities, so it is hard to get all disabilities taken care of at the same time. We knew she was delayed. We didn't know she had 5 or more diagnoses and would never graduate from high school or ever be able to go to college or live on her own."

"Our biggest challenge is the close proximity of the birth family, specifically birth dad. He does not respect the boundaries of adoption and is a constant threat and worry.

"We spent many years trying to find appropriate providers who understood our son. We were often given misinformation & guidance about our son's needs. For years, professionals looked only at behaviors rather than brain functioning & disabilities. Both he & us as parents were blamed."

"Attachment disorder has severely impacted my daughter…She has struggled with attachment and reciprocity. I, too, have struggled with attachment to her, given her lack of reciprocity. Having worked with a therapist years ago who purportedly understood attachment disorder, my daughter and I received very little helpful guidance…The fact that she is still alive is testament to my husband's and my determination to support her and find resources for her-- mostly out of state."

These reflections show that adoptive parents and guardians are largely committed to children for life. They are satisfied with some of the supports they receive, but more could be done to help families navigate educational and mental health systems, particularly when children exhibit behavioral and/or mental health difficulties. In drafting the Theory of Change in the proposal to establish the QIC-AG, the project postulated:

Interventions that target families on the brink of disruption and dissolution do not adequately serve the interests of children, youth and families. Evidence-supported, post permanency services and support should be provided at the earliest signs of trouble rather than at later stages of weakened family commitment (Koh & Testa, 2008; Testa, Bruhn & Helton, 2010). Ideally, preparation for the occasion when post permanency stability is threatened should begin prior to finalization through the delivery of evidence-supported services that prepare and equip families with the capacity to weather unexpected difficulties and seek needed services. The best way to ensure families will seek needed services and supports is to prepare them in advance of permanence for the potential need for services and supports, and to check-in with them periodically after adoption or guardianship finalization.

Through surveys and interviews (see site-specific reports in Wisconsin, Illinois, and New Jersey), adoptive parents and guardians told this project that they need support in managing relationships with birth parents and families after finalization, as well as figuring out how much contact with the birth family is beneficial to the child. They also mentioned needing advocacy and other types of support. They need mental health services that are specific to the needs of families formed through adoption and guardianship. The QIC-AG Theory of Change is confirmed in their responses. Adjustment after adoption and guardianship is a long process, and the needs of caregivers and children do not disappear after finalization. Indeed, some issues, such as mental health, identity, and educational challenges may not appear until many years after the adoption or guardianship is finalized.

Furthermore, adoptive parents and guardians have found various ways to tell the QIC-AG project that they welcome outreach from the child welfare system after finalization. Some reported this in interviews, others in responses written in surveys, and others when they called a member of the research team to thank them for reaching out. Finally, the project has tested various measures that can help child welfare systems identify families who might welcome additional support or services. Future projects should build upon these findings in creating a 21st-century child welfare system that meets the needs of families formed through adoption or guardianship, from the pre-finalization phase, through the maintenance of stable, strong families who are prepared to access evidence-supported services and supports when they need them.
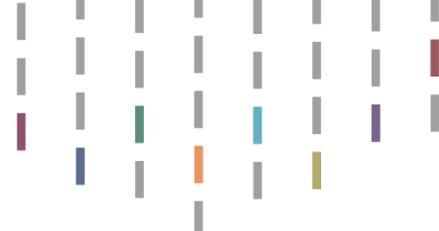
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Appendices

Appendix A. Engagement with Adoptive Families Finalized through Private Domestic and Intercountry Processes

The QIC-AG project involved outreach to private domestic and intercountry adoptive families in multiple locations, including New Jersey, Illinois, Catawba County (NC), Vermont, Wisconsin, and Tennessee. Additional information on the private and intercountry adoptive families survey in Vermont is available as an appendix to the Vermont site report. In addition, a separate report completed by the University of Nebraska – Lincoln on private domestic and intercountry adoptive families has also been completed.

Across these sites, contact with private and intercountry adoptive families was somewhat limited. There is no central registry of families who adopt via private domestic or intercountry processes, making broad outreach challenging. Recruitment efforts were different for these families than for public adoptive families. At the start of the QIC-AG, project staff met with the U.S. State Department to identify a list of Adoption Service Providers (ASPs) or professionals who help families through the private/intercountry adoption process, and sites reached out to agencies providing adoption services. Only a small number of these families responded to outreach and intervention efforts. However, findings across sites generally indicated that private domestic and intercountry adoptive families were similar to public adoptive families on many characteristics examined, with some notable differences found in individual QIC-AG sites.

In New Jersey, seven private domestic and intercountry families participated in the intervention. The private domestic and intercountry and public adoptive families were similar enough in that site that the project team decided separate TINT classes for different types of adoptive families were not needed. However, some differences were also noted between groups. Specifically, all the private domestic and intercountry adoptive families who responded to the TINT pre-survey were two-parent households, employed full-time, and had a college degree or higher. In contrast, just over half of public adoptive or guardianship families in New Jersey were in a two-parent family, 43% were employed full-time, and 63% had less than a college degree. End-of-service surveys were not sent to private/intercountry adoptive families in New Jersey, thus no intervention outcomes for these families were available.

Illinois engaged 32 private and intercountry adoptive families (i.e., 14 private domestic and 18 intercountry) who all expressed interest in the TARGET intervention. Participating families were from both sites within Illinois, with 14 in Cook County and 18 in the Central Region. The mean age of adoption for those who expressed interest was less than one year old in Cook County and almost four years old in Central Region, and the mean age of intervention was about 12 years old in both regions. Finally, 84% of the private domestic and intercountry adoptive families received the full intervention (at least four sessions). However, similar to New Jersey, end-of-service surveys were not sent to private domestic and intercountry adoptive families in Illinois, thus no information on intervention outcomes for these families was available.

Outreach efforts to private domestic or intercountry adoptive families in Catawba County started with agency staff attending community events (e.g., ball games). Catawba County staff distributed information about Success Coach services at these events. Catawba County staff also met with agencies identified by the U.S. State Department who were likely to work with families in Catawba's eight-county post permanency service region. Catawba set up trainings with these ASPs to raise awareness about adoption issues, specifically raising awareness that families who adopt through a private domestic or intercountry process were eligible for post permanency services in Catawba County. Catawba also provided the ASPs who attended training with materials about Success Coach services, which the ASPs could then disseminate to the families they work with through the private adoption process. As a result of these outreach efforts to ASPs, Catawba County had one intercountry family call the child welfare agency to ask for information about post-adoptive services, but the family did not enter into a service plan with a Success Coach.

Families who adopted a child through a private agency, either domestically or internationally, were included as a sub-population of the survey study in Vermont. Initially, the Vermont site team reached out to agencies and organizations who served families formed through private or intercountry adoption. Agencies sent a letter to families in this population to inform them about the study and requested they provide their contact information to the child welfare agency if they were interested in participation. There were 117 families throughout the state who opted into the survey, 47 (40%) intercountry adoptions, 65 (56%) private adoptions, and for 5 (4%) this information was not available. Two reports, one on private domestic adoptive families and a second on intercountry adoptive families, in Vermont are attached as an appendix to the QIC-AG final evaluation report for Vermont.

In Wisconsin, 26 of the 71 children (37%) who received the AGES intervention were private domestic or intercountry adoptions or private guardianships. Specifically, 12 were private (family court) guardianships, 9 intercountry adoptions and 6 private adoptions. Qualitative results, consisting of feedback from adoptive parents, indicated that AGES benefited caregivers in both private and intercountry and public adoptions because it helped them build a support network within their families, communities, and/or friends. In addition, AGES seemed to provide all adoptive parents and guardians with someone they could talk to when feeling isolated or frustrated.

The Tennessee QIC-AG study tested whether the NMT could promote permanency and stability in adoptive families who were referred or self-referred to Adoption Support and Preservation Program (ASAP) for services, including private domestic and international adoptive families. Of the 518 families served by the post adoption program in Tennessee during the study period, 132 (25%) were private domestic or intercountry adoption, with 78 of these families served by Harmony (who received NMT) and 54 served by Catholic Charities (who received post adoption services-as-usual). Specifically, of the 132 private and intercountry adopted children served by ASAP, 32 (24%) were intercountry adoptions, 38 (29%) were private adoptions, and for 62 (47%) this information was not available. Differences between private domestic and intercountry and public adoptions were examined in statistical tests, including child age at adoption or post adoption outreach, parental age at adoption or post adoption outreach, and averages on the BPI, BEST-AG, PFF, and caregiver commitment measures. Children adopted through the public child welfare system were, on average, older than children adopted through private domestic or intercountry means. However, on most other characteristics or measures, the families on average were very similar (e.g., age of the children at the time the families came into contact with ASAP). In regard to NMT outcomes, a small number of private domestic or intercountry adoptive families completed NMT metrics, so analyses involving private domestic or intercountry adoptive families were limited. Specifically, only 37 children had NMT metrics completed, and just 15 children had NMT post-measures. Based on this limited data, the general trends for both private domestic or intercountry and public adoptive families were similar.

Appendix B. Data Tables

Table 10.5. Key Measures by Inclination to Adopt or Assume Guardianship Again

WOULD YOU ADOPT OR ASSUME GUARDIANSHIP OF YOUR CHILD AGAIN?			
VERMONT	**HESITANT**	**DEFINITELY WOULD**	**% HESITANT**
PARTICIPANTS	176	618	22%
	MEAN	**MEAN**	***p***
BEHAVIORAL PROBLEM INDEX (BPI)	26.45	14.95	<.0001
CAREGIVER STRAIN (CS)	2.55	1.81	<.0001
NEW JERSEY	**HESITANT**	**DEFINITELY WOULD**	**% HESITANT**
PARTICIPANTS	86	364	19%
	MEAN	**MEAN**	***p***
BELONGING AND EMOTIONAL SECURITY TOOL-AG (BEST-AG)	88.55	96.16	<.0001
BEHAVIORAL PROBLEM INDEX (BPI)	21.59	8.54	<.0001
CAREGIVER STRAIN (CS)	2.35	1.48	<.0001
ILLINOIS	**HESITANT**	**DEFINITELY WOULD**	**% HESITANT**
PARTICIPANTS	284	913	24%
	MEAN	**MEAN**	***p***
BELONGING AND EMOTIONAL SECURITY TOOL-AG (BEST-AG)	85.03	95.92	<.0001
BEHAVIORAL PROBLEM INDEX (BPI)	22.15	9.17	<.0001
CAREGIVER STRAIN (CS)	2.56	1.57	<.0001

Note: Orange cells represent a statistically significant difference at the .05 level

Table 10.6. Survival Analysis Predicting Foster Care Reentry after Adoption or Guardianship

	VERMONT			NEW JERSEY			TENNESSEE			ILLINOIS			ALL FOUR SITES TOGETHER		
	HR*	95% HR CONFIDENCE		HR	95% HR CONFIDENCE		HR	95% HR CONFIDENCE		HR	95% HR CONFIDENCE		HR	95% HR CONFIDENCE	
FEMALE	0.89	0.67	1.19	1.08	0.94	1.24	0.95	0.80	1.13	0.95	0.86	1.04	0.98	0.92	1.05
CHILD OF COLOR	0.81	0.30	2.19	1.20	1.03	1.39	0.94	0.78	1.13	1.29	1.09	1.54	1.06	0.98	1.15
CHILD ACHIEVED PERMANENCY AT THE AGE OF 6 OR OLDER	3.90	2.76	5.52	2.08	1.79	2.42	15.67	11.66	21.06	2.73	2.41	3.09	2.90	2.67	3.16
CHILD SPENT THREE OR MORE YEARS IN FOSTER CARE	1.05	0.77	1.44	0.70	0.60	0.82	1.13	0.94	1.35	1.04	0.91	1.19	0.95	0.88	1.03
CHILD HAD 3 OR MORE MOVES WHILE IN FOSTER CARE	1.37	1.02	1.83	3.01	2.58	3.50	1.63	1.37	1.94	1.41	1.26	1.57	1.66	1.54	1.78
NUMBER OF OBSERVATIONS USED IN MODELS	2,779			19,493			12,012			25,532			59,816		

Note: HR stands for Hazard Ratio.