

Evaluation Results from

New Jersey

Final Evaluation Report



September 2019

QIC•AG

National Quality Improvement Center for
Adoption & Guardianship Support and Preservation

Chapter 5: New Jersey

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 (New Jersey is Chapter 5), and a cross-site evaluation (Chapter 10). The chapter numbers reflect the chapters designated in the full report.

This report 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. We thank them for their partnership and dedication to the work of translational research.



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The QIC-AG was funded through a five-year cooperative agreement between the Children's Bureau, Spaulding for Children, and its partners the University of North Carolina at Chapel Hill, the University of Texas at Austin and the University of Wisconsin-Milwaukee.

Report Authors

Kerrie Ocasio, PhD | Assistant Professor
Department of Graduate Social Work
West Chester University

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

Kevin White, PhD | Assistant Professor
School of Social Work
East Carolina University

Young Cho, PhD | Associate Professor
Community and Behavioral Health Promotion, Joseph J. Zilber School of Public Health
University of Wisconsin-Milwaukee

Roni Diamant-Wilson, PhD | Post-Doctoral Fellow
Helen Bader School of Social Welfare
University of Wisconsin-Milwaukee

Michael J. MacKenzie, PhD | Canada Research Chair in Child Well-Being (Tier 1)
Full Professor of Social Work, Psychiatry and Pediatrics
School of Social Work, McGill University

Brett Greenfield, MSW, MDiv | PhD student
School of Social Work
Rutgers, The State University of New Jersey

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

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We would like to acknowledge the staff at the Office of Adoption Operations within the State of New Jersey, Department of Children and Families, Division of Child Protection and Permanency. The site team leaders and Site Implementation Manager (SIM) who guided this work, in addition to their other roles within the agencies they work. Your partnership made this project a success.

The QIC-AG site consultants worked closely with the evaluation team to ensure the project work was implemented with integrity. Thank you for the collegial team work. In addition, special thanks to Dr. Cassandra Simmel, Rutgers University, who helped with the project transitions during staffing changes.

A special appreciation goes to Dr. Sophie Havighurst, a purveyor of TINT, who supported the site in adapting their model for this study.

Evaluation Results from New Jersey



PROJECT PARTNERS

QIC-AG partnered with the **Office of Adoption Operations within the State of New Jersey, Department of Children and Families, Division of Child Protection and Permanency.**

CONTINUUM PHASE

Selective

INTERVENTION

CP&P implemented **Tuning in to Teens (TINT)**. TINT is an evidence-based emotion coaching program designed to proactively prepare parents to support their teens in managing the complex developmental tasks of adolescence by developing the youth's emotional intelligence.

STUDY DESIGN

Experimental: Randomized Controlled Trial

The target population was **children ages of 10 to 13 years old whose caregivers were receiving an adoption or Kinship Legal Guardianship (KLG) subsidy and were not open for DCF services. Children had either previously been in group care or were between the ages of 6 and 13 at the time of finalization.**

RESEARCH QUESTION

Will children currently between the ages of 10 and 13 who are receiving an adoption or Kinship Legal Guardianship (KLG) subsidy, are not open for services with DCF, and meet one of the following criteria: at the time of finalization were between the ages of 6 and 13, or were in group care while in foster care experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health if they receive Tuning in to Teens (TINT) compared to similar children who receive services as usual?

Findings



443 FAMILIES
ASSIGNED TO THE
COMPARISON GROUP



187
COMPARISON
GROUP CAREGIVERS
COMPLETED THE
OUTCOME SURVEY

769 FAMILIES
ASSIGNED TO THE
INTERVENTION GROUP

442 (57%)
SUCCESSFULLY
CONTACTED



62
TINT CAREGIVERS
COMPLETED 4+
SESSIONS AND THE
OUTCOME SURVEY

RECRUITMENT & PARTICIPATION

Families who participated in TINT were different than families who did not participate in the intervention. Specifically, families who received the intervention were:

- more likely to struggle to effectively manage their child's behavior; and
- less confident that they could meet their child's needs.

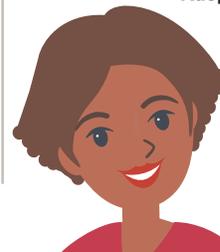
OUTCOMES

This study found no statistically significant differences between TINT families and comparison group families on primary outcomes but an improvement was observed in parents' felt ability to better manage their child's behavior. The figure below shows the slope of line is steeper for TINT families which suggests they improved more than families in the comparison group. Although this difference wasn't statistically significant, promising trends suggest that with additional time, statistically significant differences may emerge.



WHAT CAREGIVERS HAD TO SAY...

Adoption and guardianship was a positive experience!



"Adopting our son has been the single best decision we have made in our lives."

"Great experience. Would do it again if I had to."

It was also a challenging experience.

Many caregivers reported that having adopted or assumed guardianship of a child was challenging, particularly if the child had a mental health condition. Caregivers wrote that not only did caseworkers need to be "better equipped to help adoptive parents," but also shared a strong need for the improvement of the training required in order to become an adoptive parent or guardian. They pointed out that having more support from the child welfare system "especially during the teenage years" was essential.



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

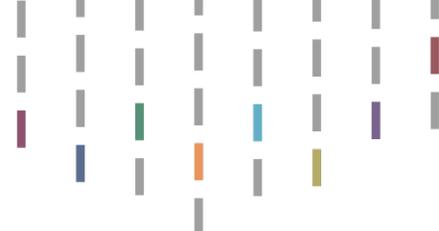
This research summary was designed by staff at the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work, in conjunction with the Jack, Joseph and Morton Mandel School of Applied Social Sciences at Case Western Reserve University.

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



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Executive Summary

Overview

The New Jersey Division of Child Protection and Permanency (CP&P), the public child welfare agency in the State, works to achieve permanence for the children and youth who are in state custody. Housed within CP&P, the Office of Adoption Operations provides services for pre adoption preparation and post adoption and kinship legal guardianship. Analysis of the available administrative data from New Jersey found that children who experienced post permanency discontinuity were typically between the ages of 14 and 16, suggesting that adolescent developmental challenges increased the risk of discontinuity. The New Jersey site team of the National Quality Improvement Center for Adoption and Guardianship Support (QIC-AG) therefore focused its efforts on adolescents whose caregivers were receiving an adoption or Kinship Legal Guardianship (KLG) subsidy and were not open for services with CP&P. No existing evidence-based intervention to date addresses the New Jersey QIC-AG Theory of Change regarding adolescent development in the adoption context. New Jersey's QIC-AG study consisted of replicating and adapting Tuning in to Teens (TINT), an intervention previously tested with a general teen population, to determine whether the model could prevent post permanency discontinuity and improve wellbeing for families formed through adoption or guardianship.

The study's Theory of Change postulated that there are developmental tasks in adolescence that may be complicated by adoption or guardianship. Adoptive or KLG families may be unprepared to address these unique challenges. Therefore, by increasing their skills and knowledge associated with caring for youth as they enter adolescence (i.e., through skills acquired with TINT), parents and guardians would increase their capacity to address the issues within their families and increase post permanency stability. The adapted intervention was within the Selective Interval of the QIC-AG Permanency Continuum Framework, in the **Replicate and Adapt** phase of the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*.

Intervention

Tuning in to Teens (TINT), an evidence-based intervention developed in Australia, is an emotion coaching program designed to proactively prepare parents to support their teens in managing the complex developmental tasks of adolescence by developing the youth's emotional intelligence. The intervention teaches parents to understand the reasons youth react with hostility or withdrawal and improves parents' skills in managing their own angry reactions. When parents refrain from responding angrily, the escalation of youth's emotions are reduced, and this allows for a connected relationship between parent and youth.

The coaching program consisted of six two-hour weekly sessions. Given the additional complexities associated with adoptive and guardianship families, a seventh week was added to the adapted curriculum. The core theoretical overview of emotion coaching, as well as the formation of the group, was purported to occur within the first two weeks. Therefore, parents could not be added to the group after the second week. The intervention was held in strategically targeted communities across the state. Community locations were selected based on where the largest proportions of families resided or the experienced the greatest needs.

Primary Research Question

The primary research question for this study was:

Will children currently between the ages of 10 and 13 who are receiving an adoption or KLG subsidy, are not open for services with DCF, and meet one of the following criteria: at the time of finalization were between the ages of 6 and 13, or were in group care while in foster care experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health if they receive Tuning in to Teens (TINT) compared to similar children who receive services as usual?

Secondarily, this study examined pre-post intervention surveys to understand whether the intervention, which was a general population program adapted for the post permanency population, performed similarly with the previous research conducted about TINT. Additionally, families in both the comparison and intervention groups were asked a set of key questions related to their familial relationships, which was explored to determine differences between the intervention and comparison groups.

An experimental design was used to determine whether TINT in New Jersey was effective in reducing post permanency discontinuity and increasing the wellbeing of parents and youth. Families in the treatment group (those who received TINT) were compared to (1) all children in the comparison group and (2) a subset of the comparison group that was matched to the treatment group on key characteristics (called a matched comparison group). Participants in the treatment and comparison groups were asked a set of key questions related to their familial relationships to determine whether the intervention affected measures of elevated risk. Pre-post intervention surveys were examined to understand whether the intervention performed similarly with the previous research related to TINT.

Key Findings and Discussion

RECRUITMENT & FIDELITY

Key findings related to recruitment and fidelity are summarized below.

- Outreach was made to families in the 769 families assigned to the intervention group. Staff successfully contacted 442 families (57% of the intervention group). A total of 178 families (23% of the intervention group) registered for the intervention, and 94 (12% of the intervention group) participated in the intervention (at least 4 sessions, the minimum suggested by the purveyor to observe an intervention effect).
- Recruitment efforts were most beneficial the first time the intervention was available to the family, and there was a diminished return on investment with repeated intensive outreach efforts.
- Families who participated in TINT (TINT participants) were different than families who did not participate in the intervention. Specifically, families who received the intervention were: 1) more likely to struggle to effectively manage their child's behavior, and 2) less confident that they could meet the needs of their child, compared to families who did not receive the intervention.

- Review of the fidelity reports found that the intervention was delivered with a high level of fidelity. TINT participants received, on average, 94% of the core content.

In sum, this study found that successful contact by the program was made with a significant proportion of adoptive and KLG families in New Jersey (57%). These families may not have had contact from the child welfare system for many years, some up to a decade. This suggests that families are willing to engage with the child welfare system, even years after adoption or guardianship finalization.

Most of the families in the target population did not engage in services: 94 (12%) of the intervention group participated in the full intervention. Offering sessions multiple times in the same community, and additional follow-up calls to remind families of the upcoming TINT session they had registered for, did not yield additional intervention uptake.

Of the families who registered for TINT, the vast majority of families (85%) completed the program. Furthermore, families who reported they were struggling were likely to participate in the intervention. The intervention was offered with a high level of fidelity.

INTERVENTION-SPECIFIC OUTCOMES

At the completion of the evaluation, not many families had completed the TINT-specific surveys. This limits our ability to compare the results of TINT in this study with the results of TINT with other populations (e.g., a general population). For instance, while an increase (from pre TINT to post TINT) was noted in youth appraisal of parent responsiveness, suggesting that parents and guardianship who participated in TINT were more responsive after participating in TINT than before, caution should be used in interpreting these results as they were based on 11 responses.

PRIMARY OUTCOMES

Primary outcomes refer to the comparisons between families who received TINT, and families who received services as usual (the comparison group). This is the strongest evaluation design because it used a randomized controlled trial.

- No statistically significant differences were found between the TINT intervention participants who had outcome data ($n = 62$) and the overall comparison group who had outcome data ($n = 187$). Similarly, no statistically significant difference was found between the TINT participants ($n = 31$) and a matched sample of the comparison group ($n = 31$) on the key short-term measures of child and family wellbeing that are related to longer-term discontinuity. However, promising trends suggest that with additional time, statistically significant differences may emerge.
- Results found improvement in parents' self-reported ability to better manage their child's behavior, approaching a statistically significant difference. Therefore, while the primary outcomes measured did not detect statistically significant improvements for the TINT participants, compared to either comparison group, parents and guardians who participated in the intervention tended to feel better able to manage their child's behavior. This is an important finding as child behavioral issues are a key factor related to post permanency stability and family wellbeing.

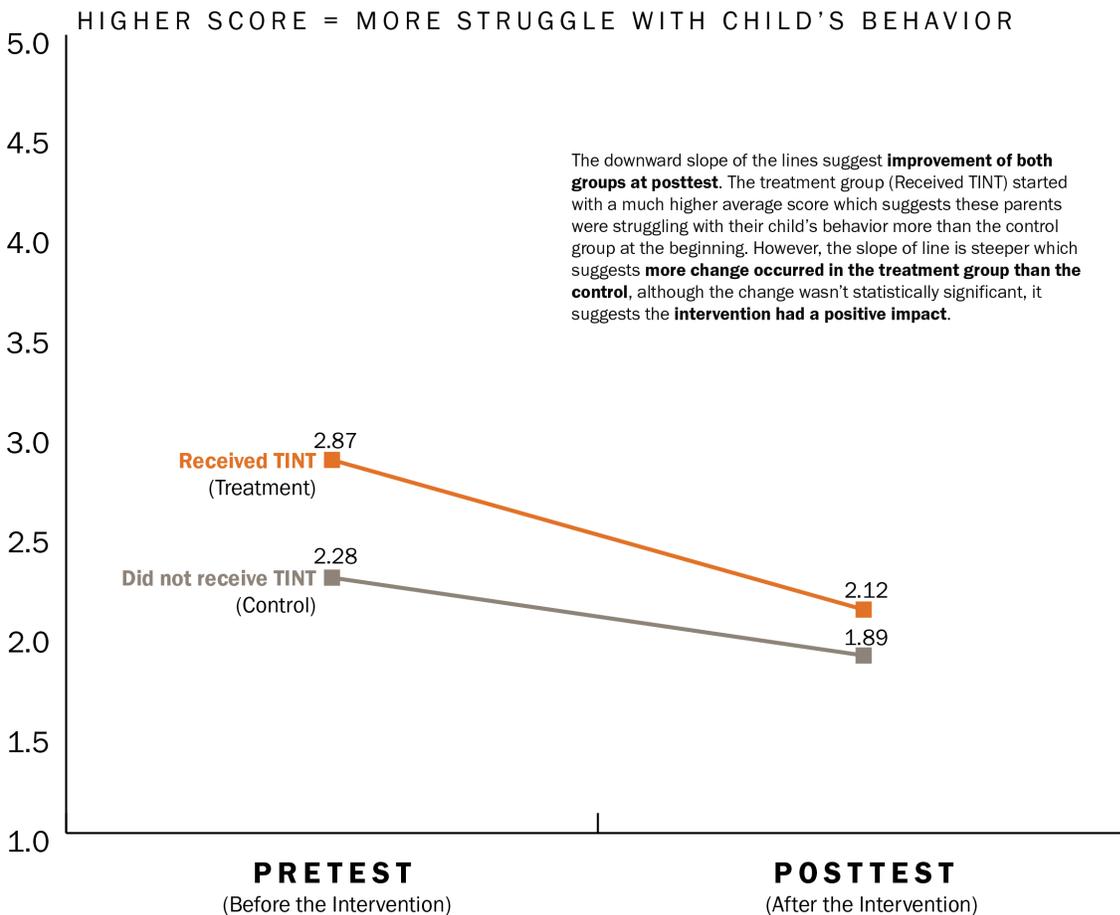
DISCUSSION

This target population in this study was narrowed to a specific group of families who fit the eligibility criteria, yet this group of families was heterogeneous; some reported struggling, and others reported doing well. This is consistent with previous studies on the experience of adoptive and guardianship families that found the majority to be adjusting well (see White, Rolock, Testa, Ringeisen, Childs, Johnson, & Diamant-Wilson, 2018 for a summary of these studies). Importantly, families who reported they were struggling were likely to participate in the intervention. This suggests that families who are struggling would be open to engaging in services. What is unclear is whether TINT is the most effective intervention to offer. Similar to other prevention efforts, preventing adoption and guardianship instability may require a continuum of services that takes into account the diversity of issues families face.

We asked parents and guardians if they had things to share about their adoption or guardianship experiences. Some described their experiences as “very positive.” Others described their experience as challenging and discussed the need for additional resources, preparation, and training for caseworkers. Further, they discussed the need for community-based services, such as school professionals, to be better trained and prepared to support children’s special education and mental health needs. In one case, a parent discussed challenges getting a school to take bullying seriously, which has serious consequences for all children but could be especially challenging for a child that has already experienced significant trauma. Of particular concern to parents were the needs of children with mental health conditions, issues with the biological parents, and the financial strain families experienced after adoption or guardianship finalization. These reflections from parents and guardians clearly underscore the need for additional supports post permanence.

There were several limitations to keep in mind for the QIC-AG evaluation in New Jersey. Most important to interpreting the data were conditions related to response rates and sample size. A small proportion of the eligible population participated in the research. This restricted number of cases for analyses, particularly among those who received the intervention (i.e., just 94 families), meant diminished power to detect statistically significant differences between TINT participants and the comparison groups. In addition, a small observation window to observe changes among the intervention group from enrollment and pretesting to outcome measurement (i.e., about 6 months), made detecting any changes due to the intervention very challenging.

Caregivers Struggled to Manage Child Behavior: Pre and Post Tests



Despite the limitations, this study had important findings. Adoptive parents and KLG families who participated in TINT reported that they felt better able to manage their children's behaviors after completing the intervention. While this change did not reach the level of statistical significance, it is an important finding, particularly because prior research has established that difficulty with challenging child behaviors is associated with post permanency discontinuity (Testa, et al., 2015). However, this study found no statistically significant changes when comparing the TINT participants to the full comparison sample or the matched comparison group on the primary outcomes of interest. It is possible that with additional time and more families enrolled, different results regarding the TINT intervention may have emerged. Personal and interpersonal change is difficult and takes time, especially given the long history of trauma that many adoptive and guardianship youth have experienced due to maltreatment and previous placement moves (Jones & Schulte, 2019). Following up with families and administrative data on return to care would be helpful to determine whether outcomes improved with the benefit of additional time for change to occur.

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.

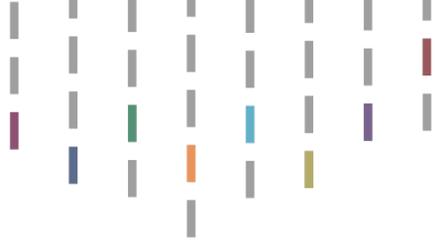
Child welfare jurisdictions interested in targeted outreach to adoptive or guardianship families may consider periodically checking in with families to assess their level of caregiver commitment and familial relationship (e.g., the parent or guardian's assessment of how well they can manage their child's 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.



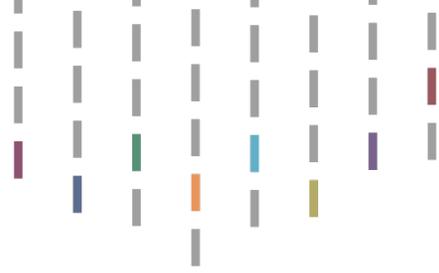
Chapter 1

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QIC-AG Overview

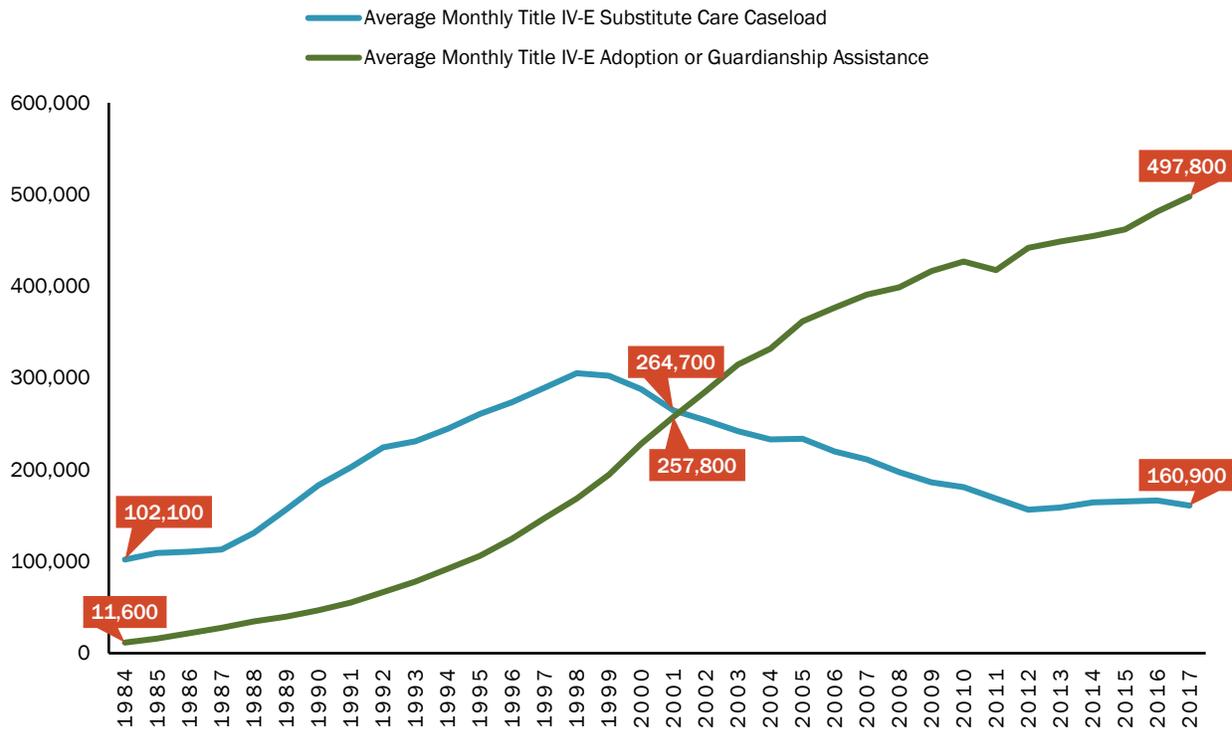
The Children's Bureau, Administration for Children and Families, and Department of Health and Human Service established the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG). In October 2014, the QIC-AG was awarded to Spaulding for Children in partnership 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

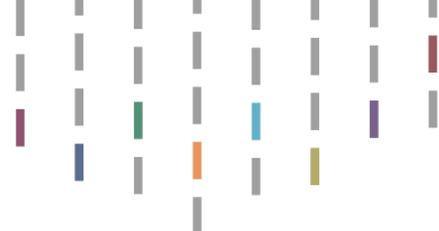


Data sources: The information on federally-funded caseloads are from the Committee on Ways and Means (CWM) of the U.S. House of Representatives and represents the average monthly Title IV-E caseloads.

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.

RESEARCH QUESTION

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**)?

THEORY OF CHANGE

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

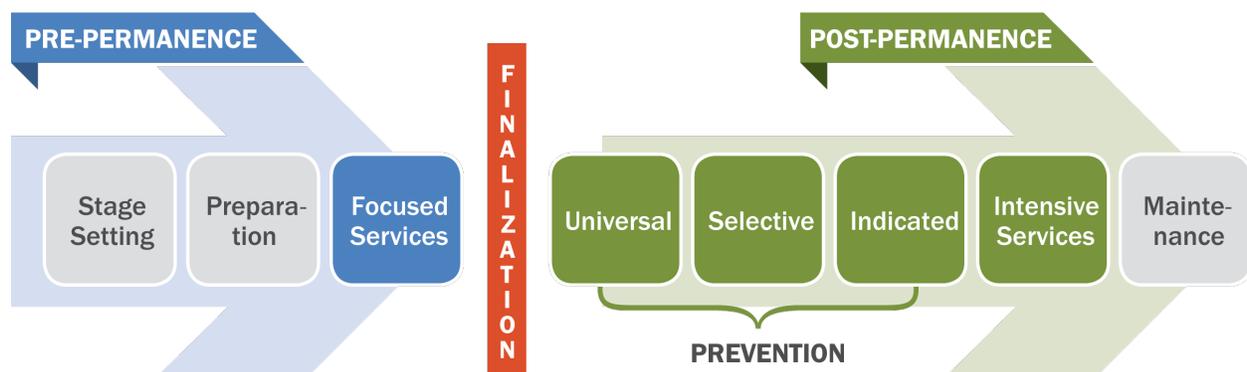
The challenges associated with providing a stable, long-term and permanent home are not consigned to adoptions and guardianships that occur through the child welfare system. Private domestic and intercountry adoptive families can also encounter post permanency disruptions and discontinuity. Children 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.

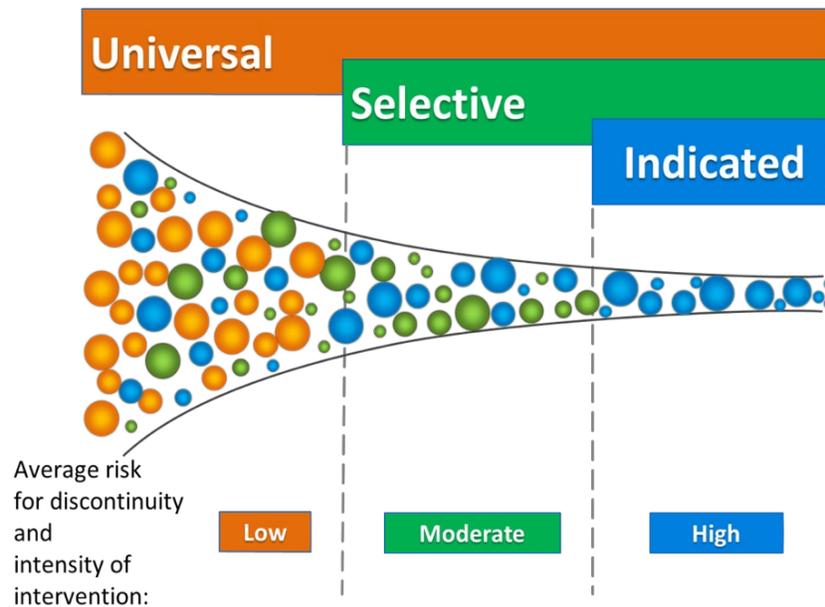
Focused Services

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).

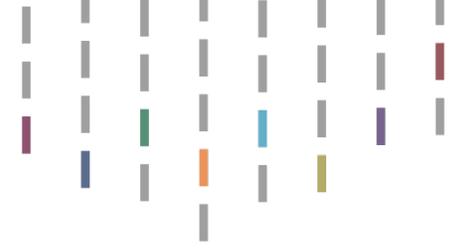
For the QIC-AG project, **Indicated** prevention efforts were defined as services that target families who request assistance to address an issue that has arisen after permanence has been achieved, but before the family is in crisis. For instance, when families call an agency with a question about a 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.

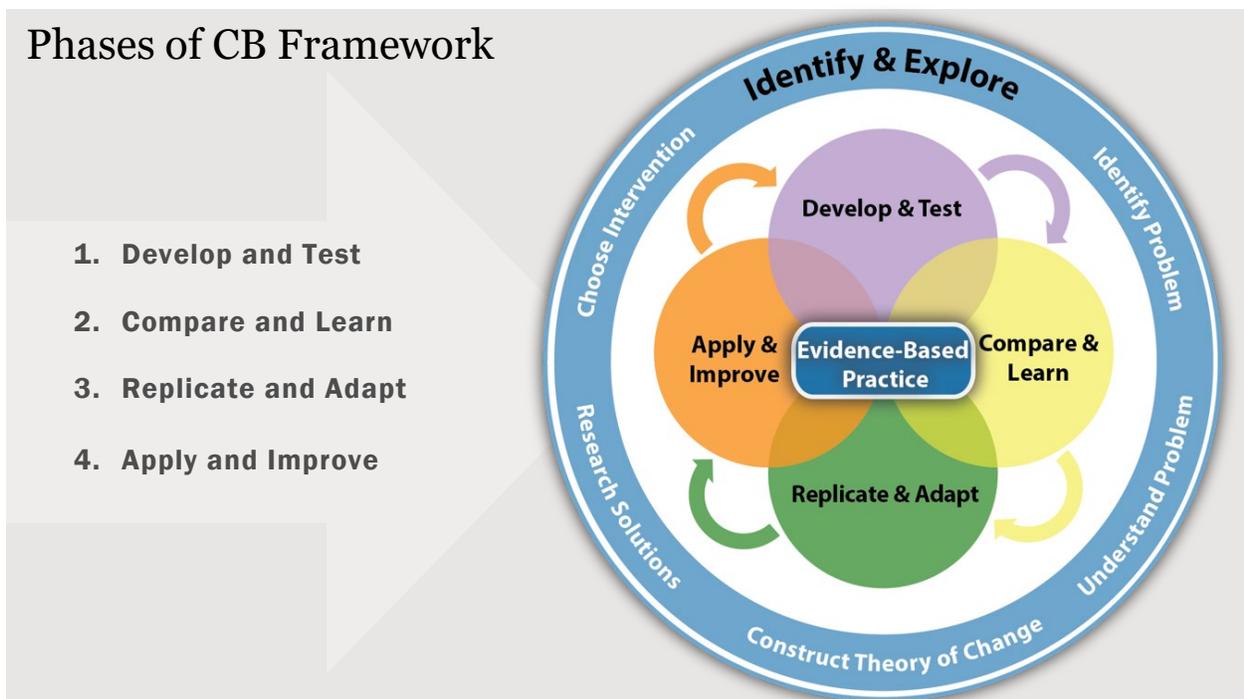
Guiding Frameworks

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



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

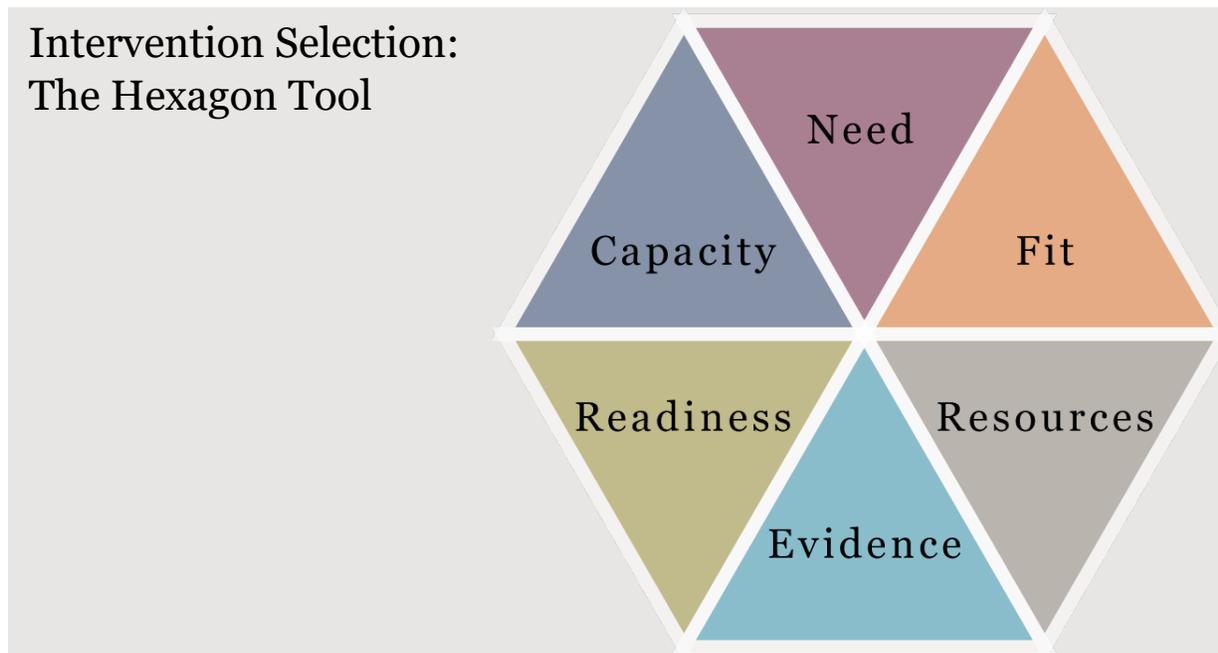


Table 1.1. Site, Target Population, Intervention and Study Design

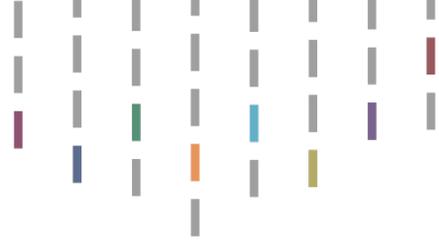
SITE	INTERVENTION	STUDY DESIGN
TARGET POPULATION: GROUP 1		
WINNEBAGO TRIBE	Family Group Decision Making (FGDM)	Descriptive
TEXAS	Pathways 2 Permanence	Quasi-Experimental
TARGET POPULATION: GROUP 2		
VERMONT	Vermont Permanency Survey	Descriptive
ILLINOIS	Trauma Affect Regulation: Guide for Education & 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.

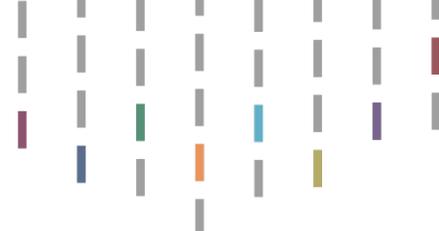
Outcomes across Target Group 2 sites are summarized in the final chapter, the **Cross-Site Evaluation**. The QIC-AG evaluation team also conducted a **Cost Evaluation** for each site. These findings are embedded in each site report.



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 5

NEW JERSEY: TUNING IN TO TEENS (TINT)

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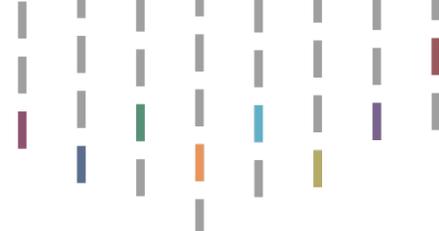
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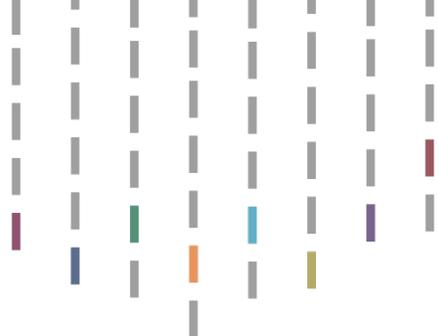
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Site Background

The New Jersey Division of Child Protection and Permanency (CP&P) is the public child welfare agency in the State that investigates allegations of child abuse and neglect, administers the state's foster care system, and works to achieve permanence for the children and youth who are in state custody. Housed within CP&P, the Office of Adoption Operations provides services for pre adoption preparation and post adoption and kinship legal guardianship. In 2015, an average of 225 trained adoption caseworkers were located in 46 local offices (New Jersey Department of Children and Families Adoption Report, 2016). Adoption workers offer adoption-related services, including preparing and placing children into adoptive homes, providing services to birth parents and attending court hearings. Workers are supported by regional and field specialists.

The Office of Adoption Operations identifies two types of adoptions:

1. **Kinship adoption**, where a child is adopted by a relative.
2. **Unrelated resource home adoption**, where a child is adopted by the unrelated foster parent that they were placed with while in care and prior to the decision to terminate parental rights (New Jersey Department of Children and Families Adoption Report, 2016).

Another permanency option is Kinship Legal Guardianship (KLG) where a child placed with a relative resource parent assumes the same rights and responsibilities of a birth parent and the birth parent no longer has legal custody of their child, but their parental rights are not terminated. The majority (98%) of adoption and KLG families receive a subsidy from CP&P (New Jersey Department of Children and Families Adoption Report, 2016).

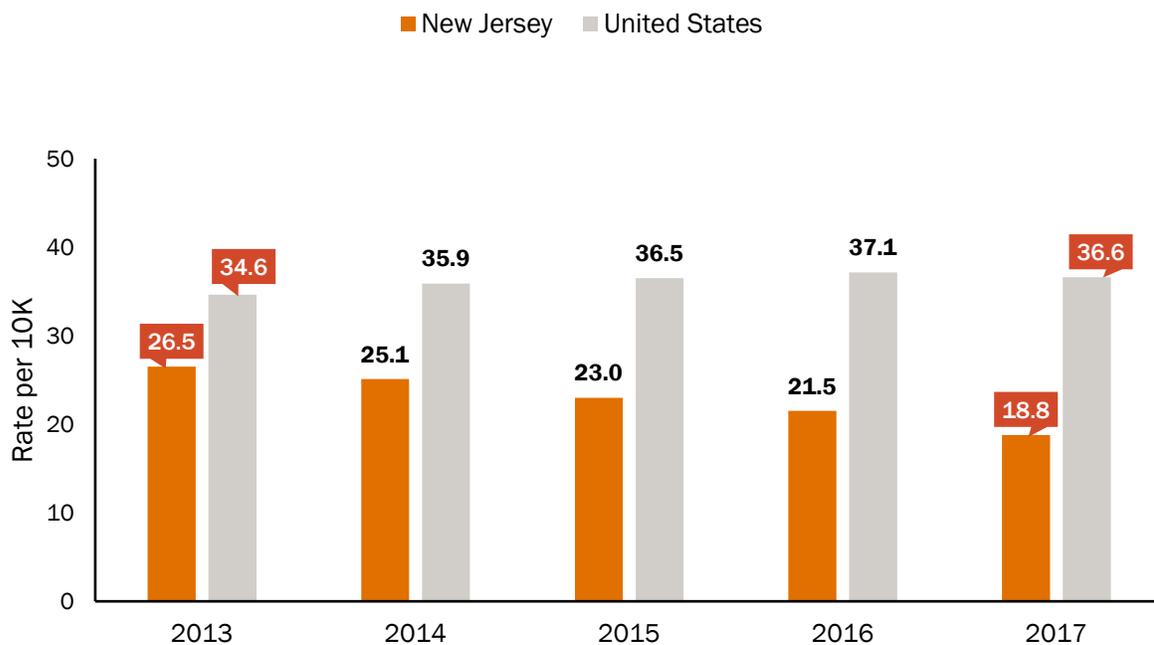
CP&P has engaged in a number of efforts to enhance adoption skills of staff and improve adoption services. In 2007, the DCF Office of Training and Professional Development (OTPD) partnered with the Institute of Families at the Rutgers School of Social Work to offer an adoption certificate program to adoption workers and students in the child welfare track. Through an attachment-based family-focused lens, the certificate program includes a series of 12 workshops focused on core issues adoptive families face (Rutgers School of Social Work website, 2018). Additionally, in 2014, the Office of Adoption Operations was awarded a federal grant to support the New Jersey Collaborative Adoption Recruitment Education and Support (NJ-CARES). The goal of the NJ-CARES initiative was to identify long-term permanent connections and strengthen recruitment efforts for children legally freed for 18-months or longer without an identified permanent home (New Jersey Department of Children and Families Adoption Report, 2016).

The purpose of this study was to adapt and test an intervention intended to prevent post permanency discontinuity for children determined to be at-risk due to adolescent development challenges. The Theory of Change postulates that there are developmental tasks in adolescence that may be complicated by adoption or guardianship. Adoptive or KLG families may be unprepared to address these unique challenges. By increasing the skills and knowledge associated with caring for youth as they enter adolescence (i.e., the prevention program TINT), parents/guardians would increase their capacity to address the issues within their families. Meeting the needs of youth would then increase post permanency stability.

National Data: Putting New Jersey in Context

The data in this section is provided to put the New Jersey QIC-AG site in context with national data. Through comparing data from New Jersey to that of the nation, we are able to understand if New Jersey 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 IV-E adoption or guardianship assistance. These comparisons are provided over the past five years to give a sense of recent trends.

Figure 5.1. New Jersey Foster Care Entry Per Capita Rate (2013 – 2017)

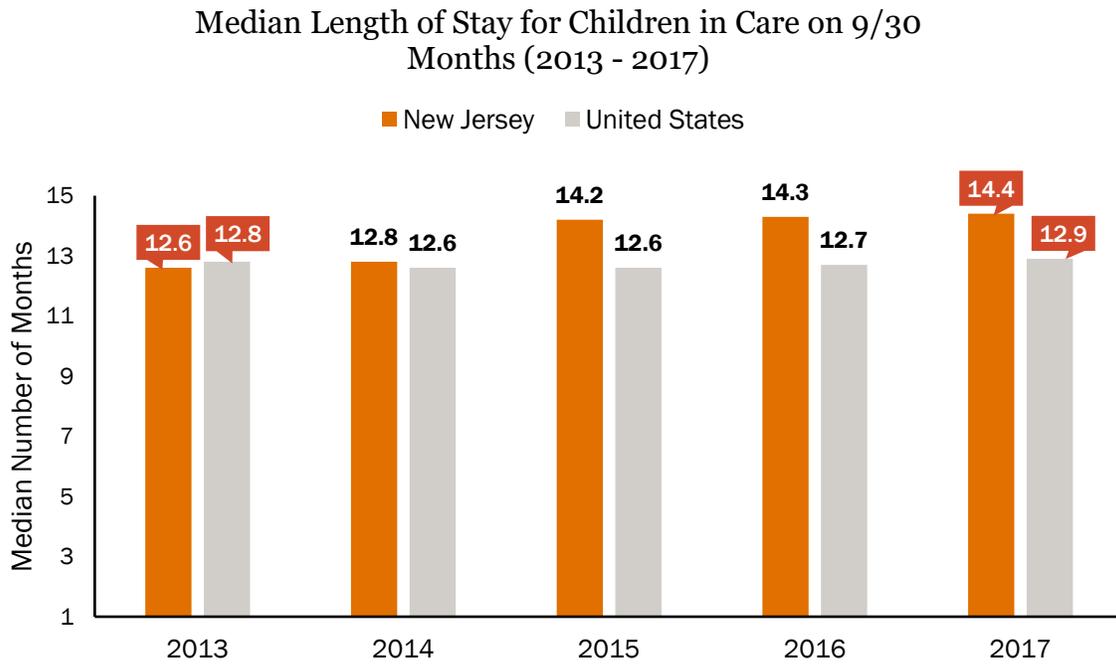


DATA SOURCE: UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION FOR CHILDREN AND FAMILIES, ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES BUREAU, [HTTPS://CWOUTCOMES.ACF.HHS.GOV/CWODATASITE/](https://cwoutcomes.acf.hhs.gov/cwodatasite/)

As displayed in Figure 5.1, between Fiscal Years 2013 and 2017, the rate¹ of children entering foster care in New Jersey decreased as the rate of children entering foster care in the U.S. increased. Between 2013 and 2017, the state's foster care entry rate decreased from 26.5 per 10K (5,361 children) to 18.8 per 10K (3,726 children). This per capita rate is 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. Thus, fewer children, per capita, entered foster care in New Jersey over each of the five years than in the U.S.

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>).

Figure 5.2. New Jersey Median Length of Stay for Children in Foster Care as Measured in (2013 – 2017)

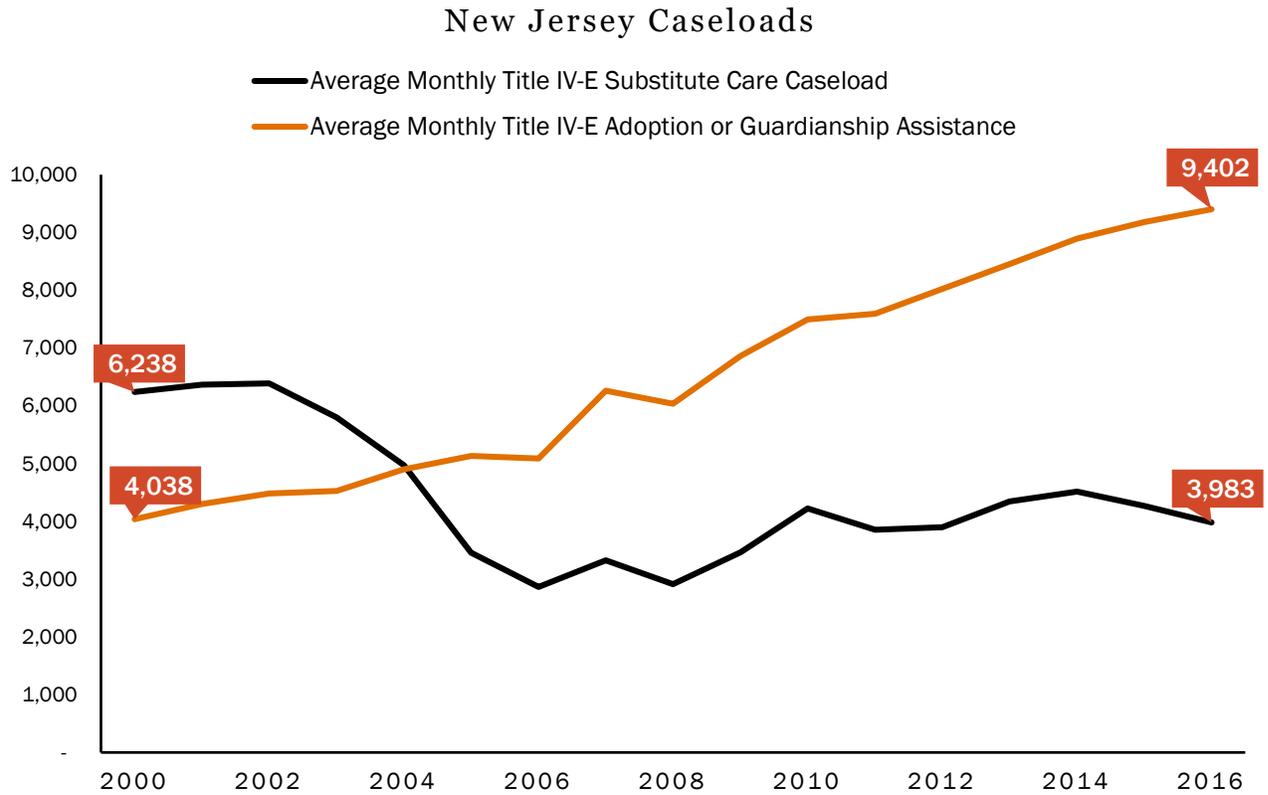


DATA SOURCE: UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION FOR CHILDREN AND FAMILIES, ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES BUREAU, [HTTPS://CWOUTCOMES.ACF.HHS.GOV/CWODATASITE/](https://cwoutcomes.acf.hhs.gov/cwodatasite/)

Between 2013 and 2017, the median length of stay for children in foster care at the end of each year (shown in Figure 5.2) increased for New Jersey and decreased slightly in the U.S. The length of stay increased in New Jersey from 12.6 months in 2013 to 14.4 months in 2017 while in the U.S. it increased slightly from 12.8 months in 2013 to 12.9 months in 2017.

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 5.3, the number of children in New Jersey in IV-E funded foster care and the number of children in IV-E funded adoptive homes in 2000 was 6,238 and 4,038 respectively. In 2016 these numbers were 3,983 children in IV-E funded substitute care and 9,402 children in IV-E funded adoptive homes.

Figure 5.3. New Jersey Caseloads, 2000-2016



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).

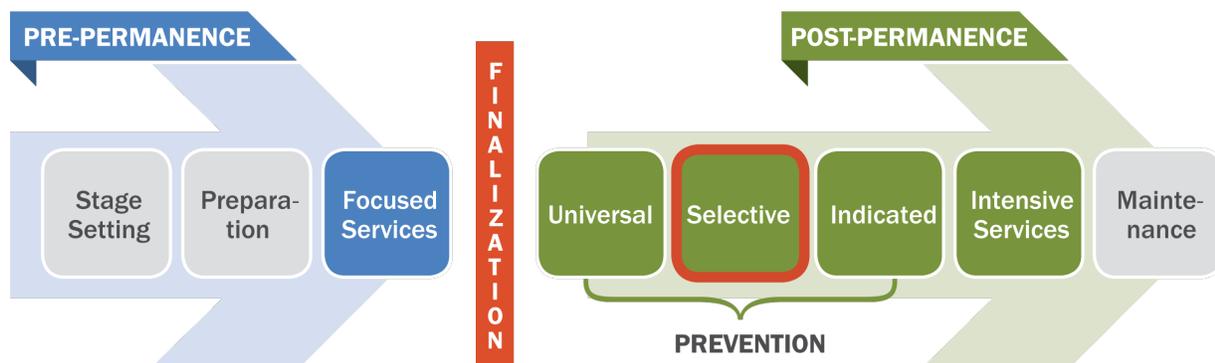
QIC-AG Permanency Continuum Interval

New Jersey is implementing an intervention within the **Selective Interval** of the QIC-AG Permanency Continuum Framework.

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 and/or have experienced multiple moves.

Figure 5.4. New Jersey QIC-AG Permanency Continuum





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) for the New Jersey site was:

Will children currently between the ages of 10 and 13 who are receiving an adoption or KLG subsidy, are not open for services with DCF, and meet one of the following criteria: at the time of finalization were between the ages of 6 and 13, or were in group care while in foster care (**P**) experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health (**O**) if they receive Tuning in to Teens (TINT) (**I**) compared to similar children who receive services as usual (**C**)?

Each component of the PICO described below.

Target Population

Analysis of the available administrative data from New Jersey found that children who experienced post permanency discontinuity were typically between the ages of 14 and 16.

Thus, given the QIC-AG project's focus on prevention, the site team decided to focus on children between the ages of 10 and 13 whose caregivers were receiving an adoption or Kinship Legal Guardianship (KLG) subsidy and were not open for services with CP&P. The target population was inclusive of all youth regardless of race or ethnicity. In addition, two other factors associated with an increased likelihood of experiencing post permanency discontinuity were identified:

- Having been placed in a shelter, treatment home, or congregate care (i.e. group care) while in out of home care, and
- Entering the subsidy between ages 6-13.

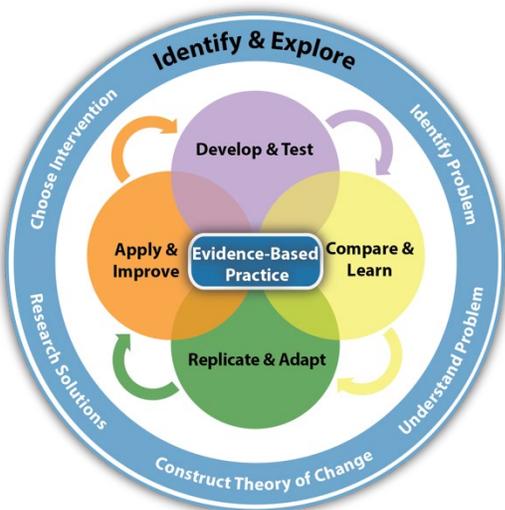
Children and families who met any of the following criteria were excluded from the study:

- A family with a child identified in open child protective service (CPS) and child welfare service (CWS) case, and/or
- Child (adopted or KLG) not living in their adoptive or guardianship home.

A family that is Non-English speaking was exclusionary. A Spanish version of the curriculum was developed and implemented during the final year of the project, however, these families were not involved in the research.

The intervention was held in strategically targeted communities across the State. Community locations were selected based on where the largest proportions of families resided or the experienced the greatest needs. A deliberate attempt was made to offer the intervention across the state, in locations accessible to families formed through adoption and guardianship.

Intervention



The intervention selection process in New Jersey found no evidence-based interventions that addressed both the adolescent developmental context and the adoption context identified as critical in the exploration phase of the project. It was determined that Tuning in to Teens (TINT), a model developed in Australia that teaches parents the technique of mindful emotion coaching when engaging with their adolescent, was the best fit for New Jersey.

This intervention was selected specifically because it addresses the adolescent developmental context identified as a primary risk factor for discontinuity. Adaption would be needed, however, to include the adoption context. According to *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*, the **Replicate and Adapt** phase should result

in “widespread, consistent, and appropriate implementation of the adopted intervention with other populations and in other contexts that continue to achieve the desired outcomes” (Framework Workgroup, p. 4). Therefore, it was determined that adaption should include the purveyor of TINT and additional steps to ensure the appropriateness of the adaptation.

The New Jersey QIC-AG site team felt a key consideration for this phase of intervention was to understand how TINT could be delivered to a population that was different than the populations it had previously been tested with, and if it could achieve the same positive results with adoptive and guardianship families as had been seen with other groups.

The QIC-AG team felt if TINT was successful with adoption and guardianship families, it would provide DCF a tool for proactively intervening with families and improving post permanency stability by increasing the emotional competence of youth and preparing families to successfully meet the challenges that may emerge during adolescence.

TUNING IN TO TEENS

TINT is an emotional coaching program designed to proactively prepare parents to support their teens in managing the complex developmental tasks of adolescence by developing the youth’s emotional intelligence. TINT teaches parents to understand the reasons youth react with hostility or withdrawal and improves parents’ skills in managing their own angry reactions. When parents refrain from responding angrily, the escalation of youth’s emotions are reduced, and this allows for a connected relationship between parent and youth. TINT has been shown to increase parents’ capacity to understand and respond effectively to their youth’s emotions and improve their youth’s emotional competence (Havighurst, Kehoe & Harley, 2015). Under the supervision of the purveyor (Sophie Havighurst), the Australian model was adapted to ensure the curriculum addressed the special dynamics common to families formed by adoption and guardianship.

Structure

The coaching consisted of seven, two-hour weekly sessions. There was a lot of material to cover in seven sessions, and therefore, facilitators needed to utilize the required time efficiently, yet stay and meet parents where they were. Activities that were missed in a session could be added to a later session. The core theoretical overview of emotion coaching, as well as the formation of the group, was purported to occur within the first two weeks. Therefore, parents could not be added to the group after the second week.

Table 5.1 depicts the goals of the original six-week session format. For the adaptation with adoptive and guardianship parents, the material traditionally covered in the sixth week was moved to the seventh week. During the sixth week, content was added to further address parental rejection sensitivity, understanding anger and meta-emotion, and managing conflict with the teen or between sibling groups.

Table 5.1. TINT Sessions and Goals-Six Week Format

TINT SESSION	KEY SESSION GOALS
1) FOUNDATIONS OF EMOTION COACHING TEENS	<ul style="list-style-type: none"> ✓ Engagement ✓ Normalizing parent and adolescent ✓ Psychoeducation (emotional intelligence) ✓ Introduction of emotional coaching ✓ Tuning in to low-intensity emotions ✓ Learn about the importance of having mental maps of teen ✓ Changes in the parent-child relationship; parent's role (from manager to consultant)
2) CONNECTING AND EMOTIONAL ACCEPTANCE	<ul style="list-style-type: none"> ✓ Increase parents' awareness of own emotions ✓ Psychoeducation: Adolescent emotional development ✓ Explore beliefs and feelings about emotions (meta-emotion) and how this affects parenting ✓ Becoming aware of and tuning in to teens emotions ✓ Recognizing opportunities to connect ✓ Learn and practice reflecting and labeling feelings (emotion coaching)
3) BUILDING INTIMACY AND SHOWING EMPATHY	<ul style="list-style-type: none"> ✓ Increase parent's awareness of own emotions ✓ Psychoeducation: Empathy ✓ Build an empathic understanding ✓ Understanding the difference between emotion dismissing and emotion coaching ✓ Recognize feelings behind statements and behaviors ✓ Manage rejection ✓ Sitting with emotions and staying alongside the young person with acceptance ✓ Learn and practice empathic reflective listening skills (emotion coaching)
4) EMOTION COACHING ADOLESCENT WORRY AND SADNESS	<ul style="list-style-type: none"> ✓ Consolidate the skills of emotion coaching for stronger intensity emotions ✓ Psychoeducation: (Self-care; Anxiety) ✓ Emotion regulation and anxiety ✓ Increase awareness of the importance of own emotional awareness/regulation ✓ Increase awareness of the developmental effects of criticism on teens ✓ Practice emotion coaching anxiety and sadness ✓ Problem-solving
5) EMOTION COACHING ANGER	<ul style="list-style-type: none"> ✓ Consolidate the skills of emotion coaching for stronger intensity emotions ✓ Psychoeducation: Anger ✓ Managing own anger and feelings of rejection ✓ Responding to teens anger ✓ Emotion regulation and anger ✓ Recognize emotion coaching opportunity/when not to emotion coach ✓ Practice emotion coaching anger ✓ Managing conflict and sibling fighting
6) EMOTION COACHING NOW AND IN THE FUTURE.	<ul style="list-style-type: none"> ✓ Review main areas of the program and further consolidate emotion coaching ✓ Understanding different parenting styles ✓ Practicing emotion coaching and problem-solving ✓ Where to find support in the local area

Kehoe (2014), p. 56.

Parent emotion coaching was delivered by a pair of co-facilitators who were experienced in working with families and addressing emotionally latent material. TINT facilitators were current post adoption counseling clinicians, former PAC clinicians and experienced child welfare workers who completed the Adoption Certificate Program. A total of 24 facilitators were trained, with even representation from the agency and private providers. Of those, 22 facilitated at least one cohort.

Each of the six sessions work to develop a specific understanding of practice skills and followed a prescribed format:

- Warm-up
- Home activity review
- Teaching including goals, rationale and procedural steps which could include exercises, role-play, and optional material

Each session concluded with preparing parents to complete their home activity. The handouts and homework activities were compiled into binders with additional pages for journaling.

The goal of the sessions was for adoptive parents and guardians to:

- Be aware of emotions
- Use emotions as opportunities for connecting and teaching
- Listen and accept youth's emotions
- Help youth to label their emotions
- Help youth to problem solve and negotiate boundaries
- Help parents to recognize, accept, label and negotiate their and their youth's emotional responses that are uniquely complicated by the experience of adoption or guardianship.

ADAPTATIONS

In keeping with the **Replicate and Adapt** framework, an Adaptations Workgroup was established as part of the New Jersey QIC-AG team. The Workgroup created an overlay to the existing Australian manual/curriculum to address the needs/issues specific to adoption and guardianship (KLG) populations and adoption competent practices. The overlay included:

- New Jersey TINT target population or children from adoption and guardianship families. The Australian TINT did not have an adoption specific lens.
- Examples of some of the unique issues of adoptive families (both private and public) and kinship guardianship families may experience (e.g., how trauma might be impacting the youth's current behavior; identity issues such as learning and discussing the youth's birth history and birth family; feelings of abandonment and rejection both on the youth's and parents' part; a sense of belonging especially as the youth seeks autonomy during the stage of adolescence, etc.).
- Vignettes and examples reflecting the experiences of adoptive parents and guardians and children.
- Parent handouts so that they were clearly understood.

The Adaptation Workgroup was mindful of the TINT participants' economic status, ethnicity, and family make up compared to parents who participated in previous TINT programs. If adjustments were needed to the manual, these changes were made by the Work Group in consultation with the purveyor before training or during the usability testing phase. In addition, the Adaptations Workgroup recommended that facilitators should have an understanding of the unique needs of families formed by adoption and guardianship, and the flexibility to skillfully address those needs within the coaching sessions.

Comparison

The comparison group was comprised of children who were randomly assigned at the start of the study. Children in these families were not contacted by the program. Families assigned to the comparison group were eligible for services as usual.

Outcomes

Short-term outcomes included:

- Decreased child behavioral issues
- Increased caregiver commitment
- Improved parent or guardian child relationships
- Improved family interactions or belongingness

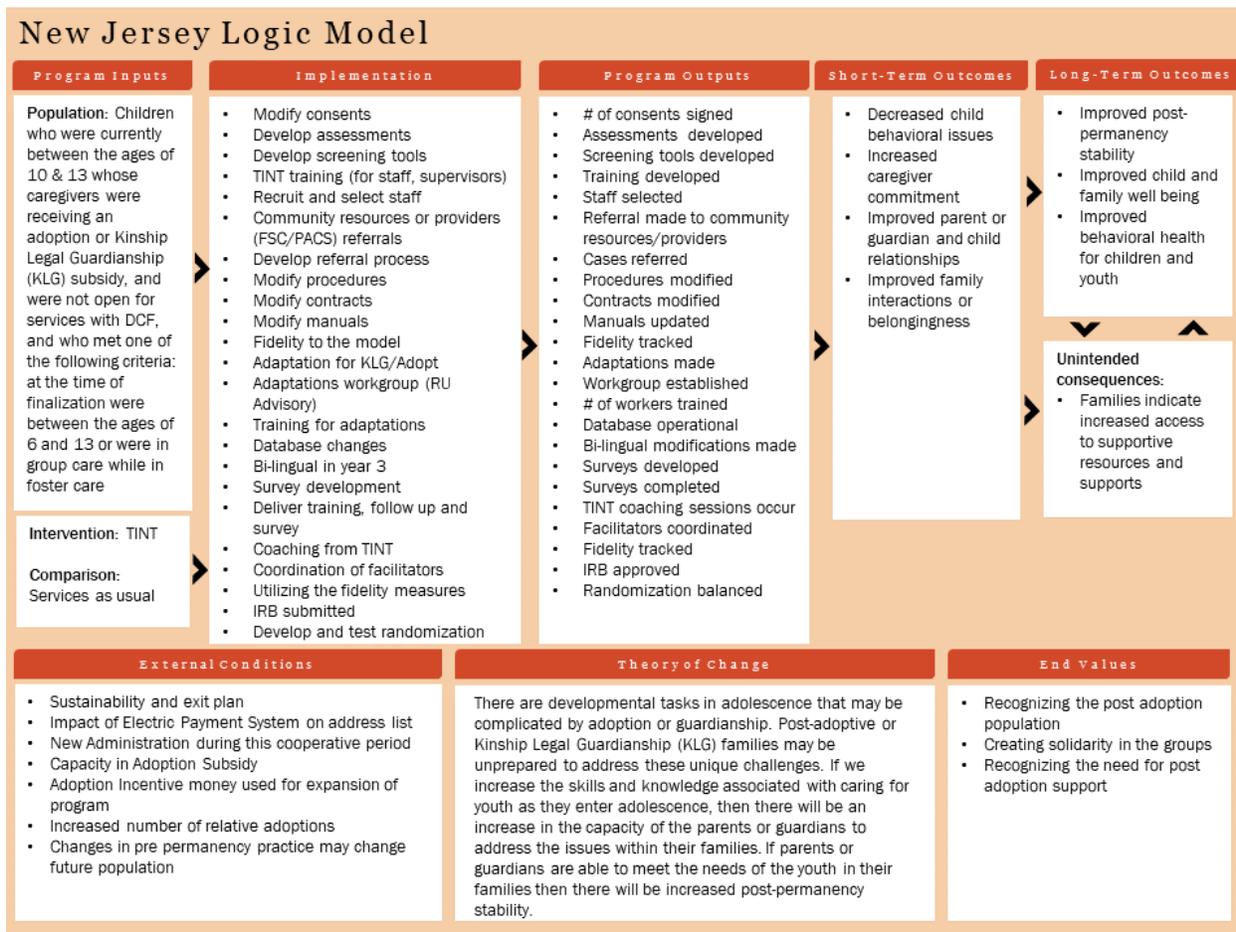
Long term outcomes included:

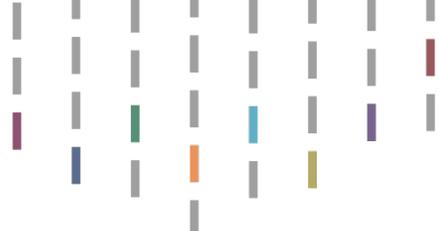
- Improved post permanency stability
- Improved child and family wellbeing
- Improved behavioral health for children and youth

Logic Model

The Logic Model (Figure 5.5) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and core developmentally informed interventions to the intended proximal and distal outcomes.

Figure 5.5. New Jersey Logic Model





Evaluation Design & Methods

An experimental design was used to determine whether TINT in New Jersey was effective in reducing post permanency discontinuity and increasing the wellbeing of parents and youth. All adoption and guardianship families who met the stated criteria for the target population (see Logic Model) were randomly assigned to either the comparison or intervention group and surveyed to collect outcome data. A randomized consent design (Zelen, 1979, 1990) was used (randomize then consent). In the randomized consent design, participants were randomized to the intervention or comparison conditions, and those in the intervention group were made aware of their assignment group prior to engaging in services. Families in the comparison group had the same eligibility and exclusionary criteria as those in the intervention group. The intervention group received an invitation to participate in the TINT program. The comparison group received services as usual. Families in the comparison group had access to Post Adoption Counseling Services (PACS), Adoption or KLG Subsidy (if applicable), Children’s System of Care (CSOC), and any other service typically accessed by families post finalization.

The evaluation design and protocol were reviewed by the Institutional Review Boards (IRB) at the University of Wisconsin-Milwaukee (UWM), Rutgers University, and the University of Illinois at Chicago (UIC). It was also reviewed by the DCF Research Review Committee.

Procedures

A brief description of data collection processes will be described in this section. Additional information on data sources and collection is included in the Appendix.

USABILITY

For the sample selected for usability testing, the evaluation team deliberately selected families with older children.

Families that had adopted or assumed guardianship of children in three counties that had children between the ages of 13 and 14 and met the other criteria for participation (i.e. permanence occurred at age 6 or older or child in congregate setting before aged 6; no active case with the Division of Child Protection and Permanency [CP&P]). A total of 150 families were assigned to the intervention group. Of the 150 assigned to the intervention, project staff were able to speak with 92 (61%). Twenty-two (15%) of those contacted registered and 12 (8%) participated in at least one session. Sessions were facilitated by two facilitators each with two observers from amongst the facilitator pool.

Following usability testing, the recruitment team made some changes to their tracking spreadsheet and added a phone call to their recruitment process in which they asked families that had registered what they would like for dinner, approximately two weeks before the TINT session was to start. Dubbed the “turkey sandwich call,” the purpose was to increase follow-through for registered families and give the team a more accurate accounting of who intended to participate.

RECRUITMENT AND IMPLEMENTATION

Eligibility was determined based on the child's eligibility status, but outreach was conducted at the family level. In each family, one target child was selected, and parents or guardians were asked to respond to the surveys about that child. Information on families was tracked at the child level using a target child ID.

The Implementation/Installation Team, in consultation with key stakeholders, identified how to best market and word the invitation and decided how invitations would be delivered. Discussions included mailings, calling, and/or email for follow up. The team managed and coordinated timeframes for invitations, follow-up on response timeframes, scheduled sessions and locations to choose from.

Clerical staff mailed or emailed workshop invitations to families. Registration was managed by the Site Implementation Manager (SIM). At the time of registration, the SIM verified eligibility (i.e., ensured the child was not DCS involved and still living in the home), reviewed logistics of the workshop location, and forwarded the workshop roster to the training facilitators. The SIM, with the assistance of clerical staff, managed the rescheduling of no shows and other scheduling needs. If necessary, the Lead Facilitator assisted the SIM with collecting information from the workshop facilitators.

FIDELITY AND ADHERENCE

Fidelity to the program model was measured in terms of the degree of practitioners' consistency with the best practice model of service delivery as intended by the developers. The purveyors of TINT, Dr. Sophie Havighurst and colleagues, have a well-developed protocol to ensure fidelity, complete with fidelity checklists and feedback, supported by coaching sessions. In addition, Dr. Havighurst noted items that were core to the model and problem solved with facilitators during the coaching sessions. This high level of involvement and follow up ensured that the core elements of the intervention were established and maintained over time. In order to track the adoption-related items, additions were made to the fidelity checklist.

Facilitators provided data to the evaluation team by completing the Fidelity Checklist at the end of each session, indicating whether or not they had completed each section of the manual and noting omissions or additions. The completed checklists were provided to the adoption practice consultant and discussed during periodic supervision with the purveyor to ensure that the curriculum was being properly implemented. For ease of use, an electronic template of each fidelity checklist was developed so that facilitators could complete and upload it. This enhanced the Master Trainer's ability to track consistency of facilitation and to discuss concerns with the purveyor. At the end of each cohort, the adoption consultant provided copies of the fidelity checklists to the evaluation team.

Fidelity Checklist Revised

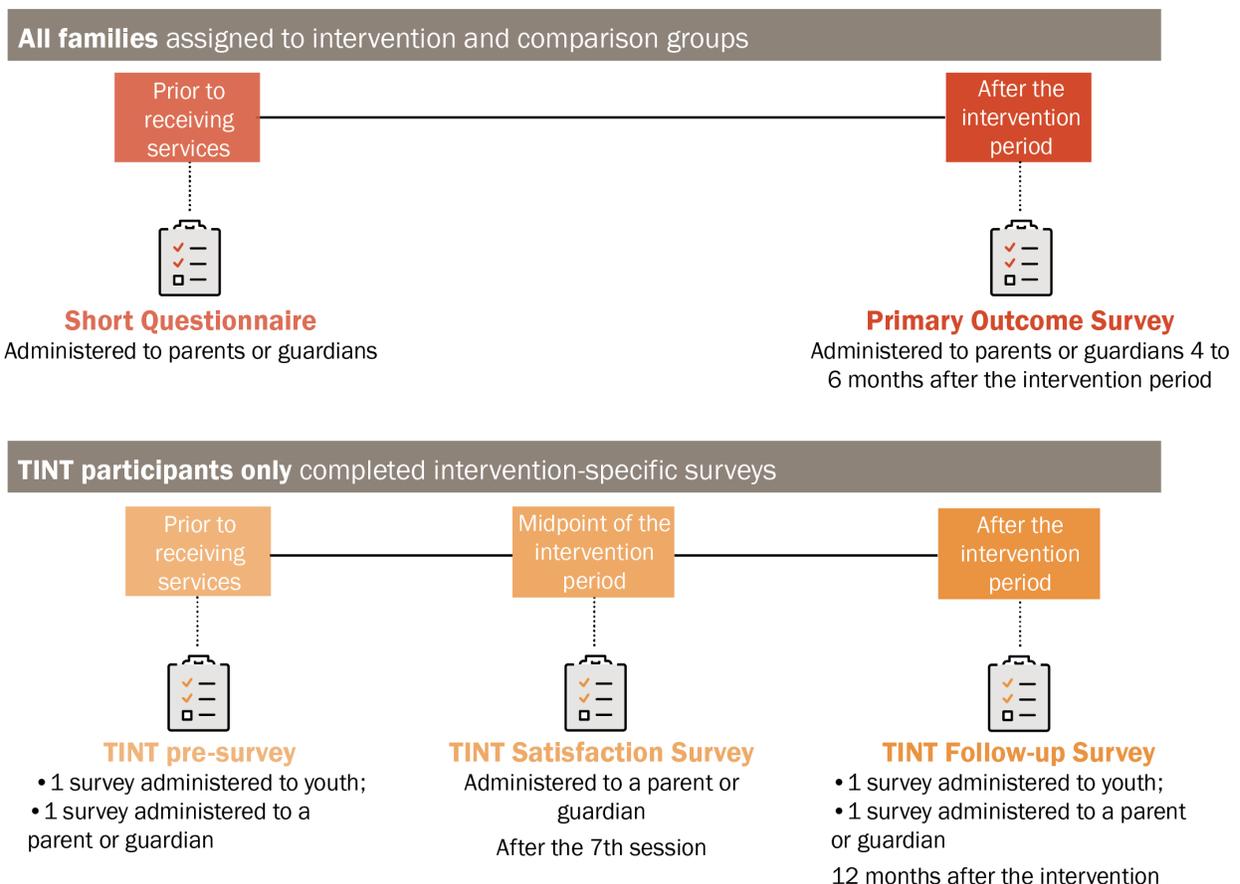
The Fidelity Checklist was revised before Cohort 4 and a number of items that were part of the adoption overlay were removed. It was determined that these items should be covered as needed, rather than be included as expected. A review was conducted on specific items to determine whether certain items were not covered in each cohort by at least 2 groups. Four items that were part of the adoption overlay and removed from the fidelity tool for Cohort 4, were often not covered, including managing rejection, adolescent emotions triggering parents' own feelings of rejection, control, and manipulation issues in adopted and guardianship teens, and the use of emotional distance to feel safe.

Adherence to the recruitment and engagement protocol was assessed by the evaluation team through the tracking of outreach activities conducted by the program staff, and utilization of the algorithm determinations for selecting the sample to provide to the agency. Protocols for recruitment included that every family should receive up to four outreach calls the first time that recruitment occurred (i.e. the first time they had an opportunity to participate in the intervention). Families that did not participate when they were first given the opportunity were re-recruited if the TINT program came to their region again AND they had agreed to be contacted again. For re-recruitment, families could receive up to two additional calls.

OUTCOMES

Outcome data were collected at various points for different reasons. Some data were collected for the intervention participants only, in order to collect information on the intervention-specific outcomes (referred to as the TINT surveys). Other data were collected to measure the primary outcomes. Primary outcome data were sent to all families assigned to the intervention and comparison groups. In addition, a short questionnaire was sent to all families assigned to the intervention and comparison groups (see Figure 5.6).

Figure 5.6. Timeframe Associated with Surveys and Questionnaires



Intervention-Specific Outcomes

Pre and post TINT surveys (Intervention-Specific Outcomes Surveys) were provided by the purveyor and administered according to the protocol established by the purveyor. Intervention-specific surveys were distributed to the intervention participants only. Participants could complete the surveys via a web-based survey link or paper-based survey – depending on parent choice – prior to the start of the intervention and approximately one-year post intervention. These surveys comprised of a number of scales designed to measure a range of characteristics about children including behaviors, mental, emotional, and physical health, and family relationships, provided by the purveyor of the program.

Agency staff distributed the surveys as part of their recruitment process; also distributing the post survey for consistency in the engagement process. The survey data were returned via mail or entered via the internet to the research team and were not directly accessible by the agency staff. Agency staff were notified regularly by the research team regarding completion of the surveys so that additional follow-up could occur. Anyone that did not complete the survey before the start of the intervention was asked to complete it within the first week of the intervention and provide a printed copy and self-addressed stamped envelope to the research team as a final effort to recruit families into the research.

Parents were asked to complete the pre and post intervention surveys and to ask the child selected for the research to also complete a pre and post survey. An incentive of \$25 was provided for the youth completion. The data were analyzed as similarly as possible to that of the purveyor in previous research of the program's effectiveness.

Primary Outcomes

The primary evaluation is the comparison between the intervention and comparison groups. Data for the primary outcome analysis was collected through a survey (Primary Outcomes Survey) distributed to the intervention group four to six months after they were eligible to participate and at similar time-points for the comparison group. These measures were chosen to allow comparison across the sites in the study regarding short- and long-term outcomes theorized to be directly related to discontinuity.

Specifically, the selection of the outcomes for this study was based on findings from extant research. In surveys from Illinois with adoptive parents and guardians, a series of questions were asked that, in later analysis, were predictive of post permanency stability (Testa, et al., 2014). Specifically, caregivers who reported that the child had behavior problems (as measured by the Behavior Problem Index) and caregivers who reported having considered ending the adoption or guardianship were more likely to experience post permanency instability. We, therefore, hypothesized that if we were able to identify families most in need and target post permanency services to them, fewer would experience instability.

The Illinois study linked the caregiver responses mentioned above with administrative data, allowing for the examination of whether caregiver responses in 2006 could inform the understanding of long-term outcomes of these children, youth and their families. The study found that the thoughts expressed at the time of the survey about ending the permanency relationship impacted post permanency instability. The study also found that children and youth with behavioral problems were more likely to experience post permanency instability, which was not surprising. What was surprising was that once caregiver thoughts about ending the relationship were added to the statistical models, that children with behavioral problems were no more likely to experience instability than children with no behavioral problems. In other words, thoughts about ending the

relationship mediated or explained away the effect of child behavioral problems on the risks of post permanency instability (Testa, et al., 2014).

The primary evaluation is the comparison between the intervention and comparison groups. This was conducted using a survey distributed to the intervention group approximately four to six months after they were eligible to participate and at similar time-points for the comparison group. The QIC-AG contracted with an outside firm, The Survey Research Lab (SRL) at the University of Illinois at Chicago (UIC) to administer surveys to participants in both the Intervention and Comparison groups. Additional information is available in the Appendix.

To assess post permanency discontinuity, administrative data was used that included information about children who entered and exited foster care and tracked their experiences while in foster care. Administrative data were linked to program data in order to examine study participants who experience post permanency discontinuity.

Measures

FIDELITY

The fidelity measure was provided by the purveyor of TINT to capture the elements of the intervention and intended to be completed at the end of each session. Facilitators checked-off whether the element was covered and wrote into an open-ended section whether other items were included, including items that were intended to be included previously.

OUTCOMES

Intervention-Specific Outcomes Survey

The Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is a brief behavioral screening questionnaire used to measure 25 psychological attributes in children ages 3-16 years old. The items can be broken up into five scales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behavior. Higher scores correspond to an increased rate of disorder. The response range is 0 (low) to 3 (high); the maximum score for the scale is 50. In this study, internalizing and externalizing scales were combined (10 questions each) with a possible range of 0-20 for each subscale. Administration: Parent, pre intervention; Youth, pre-post intervention.

Children's Depression Inventory – Short Form (CDI-S)

The Children's Depression Inventory – short form (CDI-S; Allgaier, Pietsch, Saravo, Baethmann, & Schulte-Korne, 2012) is a 10-item measure in which children are asked to respond to statements about their affect and outlook on life, with response categories between 0 (low) and 2 (high). Scores on this scale range from 0 to 20, where higher scores indicate higher levels of depressive symptoms. The parent version has some scoring differences and cannot be compared directly to the youth version. Administration: Youth, pre/post intervention.

Difficulties in Emotion Regulation (DERS)

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) is a 36-item, self-report questionnaire that assesses difficulties with different aspects of emotional dysregulation. Six subscales are included, but the summary score was what was used in this study for consistency with prior research. Higher scores on the DERS suggest greater problems with emotional regulation, with a maximum score of 180. Administration: Parent, pre intervention; Youth, pre-post intervention.

Emotions as a Child Scale (EACS)

The Emotions as a Child Scale (EACS; Magai & O'Neal, 1997) is a 45-item measure of parent emotion socialization. Parents and youth rate the degree of parent responsiveness to emotions from 1 to 5 across five subscales measuring encouraging, punishing, neglecting, overriding and magnifying behavior. Higher overall scores indicate greater emotion dismissiveness, with a maximum score of 225. Administration: Parent, pre/post intervention; Youth, pre-post intervention.

Family Assessment Device (FAD)

The Family Assessment Device (Epstein, Baldwin & Bishop, 1983) is a 60-item questionnaire based on the McMaster Model of Family Functioning and is used to assess the structural, organizational, and transactional characteristics of families. One subscale was used, with 12 items measuring general family functioning. Higher scores indicate decreased levels of family functioning. Response categories range between 1 (low) and 4 (high) and the twelve items are summed, with a maximum score of 48. Administration: Parent, pre intervention; Youth, pre-post intervention.

Family Conflict Scale

Family Conflict Scale (Netemeyer, Boles, & McMurrin, 1996) is a three-item scale rated from 1-4 to measure the degree of family conflict, with a range of 3 – 12 and higher scores indicating more family conflict. Administration: Parent, pre intervention; Youth, pre-post intervention.

Known and Unknown Causes for Physical Problems

Known and unknown causes for physical problems (Razali, M. S., 2008) were measured using four questions related to known causes and 7 for unknown causes regarding the frequency of experiencing certain problems within the last 12 months with possible response categories ranging between 1-3. Maximum scores for known causes is 9, and for unknown causes is 21. Administration: Parent, pre intervention; Youth, pre-post intervention.

The Spence Children's Anxiety Scale (SCAS)

The Spence Children's Anxiety Scale (SCAS; Spence, 2003) is a 45-item measure designed to measure children/youth's anxiety related to separation anxiety, social phobia, obsessive-compulsive disorder, panic-agoraphobia, generalized anxiety and fears of physical injury. Children and parents are asked to rate the frequency with which they or their child, respectively, experience each symptom of anxiety on a scale from zero to three. Scores greater than 42 are considered in the range of clinical anxiety. Around 5% of those that responded had scores in the range of clinical anxiety. Administration: Parent, pre intervention; Youth, pre-post intervention.

Acceptance and Action Questionnaire (AAQ-II)

The AAQ-II (Bond et al., 2011) is a 7-item form that seeks to measure psychological inflexibility/experiential avoidance. The respondents are asked to rate the measure on a 7-point scale ranging from 1 = never true to 7 = always true, regarding themselves. Scores are summed for a possible range of 7 - 49, with higher scores indicating increased inflexibility. Administration: Parent, pre-post intervention.

Primary Outcomes Survey

Caregiver Strain Questionnaire – FC/AG22 (CGSQ-FC/AG22)

The Caregiver Strain Questionnaire-Adoption/Guardianship Form (CGSQ-FC/AG22) is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger & Bickman, 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.

Family 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 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.

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

The BEST-AG, developed by Casey Family Services (Frey, Cushing, Freundlich, & Brenner, 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 formed through 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).

Illinois Post permanency Commitment Items

Several items from the Illinois Post permanency Surveys were used to evaluate the parent's commitment to 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).

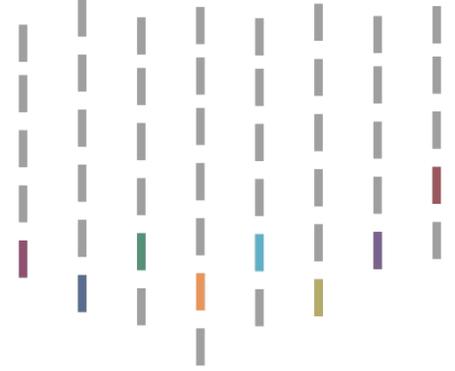
Behavior Problem Index (BPI)

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 are 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 difficult 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.

Missing Data

Missing imputation was done by replacing any item missing value with the respondent's mean on all observed items 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

DEMOGRAPHICS

Table 5.2 depicts characteristics for the sample, based on the results of randomization. Around half of the sample had experienced three or more moves while in foster care, just over half (53%) of the children were Black and just under half (46%) were White. The sample was also nearly evenly split between male and female and just over half lived in two-parent households. The average age that children entered a permanent adoption or guardianship arrangement was just over seven years and the average length of time in foster care was nearly four years. Examining the data by TINT participants and the comparison group indicates that the randomization resulted in nearly identical groups based on these demographic characteristics.

Table 5.2. New Jersey Sample Characteristics

CHARACTERISTICS FOR SAMPLE					TESTS COMPARING DIFFERENCES BETWEEN INTERVENTION AND COMPARISON GROUPS		
NEW JERSEY	FULL ADMIN DATA (N=21,048)	SAMPLE FRAME (N=1,039)	TINT PARTICI-PANTS (N=83)	COMPARISON GROUP (N=377)	χ^2	df	p
3+ MOVES IN FOSTER CARE	39%	51%	51%	52%	0.09	1	0.764
CHILD RACE					5.80	2	0.055
WHITE	37%	46%	44%	51%			
BLACK	62%	53%	56%	58%			
OTHER RACE	1%	1%	1%	1%			
CHILD IS FEMALE	49%	49%	48%	50%	0.38	1	0.539
SUBSIDY TYPE					0.12	1	0.727
ADOPTION	83%	81%	81%	82%			
KLG	17%	19%	19%	18%			
PARENTS MARRIED OR TWO-PARENTS*	33%	55%	53%	58%	1.54	1	0.215
		M (SD)	M (SD)	M (SD)	t	df	p
CHILD AGE AT PERMANENCE	6.63 (4.29)	7.27 (2.80)	7.27 (2.83)	7.29 (2.77)	0.11	1037	0.910
MEAN TIME (IN YEARS) IN CARE	3.70 (2.34)	3.91 (2.06)	3.83 (2.03)	4.04 (2.09)	1.58	1037	0.114

NOTES: 14% OF DATA IS MISSING; *THIS IS BASED ON THE DATA PROVIDED ON FOSTER PARENTS. WE ARE MAKING THE ASSUMPTION THAT THESE FOSTER PARENTS BECOME THE LEGAL ADOPTIVE PARENT OR GUARDIAN.

PRIVATE DOMESTIC AND INTERCOUNTRY ADOPTIVE FAMILIES

Primary outcome surveys sent to public adoptive and guardianship families were not sent to the families who participated in the intervention and were from private domestic or intercountry adoptions. Hence, the information we have about these participants is limited to the information related to participation, with limited information on demographics available in the pre intervention survey. Seven private, domestic or intercountry adoptive families responded to the TINT presurvey. Of them, all were two-parent households, employed full-time, with a college degree or higher. In contrast, just over half of public adoptive or guardianship families were in a two-parent family, 43% were employed full-time, and 63% had less than a college degree. Seventy-one percent of private domestic or intercountry adopted children were male, in comparison to a nearly even split of male and female children in the public adoptive and guardianship families. Additional information on private domestic and intercountry adoptive families is available in a separate report.

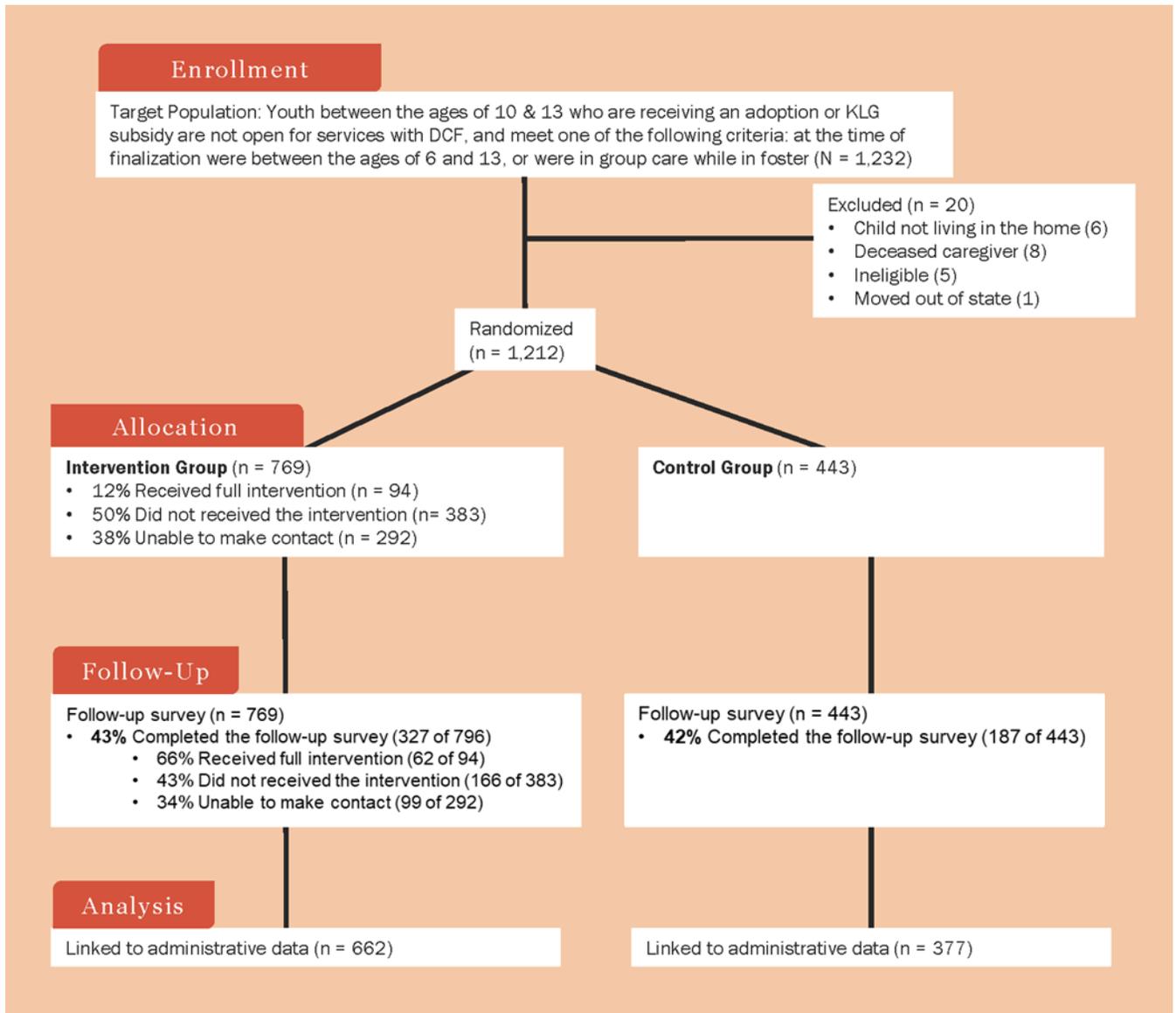
CONSORT DIAGRAM

The Consort Diagram (Figure 5.7) depicts the randomization procedure and response to outreach for the intervention and primary outcome surveys. This is different than the uptake chart on the subsequent page (Figure 5.8). The consort diagram reports how many research subjects there is data on. The uptake charts report on how many subjects were recruited and participated. Of the 1,212 families eligible for the intervention, 769 (63%) were assigned to the intervention and 443 (37%) to the comparison group.

Depicted on the left side of Figure 5.7 is the intervention group's response to outreach efforts (i.e. Allocation) and their response to survey procedures (i.e. Follow-up). For example, of those that were allocated to the intervention group, 12% (n=94) received the full TINT intervention, 50% (n=383) were contacted but did not participate in the TINT intervention and 38% (n=292) were not successfully contacted. Further, of those in the intervention group, 43% (n=327) completed the follow-up survey and 66% (n=62) of those that participated in the full TINT intervention completed the follow-up survey. We were successfully able to link 662 of those in the intervention sample (n=769) to administrative data using their encrypted ID codes.

Depicted on the right side of Figure 5.7 is the comparison group (n=443). The comparison group did not receive outreach directly after allocation to the group, so no additional information is provided at Allocation. The comparison group did receive a survey around six months after being allocated to the comparison group and 42% (n=187) of them completed the survey. Additionally, 377 of those in the comparison group were able to be linked to administrative data using their encrypted ID codes.

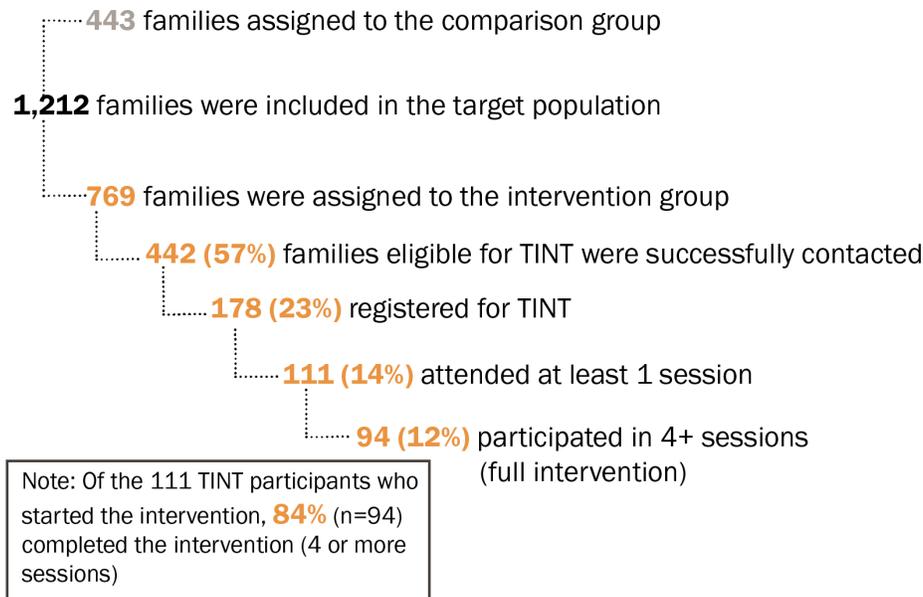
Figure 5.7. New Jersey Consort Diagram



RESPONSE TO INTERVENTION RECRUITMENT

Figure 5.8 provides a more nuanced depiction of the results of outreach to the intervention group than the Consort figure. Outreach efforts resulted in successful contact with 58% of the intervention sample, of which 40% registered for the TINT intervention. Of those that registered, 62% attended any TINT sessions and 53% attended at least 4 sessions. Those that participated in the full TINT intervention comprised 12% of the overall intervention sample (n=769).

Figure 5.8. New Jersey Recruitment Response



SAMPLE CHARACTERISTICS

This section explores whether there were differences between the comparison and intervention group and between those that participated in the intervention and those that did not participate in the intervention. While the demographics from the sampling data suggested that the groups were equivalent, there were concerns based on interactions with families that those that responded might not be representative of the group overall in regards to strain.

A short questionnaire, prior to study enrollment, was administered to all families assigned to the comparison and intervention groups, which asked questions related to the caregivers' views of their relationship with their child, a child who they had assumed guardianship of, or who they adopted.

When comparing all respondents assigned to the comparison and the intervention groups (not limited to participants), there were no statistically significant differences between these two groups (see Table 5.9 in the Appendix), on any of the questions, suggesting that randomization was successful.

However, given the relatively low rate of participation among the intervention group, additional tests were run. When examining the differences between the comparison group and those who participated in the intervention (TINT participants), statistically significant differences between these two groups were identified (see Table 5.10 in the Appendix). On average, compared to the comparison group, TINT participants reported that they were:

- More likely to struggle to effectively manage their child's behavior
- Less confident that they could meet the needs of their child

These results suggest that, contrasted with the comparison group, those who opted to participate may have been those families who were more likely struggling to provide adequate care for their child.

However, this also suggests that a comparison that examines the intervention participants to the entire comparison group may not be an apples-to-apples comparison. In other words, the comparison group is made up of all types of families – those who are doing well, and not in need of, or interested in, services, and those who, if offered services, would be interested.

For an assessment of the effectiveness of the intervention, we want to compare intervention participants with a sample of families who profile like them, who may have similar concerns about their relationship with their child as those who were offered TINT and agreed to participate.

Lastly, we examined the intervention group as a whole to see if there were differences between those who were offered the service and opted to participate, and those who were assigned to the intervention group but did not participate. Results (Table 5.11 in the Appendix) found that, on average, compared to non-participants within the intervention group, intervention participants reported that they were:

- More likely to struggle to effectively manage their child's behavior
- More likely to struggle to appropriately respond to their child
- Less confident that they could meet the needs of their child

As a result of this analysis, the outcomes for intervention participants will be compared with the full comparison group and with a subset of the comparison group, matched on key characteristics identified through the short questionnaire administered at baseline to all assigned to the project.

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). Initial implementation of TINT began when the first clients received services. At this time, the evaluators began the formative (process) evaluation and tested whether the early phases of the initiative were associated with the expected program outputs of the intervention.

FIDELITY AND ADHERENCE

Two aspects of implementation were assessed:

1. adherence to the recruitment and engagement protocol, and
2. fidelity to the program model.

RECRUITMENT AND ENGAGEMENT ADHERENCE

Outreach efforts included at least one opportunity to participate per family, with some families receiving two (48%, 371 families) or three (4%, 28 families) if the intervention was repeated at a location close to them. Additionally, families were to receive at least four phone call attempts the first time they were recruited and fewer attempts were permissible when they were eligible a second or third time. Table 5.3 depicts the percent of families who registered compared to those who declined for those that could be contacted (n=442), in relation to the number of calls they received. For example, 41% of families who registered did so the first time they were contacted, yet registration continued through call six, with additional calls beyond the sixth not yielding many more registrations. For families who spoke with an outreach worker and declined, staff continued to reach a significant number families through call seven. For the 327 families that could not be contacted, calls stopped whenever the outreach worker determined that the phone number was not viable or the requisite number of calls had been reached.

Table 5.3. Number of Calls to Reach and Register Families

NUMBER OF CALLS	SUCCESSFULLY CONTACTED AND REGISTERED		SUCCESSFULLY CONTACTED AND DECLINED	
	N	%	N	%
1	73	41%	39	15%
2	46	26%	41	16%
3	25	14%	52	20%
4	13	7%	54	20%
5	13	7%	40	15%
6	6	3%	20	8%
7 OR MORE	2	1%	18	7%
TOTAL	178	100%	264	100%
MEAN (SD)	3.06 (1.83)		2.26 (1.56)	

Responses to outreach suggested that many respondents found a variety of ways to report that they were not interested (see Table 5.4). Few respondents reported that they were struggling with issues that prevented them from attending. Also, it should be noted that every attempt was made to offer sessions in locations that were close to the majority of KLG and adoptive families, and multiple times. Some of these reasons could be understood as polite ways to say that they do not need or want the service. A stipend was provided in the form of gift cards to offset costs, such as childcare and gas, which suggests that those that indicated childcare concerns had childcare barriers of a more complex nature than available funds. Further, the addition of the “turkey sandwich” call did not appear to influence attendance rates after registration, but it did provide an opportunity for the family to inform staff that they were not going to attend, resulting in a more accurate number of expected participants prior to the initial TINT session.

Table 5.4. Reason for Not Participating in TINT

CONTACTED AND DID NOT PARTICIPATE: REASONS FOR NOT WANTING TO PARTICIPATE IN TINT		
REASON	N	%
DOES NOT FIT SCHEDULE OR TOO BUSY	140	52%
NOT INTERESTED/DOING WELL	67	25%
TOO FAR TO TRAVEL	30	11%
MEDICAL ISSUE	10	4%
CHILDCARE OR FAMILY ISSUES	13	5%
PROGRAM TOO LONG	7	3%

FIDELITY

Table 5.5 depicts the fidelity scores for each Tuning in to Teens (TINT) group for Cohorts 2-8. Each cohort had between two and five groups running simultaneously. The NJ TINT program had 7 sessions. Each session had certain activities that were expected to be delivered, as detailed in TINT manual. These items were assessed by facilitators at each session and shared with the implementation team in order to guide implementation supports, as well as the evaluation team. Activities that were missed in a session could be added to a later session and this was considered appropriate implementation.

The adoption overlay material was revised following a review of the fidelity data from the first three cohorts. Four items that were part of the adoption overlay were often not covered, including managing rejection, adolescent emotions triggering parents’ own feelings of rejection, control, and manipulation issues in adopted and guardianship teens, and the use of emotional distance to feel safe. The Fidelity Checklist was therefore revised before Cohort 4. In this revision, a number of items that were part of the adoption overlay were removed from the checklist - to be covered as needed - and core items identified to ensure the most important material was consistently covered.

All groups received 90% or more of the total TINT content and more than 93% of the core content, with the exception of Cohort 7. In Cohort 7, scores were lower than 90% for both the total and core content but were back over 95% by Cohort 8. The overall average fidelity scores were 91% for the total TINT content and 94% for the core content.

Table 5.5. Fidelity to TINT by Cohort

FIDELITY BY COHORT AS A PERCENT								
COHORT	2	3	4	5	6	7	8	Overall
TOTAL CONTENT	91%	91%	94%	92%	90%	86%	96%	91%
CORE CONTENT			98%	96%	93%	88%	97%	94%

Additionally, a brief, anonymous satisfaction survey was distributed to parents at the end of the final session and collected by the facilitators. Questions included a mix of open and closed-ended questions, which were measured on a five-point scale. In summary, parents' responses included:

- 61% found it easy or very easy to understand the ideas of Emotion Coaching (i.e. rating of 4 or 5 on a 5-point scale)
- 51% found it easy or very easy to carry out the methods of Emotion Coaching (i.e. rating of 4 or 5 on a 5-point scale)
- Parents felt they benefited much more from the program than they had anticipated, as 88% felt they benefited a lot from the program, while only 17% expected to benefit a lot from the program in retrospect (i.e. rating of 8 on an 8-point scale)
- 83% felt the program would be a lot helpful for adoptive/guardianship families like theirs (i.e. rating of 8 on an 8-point scale)
- 75% felt that TINT was a lot helpful for their family (i.e. rating of 8 on an 8-point scale)
- 61% felt they would be able to implement the concepts discussed in TINT a lot (i.e. rating of 8 on an 8-point scale)
- 72% felt that TINT would help them with the challenges they were discussing in the group a lot (i.e. rating of 8 on an 8-point scale)

Open-ended responses provided some insight into what parents found most helpful and the impact they were seeing on their families, as well as possible explanations for why some parents felt less confident than others that they could implement the concepts. Themes from the comments regarding what they learned and were using included pausing before engaging with the teen, understanding their “flipped lid” response, and the techniques used to coach teens understand their emotions. Parents noted that this was in contrast to going directly to problem-solving. Some parents noted that this was hard to put into practice at first and many parents expressed the need to keep practicing and receiving reinforcement through the program. Many of the parents felt that had already seen some changes in their communication and relationship with their teen and expressed their appreciation for the class.

SUMMARY

The TINT program was implemented in various locations across New Jersey, reaching urban, rural, and suburban populations from different racial/ethnic and socio-economic backgrounds. Implementation of the intervention was reasonably consistent and was considered relevant for the post adoption population. While the adoption context was considered relevant and in need of attention through adoption competent facilitators and materials, experienced facilitators decided that the need to cover this material was organic, rather than manualized.

The implementation of this intervention was further supported by an experienced adoption clinician with a background in training who acted as a clinical supervisor and the purveyor of the intervention, who supported the facilitators directly through periodic phone calls and by supporting the clinical supervisor. Additionally, supervision was provided via conference calls with peers, who further provided a level of support.

Further, outreach efforts resulted in families with higher need, within an already statistically higher risk population, attending TINT sessions. Also, the vast majority of those that started the intervention completed it, again suggesting that the intervention was considered worthwhile and helpful. Parent reports on satisfaction surveys were also positive, indicating that the intervention was useful, but also somewhat challenging to put into practice.

It is unknown whether continued clinical supervision would be necessary once facilitators are trained, nor were various implementation processes tested. However, it is likely that implementation was more consistent and of better quality with the use of experienced, adoption competent facilitators and support from a clinical supervisor and peers.

Outcome Evaluation

This section will first describe the intervention-specific outcomes. These outcomes are based on the surveys provided by the purveyor and used in extant research related to TINT (research from a general population, rather than a sample of adoptive and guardianship families). The next section will focus on the primary outcomes, those set by the project and expected to be predictive or the long-term project outcomes. As a reminder, Figure 5.6 provides a summary of who received which survey or questionnaire.

INTERVENTION-SPECIFIC OUTCOMES

Baseline Scale Scores

At baseline, youth and their parents completed the same set of scales with parents responding about their child, and youth about themselves (Table 5.12 in the Appendix). A total of 41 parent and child dyads completed the survey from all TINT participants (families who participated in the full TINT intervention). For all scales, higher scores indicate greater difficulty with the construct being measured. The results of the pairwise correlation between parent and youth scores show moderate and statistically significant correlation between many of the measures, suggesting that parents and youth had similar perspectives on the child and family functioning.

Follow-Up Scale Scores

Follow-up surveys were administered to TINT participants one-year after the start of the intervention. At the time of this paper's publication, 39 (41%) parent or guardian and 13 (14%) youth surveys had been returned, making inferences to all TINT participants (n=94) difficult. Table 5.13 (in the Appendix) provides the results from the available surveys. The youth surveys have the same measures on the pre and posttests; parent or guardian surveys were more robust at baseline but had only a few measures on the postsurveys. The parent rating of their own responsiveness to the child's emotions (Emotions as a Child Scale) and their rating of their avoidance of their own emotional state (Acceptance and Action Questionnaire) were statistically significant and indicate that parents feel they are less responsive after the TINT intervention than prior to the intervention. While not a matched comparison, and with only 11 youth responding, youth ratings on the Emotions as a Child Scale, where they rated their parents' responsiveness, were statistically

significant in the opposite direction from parents (i.e. towards more responsive parenting). In addition, the magnifying subscale of the Emotions as a Child Scale was significant, but the encouraging and punishing subscales were also noticeably improved. Importantly, the low response rates coupled with so few youth responses, make strong conclusions around these outcomes difficult. Additional responses, from youth and their parents or guardians, would allow stronger conclusions to be drawn and additional analysis of responses within a family.

PRIMARY OUTCOMES

The study's short-term outcomes were measured by examining differences between the TINT participants and the comparison group on responses to measures and questions asked of the intervention and comparison groups. The outcomes and how they were measured are listed below.

- Decreased child behavioral issues. This was measured through the Behavioral Problem Index (BPI).
- Improved family interactions or belongingness. This was measured through the Belonging and Emotional Security Tool for Adoptive Parents and Guardians (BEST-AG).
- Increased caregiver commitment. This was measured through a series of questions related to caregiver commitment (e.g., How often do you think of ending the adoption or guardianship? 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/her?)
- Improved parent or guardian child relationships. This was measured through the Protective Factor Survey.

The primary outcome survey was administered to all families assigned to both the intervention and control groups. The purpose of this survey was to gather data related to the project outcomes.

As previously noted, a randomized consent design was used, which resulted in statistically equivalent groups when examining the characteristics of the intervention and comparison populations. The TINT participants, however, were statistically different from the comparison and intervention/non-participant groups. Therefore, the results of the experimental design compare: 1) the TINT participants with the overall comparison group and 2) the TINT participants with a matched sample from the comparison group.

Terminology

Intervention group: The families randomly assigned to the intervention group. Families were assigned at the start of the project. Outreach occurred with all families assigned to the intervention group.

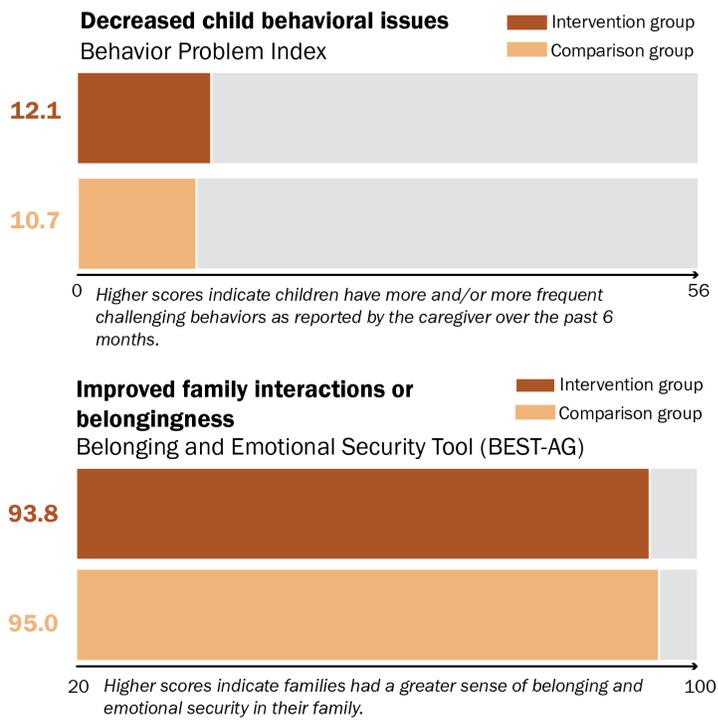
TINT participants (also called treatment participants): Families who participated in the intervention, and received at least 4 TINT sessions.

Comparison group: Families randomly assigned to the comparison (or control) group. Random assignment into the comparison group occurred prior to the start of the project. The staff did not reach out to families assigned to the comparison group. These families were eligible to receive services as usual.

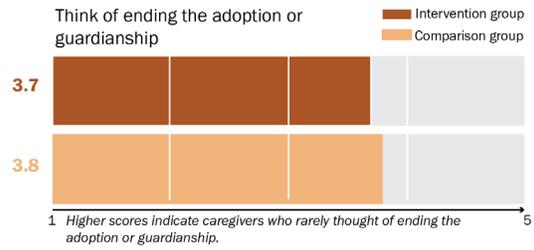
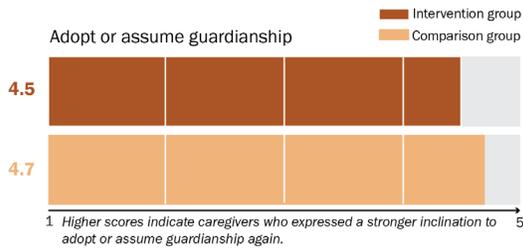
Matched comparison group: Statistically significant differences were observed when comparing TINT participants to the comparison group on baseline measures. Thus, propensity score analysis was conducted using matched groups, to provide a less biased comparison of outcomes. The matched group is referred to as a matched comparison group.

Results related to the primary outcomes are summarized in Figure 5.9 and detailed in the Appendix (see Table 5.14). Findings showed no statistically significant differences between groups when comparing TINT participants to the comparison group.

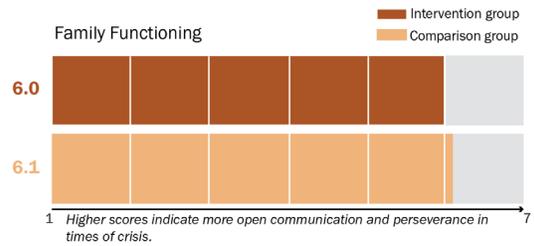
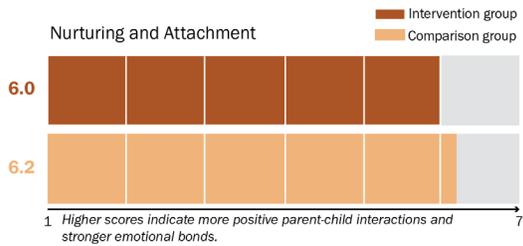
Figure 5.9. Outcomes for Intervention and Comparison Groups



Increased Caregiver Commitment



Improved Parent or Guardian Child Relationships



The evaluation found that intervention and comparison groups differed on two pretest measures of caregiver commitment. Specifically, the more parents struggled to parent the child and the less confident they were in being able to meet the needs of the child, the more likely they were to be in the intervention group. Thus, in order to provide a less biased comparison of outcomes by group, the evaluation team matched the intervention to comparison cases on four caregiver commitment variables, using nearest-neighbor within caliper for propensity score matching. Then the matched intervention and comparison groups were compared on the primary outcomes. The results of these comparisons are shown in Table 5.6. Findings showed no statistically significant differences between matched groups. It could be that with additional enrollments into the intervention, and additional time to track proximal and distal outcomes, that differences between the two groups would emerge.

Table 5.6. Comparison of Outcomes for TINT Participants and Comparison Groups After Propensity Score Matching

COMPARISON OF OUTCOMES FOR TINT PARTICIPANTS AND THE COMPARISON GROUP AFTER PROPENSITY SCORE MATCHING ^A (N = 49)						
OUTCOMES ^B	ATE (MEAN DIFF. OF COMPARISON - INTERVENTION) ^C				t	p>t
	ATE	SE	95% CI			
BEHAVIORAL PROBLEM INDEX	2.88	3.19	-3.55	9.30	0.90	0.372
BPI - INTERNALIZING	0.51	1.15	-1.80	2.82	0.44	0.661
BPI - EXTERNALIZING	2.02	2.34	-2.68	6.72	0.86	0.392
BEST-AG	1.01	1.69	-2.38	4.40	0.60	0.552
BEST-AG CLAIMING	0.47	0.46	-0.46	1.40	1.01	0.317
BEST-AG EMOTIONAL SECURITY	0.54	1.31	-2.09	3.18	0.41	0.680
CAREGIVER STRAIN (CS)	0.08	0.22	-0.36	0.52	0.38	0.708
CS - SUBJECTIVE STRAIN	0.04	0.23	-0.42	0.49	0.16	0.877
CS - OBJECTIVE STRAIN	0.14	0.23	-0.32	0.60	0.60	0.550
PFS NURTURING/ATTACHMENT	-0.02	0.24	-0.49	0.45	-0.08	0.935
PFS FAMILY FUNCTIONING/RESILIENCY	0.19	0.24	-0.30	0.67	0.77	0.447

Notes:

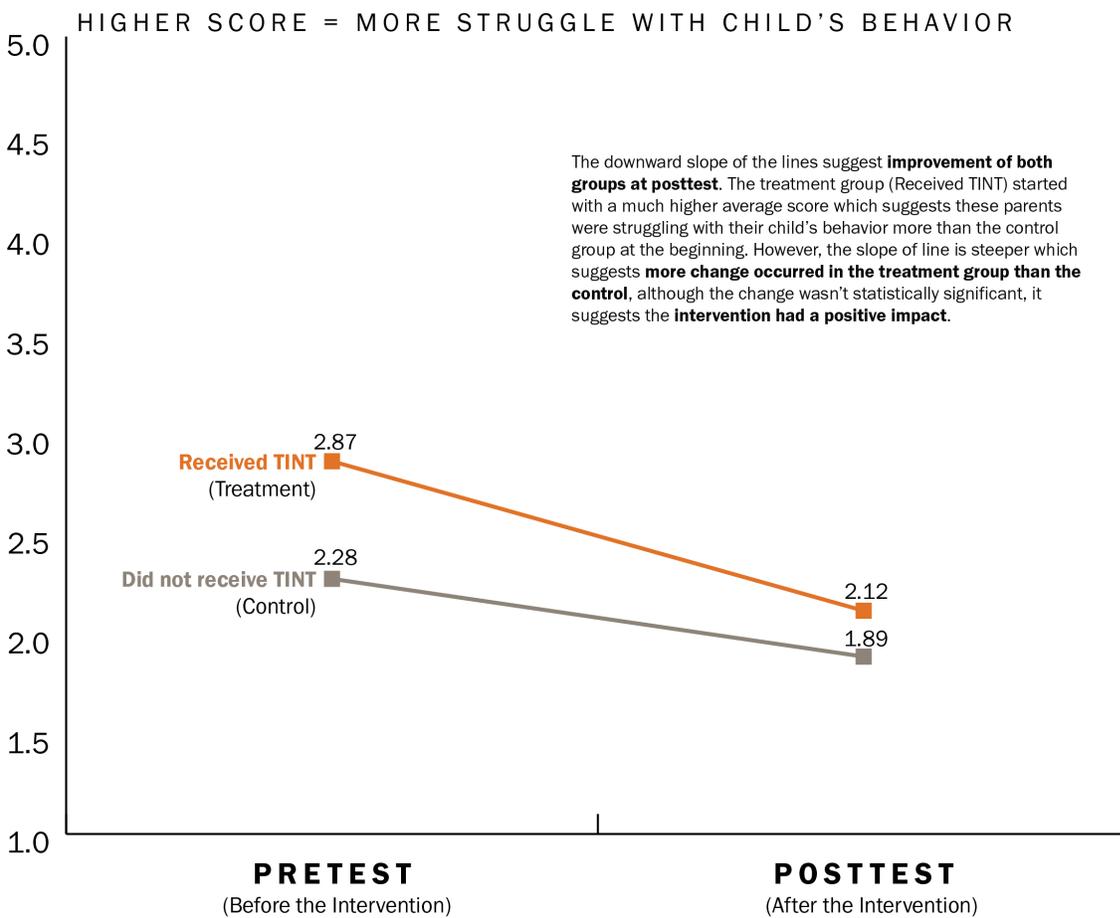
a nearest neighbor within caliper matching, with caliper set to 0.25 * sd, and the logit of propensity used as the propensity score

b INTERVENTION AND COMPARISON groups matched on four caregiver commitment variables measured at pre test

c ATE is estimated by mean (COMPARISON) – mean (INTERVENTION); t-tests indicate whether ATE's were statistically significant

Differences were examined between the comparison and TINT participant groups for cohorts 4-8. While these were not the main outcome measures, these questions asked parents and guardians to rate how well they felt they were doing. Baseline differences were noted and discussed previously (Tables 5.3-5.5) and these differences at baseline resulted in our decision to examine a matched comparison. To determine whether these measures were affected by the intervention, mixed linear models were estimated for each of the caregiver relationship variables to examine the interaction of the intervention over time for these outcomes. One model revealed a statistical trend, with the intervention having a slightly positive impact on one outcome over time: the extent to which parents struggled to manage their children's behavior. Figure 5.10 illustrates the slightly larger decrease in this outcome between pre test and posttest for the TINT participants versus the comparison group, a slight intervention effect that approached statistical significance. Table 5.15 in the Appendix provides more model details.

Figure 5.10. Caregiver Struggled to Manage Child Behavior: Pre and Post Tests (n=338)



Limitations

There were several limitations to keep in mind for the QIC-AG evaluation in New Jersey. First, as noted above, New Jersey is a unique state that has implemented significant policy and practice changes in the past few decades to promote permanence and better support for adoptive and guardianship families. For example, recent grant-funded work has been implemented to child welfare staff and create trauma-focused practice strategies. Therefore, the adoptive and guardianship experiences of families in New Jersey may not be representative of other states in the U.S.

Another limitation for this study was that only a small proportion of the eligible population participated in the research, and a significant proportion of those who agreed to participate in TINT did not actually receive the full intervention. For example, only 178 families out of the eligible population in New Jersey registered for TINT, and of these families, only about 53% (94) participated fully in the intervention. Further, the results presented above indicate that those families who agreed to participate in the study (versus those who did not agree to participate) and those who completed the full TINT intervention (versus those who did not complete the full intervention) both reported more difficulty in providing effective care for children. Thus, these findings show the limitations and potential biases of even sophisticated, randomized evaluation

designs in child welfare research, such as the random consent design (intended, at least in part, to increase participant enrollment; Testa & White, 2014). Specifically, external validity may be compromised when only a small proportion of the eligible population agreed to participate in the study, and internal validity may also be compromised when those who agreed to participate did not actually complete the required, full intervention (or the full “dose”) at significant rates, a problem analogous to attrition in medical intervention studies.

Related to intervention uptake, a final limitation of this study was that a low number of families had outcome data available for analyses. This restricted number of cases for analyses, particularly among TINT participants (i.e., just 94 families) meant diminished power to detect statistically significant differences between TINT participants and the comparison groups. In addition, small sample size, combined with a small observation window to observe changes among the TINT participants from enrollment and pretesting to outcome measurement (i.e., about 6 months), made detecting any changes due to the intervention very challenging. Thus, future studies should increase sample sizes and observe families for longer periods of time to examine if TINT has an impact on longer-term wellbeing or placement instability outcomes. However, the current study should be helpful for future research to provide information about potential outreach response rates associated with the offer of services for adoptive and guardianship families, the types of families who are likely to engage with TINT or another service at the selective interval, and possible strategies to improve recruitment or service delivery.

Thoughts from Parents and Guardians

At the end of the primary outcome survey sent to all parents and guardians, we asked respondents, *“Is there anything else about your experience of adoption or assuming guardianship of your child that you would like to share?”* Their responses reflect a wide variety of experiences within the narrow target population that we defined. Of the 514 families surveyed (from the intervention and comparison groups), almost 46% (N = 235) wrote comments about their experiences. For those interested in helping families formed through adoption or guardianship, the direct responses from parents and guardians may assist in thinking through what is needed. Regarding the experience of being an adoptive parent or guardian:

“Adopting our son has been the single best decision we have made in our lives.”

“Great experience. Would do it again if I had to.”

“I thank God every day for him being in our lives.”

“He is my world.”

A number of respondents wrote that their adopted child was “loved no less than” their biological children and was not “treated” as if they were adopted. Many felt “lucky” that they had adopted or were guardians and described their child as “smart,” “a joy,” and “awesome.” The word “love” or “loved” was written 32 times. Respondents wrote they wanted to be supportive of other caregivers and provided advice, such as “You have to be level headed at all times.” One participant remarked:

“Some children need to not only feel love but show it with actions. We must show patience and lots of prayer for our children. By being the best parent for that child – showing them we will fight for them to be successful adults when they grow up.”

Most respondents described their adoptive or guardianship experience as positive but also challenging. As one parent noted, adopting a child is a “great blessing but difficult. Not for everyone.” Another caregiver said it had its “ups and downs.” Problems were on a continuum.. A number of respondents wrote that tensions in their families were high when their teenager began exhibiting “emotional and physical changes” or “typical teenage conflicts.” One participant suggested that therapy should be provided during adolescence to help youth with identity issues:

“While there have been challenges throughout, now that my child is a teenager, issues with racial identity, adoption, and medical issues have become more pronounced. However, adopting Jan [pseudonym] has been one of the best things in my life.”

On the other end of the spectrum were difficulties in managing problems stemming from diagnoses such as ADHD, ODD, Bi-Polar Disorder, PTSD, and RAD. One survey participant wrote that her child’s “Bi-Polar Disorder/ADHD/ODD have torn apart my family.” Another noted that adoption “... has ruined my partner and my relationship. It has put us deeply in debt.” Problems were compounded when caregivers had not received information about their child’s past medical and mental health histories prior to adopting or becoming guardians. One caregiver wrote that the lack of disclosure from the public child welfare system about her child’s background history “impeded his healing.”

Many respondents expressed their disappointment in the lack of available resources, services and support from the public child welfare system after adoption or guardianship was finalized. As described in the following quotes, the lack of support in addressing their child’s mental health needs and behavioral issues was of particular concern:

“We have adopted seven kids from foster care. Three have Borderline Personality Disorder. I believe this is common but needs to be addressed when the child is young. There must be education AND on-going assistance for this.”

“Once I gained legal guardianship it seemed as though all resources disappeared. When my daughter was in need of a therapist, I was given no help or advice, I knew to go through her insurance. I was and am very disappointed in that.”

Survey participants wrote that not only did caseworkers need to be “better equipped to help adoptive parents,” but also shared a strong need for the improvement of the training required in order to become an adoptive parent or guardian. They pointed out that having more support from the child welfare system “especially during the teenage years” was essential.

Caregivers wrote they also needed to be better supported by school district professionals. One respondent described the lack of services her child was receiving for his dyslexia. Another described how her son has been bullied at school for years and that the slow response exhibited by teachers and administrators in protecting him was detrimental to his health:

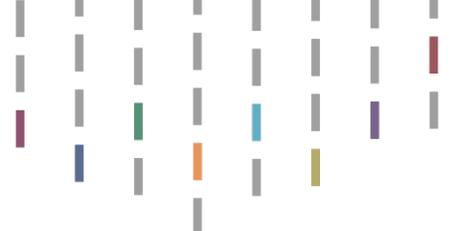
“My son is a sweet boy and I am very upset with the rules in school. He had been suffering from bullying abuse for two years at school. We had confronted all the parts including the principal and teachers. He broke a hand defending himself. He is very scared, nobody does nothing. I am always walking him to school and picking him up. I need help.”

In addition to needing greater support and services, respondents described other problems that affected their child and family. Stressors included the family’s finances, lengthy adoption and guardianship process, and interactions with biological family. One caregiver noted the precarious balance between meeting her child’s needs and her obligations at work: “The most challenging part is trying to maintain a full-time job while supporting her with all of her medical and physical needs.” Caregivers also expressed the financial strain they incurred:

“I was told at the adoption that because they are special needs children their adoption subsidy will continue until they are 21 years of age. Now, I'm being told something different. I'm concerned as we will always have to pay additional money for someone to care for them while we work.”

At least 9 quotes focused on adoptive parents and guardians wanting the state to be responsible for paying for their child’s education or college assistance. For example, the following quote was typical of survey responders: “My niece just graduated high school, is turning 18 and the subsidy check will stop. This is a crucial age - She is attending a technical institute. Without my support she has no funding.”

To summarize, a significant percentage of adoptive parents and guardians provided comments in the survey. While many respondents expressed that their adoption or guardianship was a very positive experience, many also wrote that having an adopted or guardian child was challenging particularly if the child had a mental health condition. Most of the respondents felt they needed more services and financial support. Respondents also reported wanting more training and a venue where they could support others in their situation.



Cost Evaluation

The New Jersey QIC-AG project implemented and tested the effectiveness of Tuning in to Teens ('TINT'). TINT is a group intervention for caregivers who are parenting children who have experienced trauma, grief, and loss. The New Jersey QIC-AG site tested the impact of TINT on children between the ages of 10 and 13 whose caregivers were receiving adoption or guardianship subsidies. The project served 94 caregivers who attended at least four group sessions.

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 was applied to the outcomes identified by New Jersey.

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 New Jersey 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 post permanency interventions such as New Jersey, the desired impact of the programs is to prevent re-entry into foster care for the target child. However, improvement of parent knowledge and/or child behaviors are also considered to be positive outcomes. While the New Jersey 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

Constraints are factors that are external to a program but have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For New Jersey, constraints include challenges with the outreach tracking system, which was used inconsistently amongst workers and experienced technical glitches in several instances, which resulted in lost data or duplicated data that needed to be revised. DCF staff facilitating TINT sessions needed special permission to do this work over and above their traditional duties, which was facilitated through the use of overtime. Additionally, during this initiative, the agency Commissioner changed, leading to widespread change amongst leadership in the agency. These outside conditions were navigated by the site team but had an impact on time and work effort.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. Conditions in New Jersey include prior experience and capabilities in research. New Jersey's DCF has invested considerable resources in developing internal support for research, including a staff of researchers to support internal and external research projects, a Data Fellows project that teaches staff to explore practice issues in the administrative data, and a regular process for reviewing external research requests for compliance with agency ethics and standards. In addition, the Office of Adoption Operations had just completed an experimental study of a practice approach innovation, supported by the Children's Bureau and in collaboration with a university research partner.

Cost Estimation

The next step in this cost analysis is to estimate the costs New Jersey incurred to implement the intervention. This cost estimation includes actual costs paid to New Jersey by Spaulding for Children on behalf of the QIC-AG.

KEY POINTS IN COST ESTIMATION

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 New Jersey.

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. 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 New Jersey 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 New Jersey implemented this intervention for a three-year period, costs did not change dramatically. The major cost that would be impacted in this short time frame was staff salary and this change was accounted for in the direct expenses that New Jersey incurred each year.

Both variable and fixed costs should be captured in cost estimation. For New Jersey, fixed costs included salaries, fringe and facility/office space. Variable costs were charged to the project as needed for items such as meals for families, gift cards and program supplies.

Marginal and average costs should be examined in 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 New Jersey were taken from monthly budget forms and summarized into Table 5.7.

Table 5.7. Costs for New Jersey

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL COSTS				
SITE IMPLEMENTATION MGR-SALARY	\$75,219	\$75,139	\$75,219	\$225,577
SITE IMPLEMENTATION MGR-FRINGE	\$34,037	\$38,343	\$34,037	\$106,416
NON-PERSONNEL DIRECT EXPENSES				
CONTRACTED SERVICES: RUTGERS ADMIN. ASST.		\$19,885	\$38,202	\$58,087
CONTRACTED SERVICES: UNIV. OF MELBOURNE			\$5,148	\$5,148
CONTRACTED SERVICES: UNIV. OF MELBOURNE- FACILITATOR TRAINING		\$49,091		\$49,091
CONTRACTED SERVICES: LEAD FACILITATOR	\$19,899	\$69,827	\$69,644	\$159,370
CONTRACTED SERVICES: CONTRACTED FACILITATORS	\$2,571	\$40,284	\$38,142	\$80,997
CONTRACTED SERVICES: SPANISH TRANSLATION OF MATERIALS			\$5,000	\$5,000
CONTRACTED SERVICES: STORAGE		\$948	\$840	\$1,788
COMPUTER-IT NETWORK			\$6,153	\$6,153
FACILITIES/OFFICE SPACE	\$449			\$449
GIFT CARD INCENTIVES			\$10,277	\$10,277
POSTAGE	\$1,339		\$1,023	\$2,363
PRINTING/DUPLICATION	\$749			\$749
PROGRAM SUPPLIES	\$316	\$8,863	\$535	\$9,713
PROGRAM SUPPLIES: TINT FACILITATORS SUPPLIES	\$391	\$8,750		\$9,141
PROGRAM SUPPLIES: TINT MANUALS		\$115		\$115
TELEPHONE		\$1,559		\$1,559
TRAVEL	\$6,420	\$8,591	\$20,496	\$35,506
OTHER: CPFA REGISTRATION		\$160		\$160
OTHER: FOOD FOR FAMILIES	\$1,951	\$13,123		\$15,074
OTHER: FACILITATOR OBSERVATIONS			\$1,428	\$1,428
OTHER: RECRUITMENT FOR PRIVATE FAMILIES			\$369	\$369
OTHER: HONORARIUM FOR ADOPTIVE PARENT ON PMT			\$208	\$208
OTHER: REIMBURSEMENT FOR CLEAR		\$935	\$1,122	\$2,057
INDIRECT EXPENSES				\$0
TOTAL	\$143,340.96	\$335,612.07	\$307,842.32	\$786,795.35

*FY2019 ended 3/31/19

**FY2017 began 4/1/17

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 5.7.

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 were used in this cost estimation. Multiple direct costs were billable to the project. Each of these is described below.

Personnel

Personnel costs totaled \$225,577 for the salary of the SIM during the implementation phase. The SIM provided program support by organizing all aspects of groups, including coordinating locations, recruitment, and meals. The SIM 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.

Fringe

Overall fringe for all employees totaled \$106,416. Fringe for the SIM was calculated based on state agency requirements.

Contractual Expenses

New Jersey contracted for services from six entities.

A DCF Administrative Assistant was paid \$58,086 to hire an administrative assistant to support the SIM in conducting intervention outreach and support activities, such as outreach to families to invite them to participate, securing site locations, and ordering food.

The TINT curriculum was developed and is owned by the University of Melbourne. The University of Melbourne was paid \$49,090 for initial facilitator training. This cost covered training and licensing fees as well as the trainer's travel to New Jersey. The University of Melbourne was also paid \$5,148 for coaching and consultation.

An experienced adoption clinician was paid \$159,369 for serving as the lead facilitator for the TINT implementation. In addition to direct facilitation, she provided oversight and support to all facilitators and tracked fidelity to the intervention problem-solving as necessary.

Additional expenses included: Additional contracted facilitators were paid \$80,997 for facilitating various groups. A translation specialist was paid \$5,000 for translation of the TINT manual into Spanish. \$1,788 was paid to a storage facility for books, binders, and other program supplies.

Gift Cards

Gift cards were provided to participants. A total of \$18,239 was spent on gift card incentives to encourage participation in TINT. Parents were provided \$150 to offset costs they may have incurred, such as childcare or transportation, in the form of three \$50 gift cards provided at regular intervals over the course of the TINT program. A total of 360 gift cards were provided to participants.

Materials and Supplies

Over the implementation period, \$17,587 was spent on program supplies that were specific to the operation of the intervention. \$114 was spent on TINT manuals. \$9,140 was spent on TINT Facilitator supplies. \$8,331 was spent on general supplies.

Travel

Over implementation, \$35,506 was paid for travel. Travel funds were used to cover the travel of SIM to attend grantee and other required meetings. Travel also covered the costs of travel for facilitators.

Facilities/Office Space

\$449 was paid for facility rental fees to secure space for groups.

Other Direct Charges

Other direct charges include all non-personnel direct costs that do not fit into the categories listed above, such as postage (\$2,362); printing (\$748); food for groups (\$215,073); computer IT support for the specific program and evaluation (\$6,153); Concerned Persons for Adoption (CPFA) (\$160). Facilitator observations (\$1,428); recruitment of families formed by private adoption (\$368); Reimbursement for CLEAR (\$2,057), which is an address search company; and an honorarium for an adoptive parent who served on the PMT and was provided a small stipend to offset her travel and time (\$208).

Estimation of Indirect Costs

Descriptions of all indirect costs billable to Spaulding were defined by Spaulding. These same descriptions were used in this cost estimation. The New Jersey site did not charge indirect costs to the program. Each of these is described below.

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. Since the state agency was the project lead, the New Jersey site had a substantial infrastructure. Because the evaluation team assumed that other interested child welfare agencies would also have 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; some administrative support for contracting and financial management; access to a computer, printer, and phone, as well as supervision of project staff.

Summary of Costs

Total implementation costs for New Jersey were \$794,758 over the course of the implementation of the intervention.

Cost Calculations

Using the data from the cost estimation, cost calculations were completed based on project participation and outcomes.

COST PER PARTICIPANT

Based on the total costs of \$794,758 and 94 families, the cost per family for this intervention was \$8,455.

COST-EFFECTIVENESS ESTIMATION

Given that there are no significant differences in the short-term outcomes, a cost-effectiveness ratio was not calculated.

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 have been removed from the cost calculation. Inclusion or exclusion of costs in a sensitivity analysis such as this one is subjective. A decision was made based on the following question: Is this expense critical to the functioning of the intervention? Another agency would want to adjust costs specific to their program needs. 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 other staff positions.

2. Fees for storage and office space were removed, as this was not necessary for the intervention.
3. Gift cards were removed from the cost calculation. Gift cards were provided to offset childcare and transportation costs. Other agencies would want to consider how to best meet these needs, as this may not be with gift cards.
4. Program supplies not related to TINT were excluded.
5. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings.
6. Costs related to computers/IT resources, phones, postage, and printing were removed. It is not clear to what extent these costs are actually needed for the intervention.
7. Costs related to facilitator observations were removed because this was related to the evaluation.
8. Costs related to food were removed. While meals are an important component, other agencies may be able to get in-kind donations or find other ways to cover food costs.
9. Other direct charges that were excluded consist of CPFA registration, recruitment of private families, honorarium, reimbursement for CLEAR. These expenses were not necessary for the implementation of the intervention.
10. 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 5.8 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was \$366,948, which amounted to \$3,904 per participant.

Table 5.8. Sensitivity analysis: Adjusted costs for New Jersey

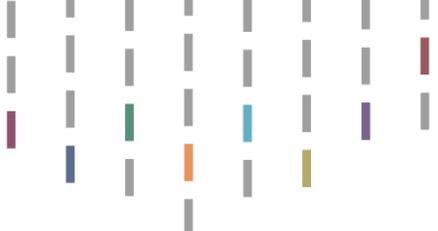
	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
CONTRACTED SERVICES: RUTGERS ADMIN. ASST.		\$19,885	\$38,202	\$58,087
CONTRACTED SERVICES: UNIV. OF MELBOURNE			\$5,148	\$5,148
CONTRACTED SERVICES: UNIV. OF MELBOURNE- FACILITATOR TRAINING		\$49,091		\$49,091
CONTRACTED SERVICES: LEAD FACILITATOR	\$19,899	\$69,827	\$69,644	\$159,370
CONTRACTED SERVICES: CONTRACTED FACILITATORS	\$2,571	\$40,284	\$38,142	\$80,997
CONTRACTED SERVICES: SPANISH TRANSLATION OF MATERIALS			\$5,000	\$5,000
PROGRAM SUPPLIES: TINT FACILITATORS SUPPLIES	\$391	\$8,750		\$9,141
PROGRAM SUPPLIES: TINT MANUALS		\$115		\$115
INDIRECT EXPENSES				\$0
TOTAL	\$22,860	\$187,952	\$156,136	\$366,948

*FY2019 ended 3/31/19

**FY2017 began 4/1/17

Cost Evaluation Summary

Based on the total costs of \$794,758 and 94 families, the cost per family for this intervention was \$8,455. However, the sensitivity analysis demonstrated that multiple costs could be reduced if TINT were replicated with projects. Thus, the more realistic cost per participant is \$3,904.



Discussion

The primary research question addressed in the New Jersey QIC-AG project was: Will children currently between the ages of 10 and 13 who are receiving an adoption or KLG subsidy, are not open for services with DCF, and meet study inclusion criteria experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health if they received Tuning in to Teens (TINT) compared to similar children who receive services as usual?

This study found no statistically significant changes when comparing the intervention participants to the full comparison sample or to a matched-subset of the comparison sample. However, an improvement was observed in adoptive parents and guardians' self-reported ability to better manage their child's behavior. While this change did not reach the level of statistical significance, it is an important finding, particularly because prior research has established that difficulty with challenging child behaviors is associated with post permanency discontinuity (Testa, et al., 2015). In addition, it is possible that the parents' self-appraisal could be predictive of future, longer-term changes. The ultimate outcome of interest is post permanency stability. More time is needed to detect this outcome. Following up with families and administrative data on return to care would be beneficial to determine whether outcomes improved.

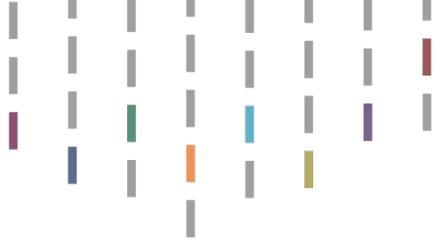
Secondarily, this study was interested in exploring whether TINT would have similar results with an adoption and KLG sample as it has had with a more general population of parents. However, the response rates from the TINT surveys limited our ability to draw conclusions. For instance, an increase (from pre TINT to post TINT) was noted in youth appraisal of parent responsiveness, suggesting that parents and guardianship who participated in TINT were more responsive after participating in TINT than before. However, caution should be used in interpreting these results as they are based on 11 responses.

This study provides some important information on how families who have higher risk characteristics are faring post permanence. It also provides insight into how families responded to the offer of parental opportunities for support. Successful contact by the program was made with a majority of (57%) of families. This is a significant proportion of adoptive and KLG families in New Jersey. These families may not have had contact from the child welfare system for many years, some up to a decade. This suggests that families are willing to engage with the child welfare system, even years after adoption or guardianship finalization. Most of the families did not engage in services: 94 (12%) of the intervention group participated in the full intervention. Offering sessions multiple times in the same community, and additional follow-up calls to remind families of the upcoming TINT session they had registered for, did not yield additional intervention uptake. Additionally, within this population, those that reported they were struggling were likely to participate in the intervention. This suggests that many families that are struggling would be open to agency outreach and support after adoption and guardianship finalization.

Consistent with previous studies on the experiences of adoptive and guardianship families (summarized in White, Rolock, Testa, Ringeisen, Childs, Johnson, & Diamant-Wilson, 2018), this study provides evidence that the majority of families are adjusting well. Families who were struggling seemed receptive to TINT, and TINT was offered with a high level of fidelity. It is possible that no intervention effects were observed when comparing TINT participants and comparison group populations due to the limited observation window. Personal and interpersonal change is difficult and takes time, especially given the long history of trauma that many adoptive and guardianship youth have experienced due to maltreatment and previous placement moves (Jones & Schulte, 2019). The observation window in this study was only about 6 months from pretest to posttest. Thus, perhaps with additional time, and more families enrolled, different results regarding the TINT intervention may have emerged.

This study found that, the target population was narrowed to a specific group of families who fit the eligibility criteria, yet this group of families was heterogeneous; some reported struggling, and others reported doing well. Importantly, families who reported they were struggling were likely to participate in the intervention. This suggests that families who are struggling would be open to engaging in services. What is unclear is whether TINT is the most effective intervention to offer. It is possible that additional support, such as booster sessions, a companion youth group, or some additional family therapy would be beneficial to increase the efficacy of this intervention.

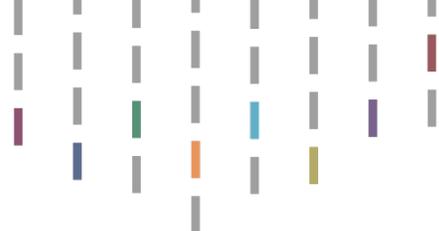
We asked parents and guardians if they had things to share about their adoption or guardianship experiences. Almost a third of the quotes written described their adoption or guardianship experiences as “very positive.” However, many parents also described their experience as challenging and discussed the need for additional resources, preparation, and training for caseworkers. Further, they discussed the need for community-based services, such as school professionals, to be better trained and prepared to support children’s special education and mental health needs. In one case, a parent discussed challenges getting a school to take bullying seriously, which has serious consequences for all children but could be especially challenging for a child that has already experienced significant trauma. Of particular concern to parents were the needs of children with mental health conditions, issues with the biological parents, and the financial strain families experienced after adoption or guardianship finalization. These reflections from parents and guardians underscore the need for additional supports post permanence. Thus, similar to other prevention efforts, preventing adoption and guardianship instability may require a continuum of services that take into account the diversity of issues families face. Listening to the experiences of parents and guardians clearly underscore the need for additional supports post permanence.



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Appendices

Appendix A. Data Sources and Collection

ADMINISTRATIVE DATA

Administrative data, derived from the *NJ Spirit* administrative system, was used in New Jersey to help select the sample frame, and to help understand characteristics of adoptive and KLG families. These data came from DCS, in the form of specific data requests from the QIC-AG evaluation team, and through copies of the NJ Adoption and Foster Care Analysis and Reporting System (AFCARS) files. Federal law and regulation requires state child welfare agencies to submit AFCARS data on a bi-annual basis. These data are collect case-level information on all children for whom the agency is responsible for placement, care, or supervision and on children adopted under the auspices of the agency and submitted to the Administration for Children and Families of the Department of Health and Human Services (ACF).

FIDELITY MEASURES

Fidelity in TINT relies on adherence to a parent coaching style involving five steps (Gottman & DeClaire, 1997). These are (1) become aware of the child's emotion, especially if it is at a lower intensity; (2) view the child's emotion as an opportunity for intimacy and teaching; (3) communicate understanding and acceptance of emotions with empathy; (4) help the child to use words to describe how they feel; and (5) if necessary, assist them with problem solving. The coaching manual provided a structured implementation of the curriculum that ensured all elements critical to the coaching model were addressed by the facilitator. Facilitators completed a brief fidelity checklist to indicate whether or not they completed each section of the manual and made notes regarding the implementation. The QIC- AG team created an electronic template of each fidelity checklist that facilitators completed and shared with the university partners.

TINT SURVEYS

A series of surveys were developed by the purveyor for use with TINT participants. These surveys were administered on-line by Rutgers University to TINT participants only. When families register for TINT sessions, DCF collected e-mail addresses. This included e-mail addresses for the adult and one youth per family. DCF shared email addresses with Rutgers for survey administration. For families who did not have email addresses, or regular access to a computer, paper surveys were mailed by Rutgers to participants. These instruments were and were adapted slightly for our initiative.

The following TINT surveys were administered:

- **TINT Pre Program Survey** - at time of registration. A baseline questionnaire was completed by participants at the beginning of the coaching sessions. This was administered to one adult and one youth per family.
- **TINT Post Program Satisfaction Survey** - at time of completion of TINT
- **TINT Post Program Survey** - at 10 to 12 months post TINT. This was administered to one adult and one youth per family.

After completing the *follow-up survey* youth received a \$25 gift card. Gift cards were sent once both surveys (from parent and teen) were received by Rutgers.

PRIMARY OUTCOME SURVEY

The primary evaluation is the comparison between the intervention and comparison groups. The QIC-AG contracted with an outside firm, The Survey Research Lab (SRL) at the University of Illinois at Chicago (UIC) to administer one-page questionnaires and primary outcome surveys to participants in both the Intervention and Comparison groups. All were administered to a parent or guardian.

- The one-page questionnaire was sent prior to outreach by the program staff. The purpose of this one-pager was to gather preliminary information about all families. The SRL protocol for survey administration included a \$5 non-contingent incentive attached to the request to participate. Finally, the one-pager informed respondents that they should expect a follow-up survey in approximately 6 months and asked the respondent to contact SRL if they moved before receipt of the main survey. These one-pagers were sent to families assigned to Cohort 6 and later, cohorts prior to 6 received the primary outcome survey only. This questionnaire asked questions related to the caregivers' views of their relationship with their child, a child who they had assumed guardianship of, or who they adopted.
- The primary outcome survey was administered to all families assigned to both the intervention and comparison groups. The purpose of the survey was to gather information related to the outcomes. The SRL protocol for survey administration included a \$5 non-contingent incentive attached to the request to participate, and a \$20 incentive for survey completion.

Appendix B. Site Teams

The New Jersey QIC-AG site team selected members to participate on the Project Management Team (PMT), the Stakeholder Advisory Team (SAT) and the Implementation Team to help design and implement the project. The PMT included key leaders across DCF's 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 private, domestic, and international adoption; adoptive and KLG families; and representatives from support agencies.

The Implementation Team was responsible for planning, assessing, and implementing the intervention, including rolling out training to selected families. Example of team member duties included: reserving training space, preparing invitations, planning food orders, locating and hiring child care professionals, modifying the curriculum, coordinating training for facilitators, communicating with SIM and Facilitator Supervisor.

In addition to the QIC-AG Site Consultant, QIC-AG Site Implementation Manager, and intervention purveyor (Sophie Havighurst), the Implementation Team had numerous system partners such as the Adoption Council of New Jersey (AACNJ); Division of Children's System of Care (CSOC); Concerned Persons for Adoption (CPFA); Family Support Organization (FSO); Foster and Adoptive Families Support FAFS); NJ Adoption Resource Clearinghouse (NJ ARCH), and most importantly; adoptive and KLG parents. The AACNJ assisted in building communication with families who adopted privately or internationally in New Jersey.

Two other teams in New Jersey that worked closely on the QIC-AG project were the Data Workgroup and the Adaptation Workgroup. Connecting the data teams from DCF, Rutgers, and the QIC-AG, the Data Workgroup organized existing data, helped set the sample size, and as the project progressed, analyzed the data collected during the project. The Adaptation Workgroup adapted the TINT curriculum and manual to include the post permanency populations and adoption competent practice. The workgroup consisted of DCF and QIC-AG staff who worked closely with the purveyor to make adaptations. The Adaptation Workgroup team operated during the implementation planning phase and continued to meet and function throughout training and usability testing.

Appendix C. Data Tables

Table 5.9. Baseline Differences between Families Assigned to the Comparison and Intervention Groups

BASELINE DIFFERENCES BETWEEN FAMILIES ASSIGNED TO THE COMPARISON AND INTERVENTION GROUPS									
	COMPARISON (N=105)			ALL INTERVENTION CASES (N=175)			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	t	df	p
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	105	1.56	0.73	175	1.65	0.86	-0.83	278	0.405
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	101	2.19	1.21	171	2.39	1.23	-1.33	270	0.186
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	101	2.78	1.24	170	2.78	1.23	0.00	269	0.999
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	101	2.07	1.24	167	2.16	1.26	-0.55	266	0.585
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	104	4.39	0.73	174	4.36	0.78	0.34	276	0.734
HOW OFTEN DO YOU THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	105	4.72	0.69	172	4.72	0.73	0.10	275	0.922
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	104	6.37	1.34	172	6.44	1.12	-0.47	274	0.639
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	104	4.74	0.76	174	4.66	0.84	0.85	276	0.397

Table 5.10. Baseline Differences between Comparison and Intervention Participants

BASELINE DIFFERENCES BETWEEN COMPARISON AND PARTICIPANTS									
	COMPARISON (N=105)			INTERVENTION PARTICIPANTS (N=33)			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	t	df	p
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	105	1.56	0.73	33	1.79	0.82	-1.50	136	0.136
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	101	2.19	1.21	33	2.82	1.31	-2.55	132	0.012
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	101	2.78	1.24	33	3.03	1.29	-0.99	132	0.324
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	101	2.07	1.24	33	2.55	1.37	-1.86	132	0.065
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	104	4.39	0.73	33	4.03	0.73	2.50	135	0.014
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	105	4.72	0.69	32	4.78	0.55	-0.43	135	0.666
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	104	6.37	1.34	32	6.25	1.37	0.42	134	0.673
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	104	4.74	0.76	33	4.67	0.60	0.51	135	0.613

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

Table 5.11. Baseline Differences within Intervention Group (Non-Participants vs Full Participants)

WITHIN INTERVENTION GROUP (NON-PARTICIPANTS VS FULL PARTICIPANTS)									
	NON-PARTICIPANTS (n=142)			INTERVENTION PARTICIPANTS (n=33)			BASELINE DIFFERENCES WITHIN INTERVENTION		
	N	M	SD	N	M	SD	t	df	p
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	142	1.61	0.87	33	1.79	0.82	-1.06	173	0.292
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	138	2.29	1.20	33	2.82	1.31	-2.24	169	0.027
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	137	2.72	1.22	33	3.03	1.29	-1.29	168	0.199
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	134	2.06	1.22	33	2.55	1.37	-2.00	165	0.047
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	141	4.44	0.78	33	4.03	0.73	2.75	172	0.006
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	140	4.70	0.77	32	4.78	0.55	-0.57	170	0.571
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	140	6.48	1.06	32	6.25	1.37	1.04	170	0.301
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	141	4.65	0.89	33	4.67	0.60	-0.09	172	0.931

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

Table 5.12. TINT Surveys: Baseline (Pre Intervention) Scale Scores

PRE INTERVENTION SCALE SCORES							
SCALE	N	M (SD)				CORRELATION	
		YOUTH		PARENTS		R	p
STRENGTHS AND DIFFICULTIES	41	14.69	(6.50)	14.46	(8.27)	0.61	<0.001
SDQ: INTERNALIZING BEHAVIORS	41	5.01	(3.05)	5.00	(3.56)	0.61	<0.001
SDQ: EXTERNALIZING BEHAVIORS	41	7.38	(3.82)	7.53	(4.51)	0.60	<0.001
SPENCE CHILDREN'S ANXIETY SCALE	41	21.87	(13.50)	14.99	(11.64)	0.60	<0.001
CHILDREN'S DEPRESSION INDEX +	40	2.24	(2.78)	11.33	(8.08)	0.29	0.067
PHYSICAL PROBLEMS	40	4.43	(1.24)	5.00	(1.57)	0.26	0.100
PHYSICAL PROBLEMS W/OUT KNOWN CAUSE	41	9.28	(1.87)	8.96	(1.83)	0.30	0.054
EMOTIONS AS A CHILD SCALE	39	103.57	(17.04)	89.40	(16.74)	0.27	0.094
EACS: ENCOURAGING SUBSCALE	39	19.73	(9.59)	13.84	(5.57)	0.15	0.335
EACS: PUNISHING SUBSCALE	39	16.37	(4.95)	13.47	(4.53)	0.43	0.007
EACS: NEGLECTING SUBSCALE	39	23.73	(4.80)	20.79	(4.50)	0.08	0.618
EACS: MATCHING SUBSCALE	39	18.62	(6.92)	16.87	(5.02)	0.15	0.375
EACS: OVERRIDING SUBSCALE	39	25.13	(7.96)	24.43	(8.15)	0.42	0.007
FAMILY CLIMATE SCALE	39	6.15	(2.38)	6.18	(2.28)	0.47	0.003
FAMILY ASSESSMENT DEVICE	40	21.46	(5.39)	19.66	(5.89)	0.38	0.015
DIFFICULTIES IN EMOTIONAL REGULATION	36	77.25	(23.85)	57.12	(13.46)	0.01	0.971
ACCEPTANCE & ACTION QUESTIONNAIRE (AAQ)	51			10.25	(4.64)		

+ Note: Children's Depression Inventory is scored differently for parents and youth and scores should not be compared using pairwise correlations

Red cells represent a statistically significant difference at the .05 level

Table 5.13. TINT Surveys: Parent and Youth Paired Sample Results Pre and Post Intervention

PARENT AND YOUTH PAIRED SAMPLE RESULTS PRE AND POST INTERVENTION							
	N	T ₁ M	(SD)	T ₂ M	(SD)	t	p
PARENT							
EMOTIONS AS A CHILD SCALE	39	89.40	(16.74)	103.57	(17.04)	-4.34	<0.001
ACCEPTANCE & ACTION QUESTIONNAIRE	21	9.05	(4.22)	11.29	(6.46)	-2.38	0.027
YOUTH							
STRENGTHS AND DIFFICULTIES QUESTIONNAIRE	13	15.19	(6.96)	15.54	(6.97)	-0.158	0.877
SDQ: INTERNALIZING BEHAVIORS	13	5.23	(3.83)	5.23	(4.27)	0.00	1.000
SDQ: EXTERNALIZING BEHAVIORS	13	7.69	(4.09)	7.85	(3.53)	-0.15	0.881
SPENCE CHILDREN'S ANXIETY SCALE	12	23.19	(15.94)	21.49	(17.72)	0.42	0.683
CHILDREN'S DEPRESSION INVENTORY	11	2.18	(2.75)	2.73	(3.93)	0.54	0.599
EMOTIONS AS A CHILD SCALE	11	103.97	(22.09)	91.29	(22.18)	2.55	0.029
EACS: ENCOURAGING SUBSCALE	11	19.54	(9.35)	15.81	(5.92)	1.33	0.213
EACS: PUNISHING SUBSCALE	11	16.61	(5.25)	14.27	(4.71)	1.46	0.173
EACS: NEGLECTING SUBSCALE	11	22.63	(4.98)	21.98	(4.67)	0.56	0.585
EACS: MATCHING SUBSCALE	11	21.36	(7.89)	15.27	(5.85)	2.25	0.049
EACS: OVERRIDING SUBSCALE	11	23.82	(6.18)	23.96	(8.25)	-0.05	0.960
FAMILY ASSESSMENT DEVICE	12	20.71	(6.42)	21.09	(6.93)	-0.26	0.802
FAMILY CONFLICT SCALE	11	5.82	(2.18)	5.36	(1.80)	0.86	0.410
DIFFICULTIES WITH EMOTION REGULATION	10	82.96	(25.40)	76.54	(21.94)	1.08	0.340

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

Table 5.14. Primary Survey: Comparison of TINT Participants and the Comparison Group

OUTCOMES COMPARISON OF TINT PARTICIPANTS AND COMPARISON GROUP									
CAREGIVER COMMITMENT QUESTIONS	INTERVENTION PARTICIPANTS			COMPARISON			t	df	p
	N	M	SD	N	M	SD			
ADOPT OR GUARDIANSHIP AGAIN	62	4.48	1.04	187	4.66	0.82	-1.35	247	0.179
THINK OF ENDING THE ADOPTION/GUARDIANSHIP +	59	1.29	0.64	185	1.21	0.63	0.88	242	0.381
CAREGIVER CONFIDENCE	61	4.18	0.72	185	4.31	0.79	-1.17	244	0.243
STRUGGLE TO UNDERSTAND	62	2.15	0.90	185	2.05	1.01	0.67	245	0.505
IMPACT OF THE ADOPTION OR GUARDIANSHIP	62	6.29	1.03	186	6.29	1.31	0.00	246	1.000
BEHAVIORAL PROBLEM INDEX (BPI)	60	12.12	10.12	186	10.66	10.56	0.95	244	0.345
BPI - EXTERNALIZING	60	8.97	7.94	186	7.73	7.72	1.08	244	0.282
BPI - INTERNALIZING	60	3.72	3.50	186	3.26	3.73	0.84	244	0.402
BEST	62	93.80	5.22	186	94.98	5.38	-1.50	246	0.134
BEST - EMOTIONAL SECURITY	62	59.92	4.33	186	60.94	4.28	-1.63	246	0.105
BEST - CLAIMING	62	33.88	1.57	186	34.04	1.81	-0.59	246	0.557
CAREGIVER STRAIN (CS)	62	1.73	0.66	186	1.68	0.73	0.51	246	0.609
CS - OBJECTIVE STRAIN	62	1.56	0.77	186	1.49	0.80	0.57	246	0.566
CS - SUBJECTIVE STRAIN	62	1.87	0.71	186	1.83	0.74	-1.33	246	0.185
NURTURING/ATTACHMENT	62	5.99	0.83	186	6.16	0.86	-0.47	245	0.638
FAMILY FUNCTIONING/RESILIENCY	61	6.01	0.78	186	6.08	0.93	-1.35	247	0.179

Note: + The inverse was graphed for the “Think of ending the adoption or guardianship” variable in Figure 5.9. This was done for ease of interpretation (so that both caregiver commitment questions that were graphed reflected higher scores were a more positive outcome).

Table 5.15. Results of Linear Mixed Effects Model: Outcome: The Extent to which Parents Struggled with their Child’s Behavior

RESULTS OF LINEAR MIXED EFFECTS MODEL						
OUTCOME: EXTENT TO WHICH PARENTS STRUGGLED WITH THEIR CHILD’S BEHAVIOR (N=338)						
FIXED-EFFECTS	COEFFICIENT	SE	z	p	95% CI	
TINT PARTICIPANTS (COMPARISON AS REFERENCE)	0.58	0.23	2.49	0.013	0.12	1.04
TIME: PRETEST OR POSTEST	-0.39	0.11	-3.51	<0.000	-0.61	-0.17
INTERACTION: TREATMENT X TIME	-0.36	0.20	-1.74	0.082	-0.76	0.04
CONSTANT	2.28	0.12	18.27	<0.000	2.04	2.53
RANDOM-EFFECTS	ESTIMATE	SE			95% CI	
CONSTANT	1.05	0.14			0.81	1.36
RESIDUAL	0.46	0.07			0.34	0.61
WALD CHI SQUARE	ESTIMATE	df		p		
	35.25	3		<0.000		

Chapter 10

CROSS-SITE EVALUATION

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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



NEW JERSEY



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.

SERVICE ENGAGEMENT FOR INDICATED PREVENTION SITES

CATAWBA COUNTY (NC)



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 Jersey¹. 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.

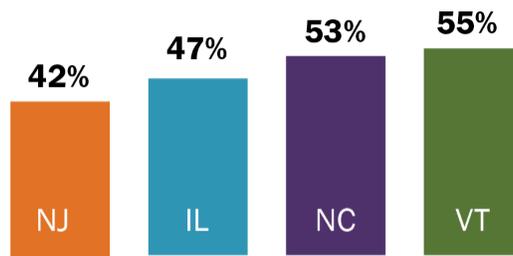
¹ The survey responses from Illinois and New Jersey discussed in this section are from the primary outcome surveys only.

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 administrative 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%

SUMMARY OF SERVICE NEEDS FROM WISCONSIN, ILLINOIS AND NEW JERSEY

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 legitimized 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.

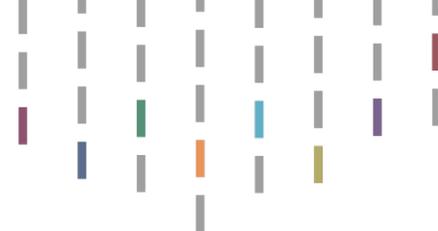
- In Catawba County (NC), families who needed post adoption services and supports were largely already engaged in services through the existing outreach methods and service delivery systems. Few additional families requested Success Coach services as a result of Reach for Success. However, through the 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.

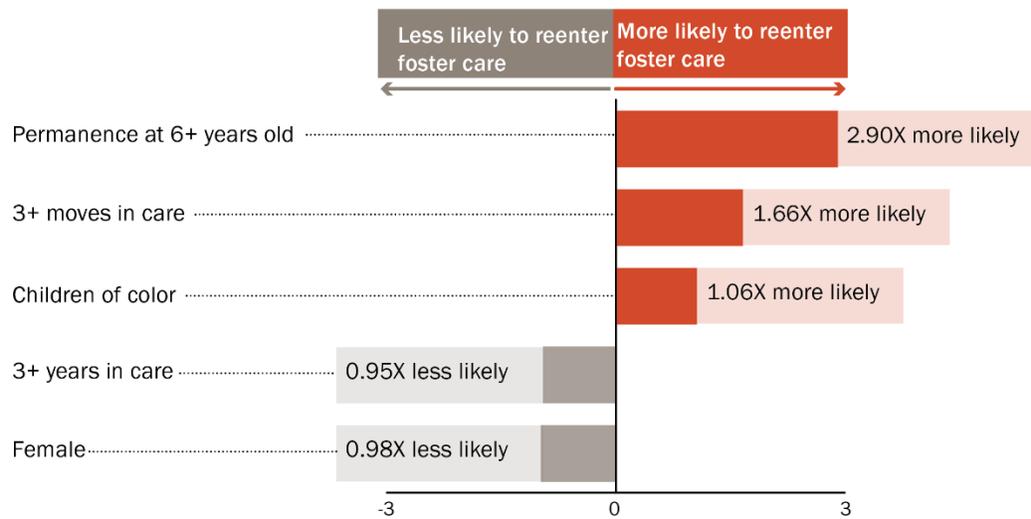
In sites that used BPI and caregiver commitment measures, families were compared across the continuum to see if there were differences in the families targeted for outreach. Specifically, it was hypothesized that families targeted for outreach at the Universal level would, on average, have low-risk scores 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

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

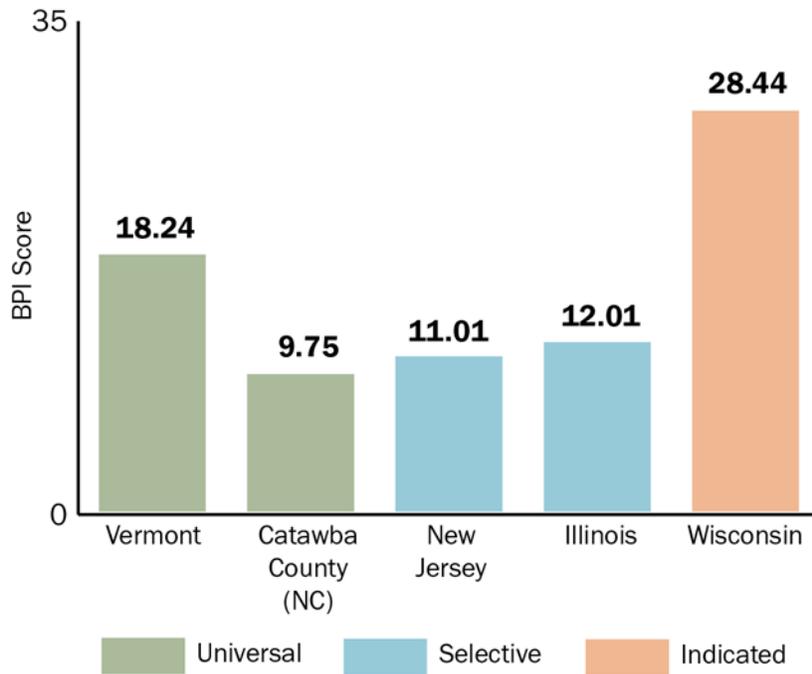


Figure 10.2 note: It should be noted that we expect to see higher levels of behavior problems in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are 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

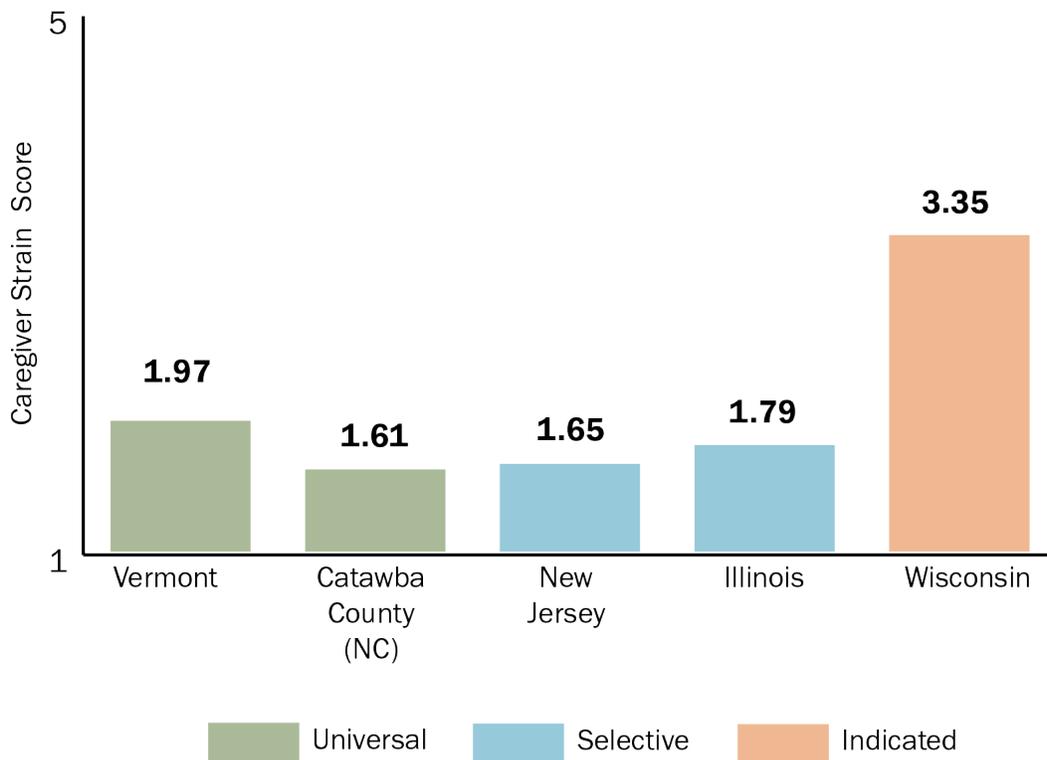


Figure 10.3 note: It should be noted that we expect to see higher levels of caregiver strain in the site that is serving families who reach out to request assistance (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin 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

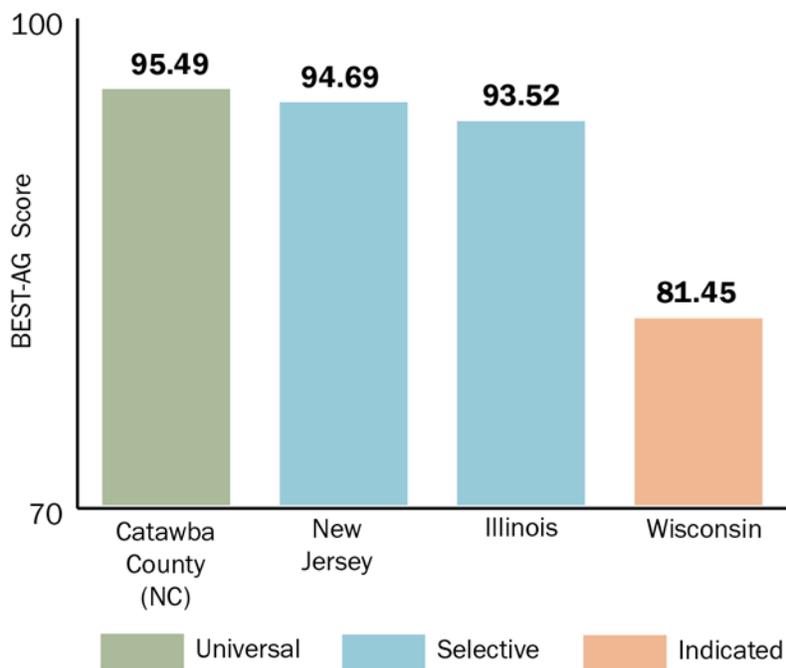


Figure 10.4 note: It should be noted that we expect to see lower levels of belonging and emotional security in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families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

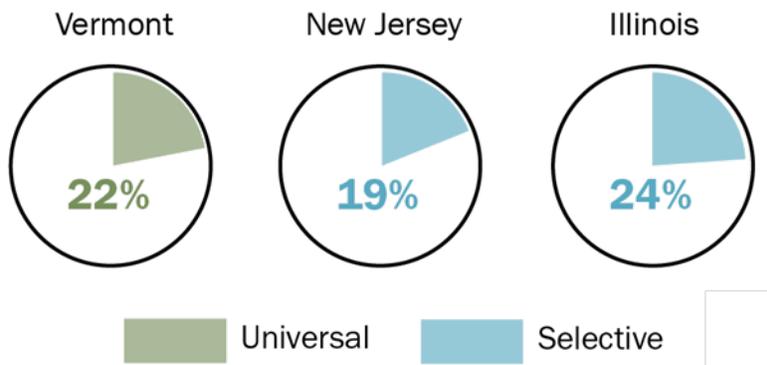
Keeping in mind the significant role caregiver commitment has played in understanding post permanency discontinuity and other challenges in prior studies (Liao & Testa, 2016; Testa et al., 2015; White et al., 2018), a series of commitment questions were asked of parents and guardians involved with this 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'.



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 again³:

- 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).

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

GUIDE TO FIGURES 10.6 – 10.8

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).

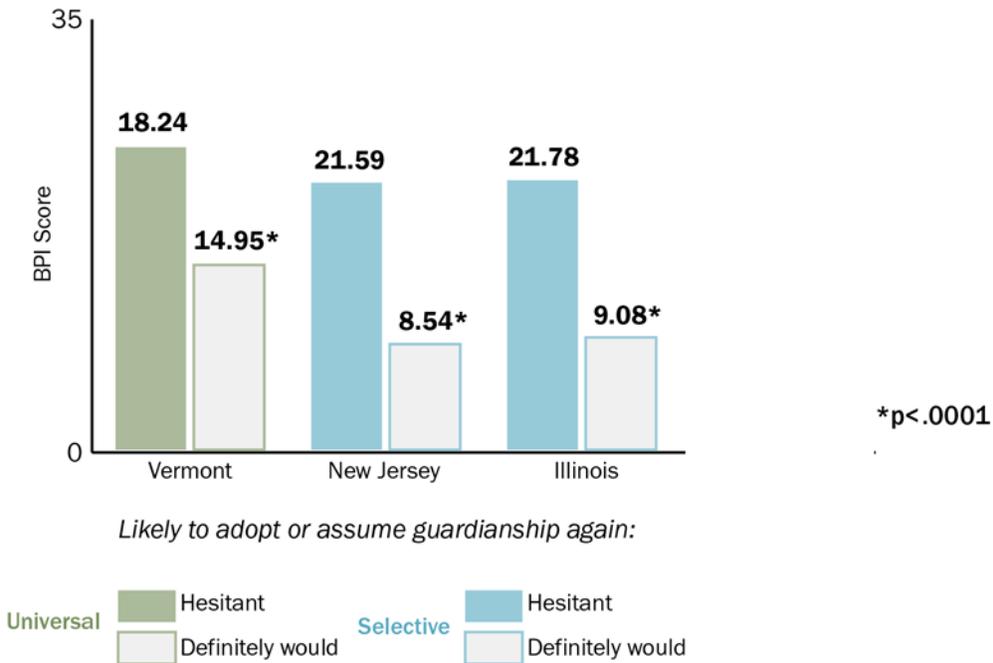
2. In Figure 10.6, the bars and the numbers above the bars are the mean BPI scores for each group.

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).

BEHAVIORAL PROBLEM INDEX (BPI)

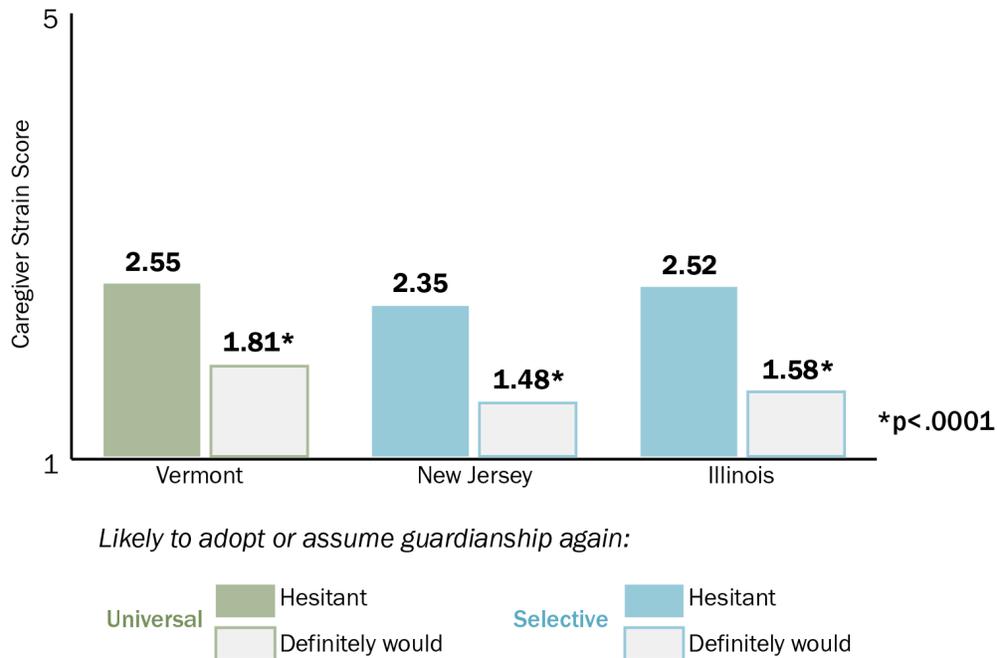
Figure 10.6. Behavior Problem Index (BPI) by Inclination to Adopt or Assume Guardianship Again



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.

CAREGIVER STRAIN

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

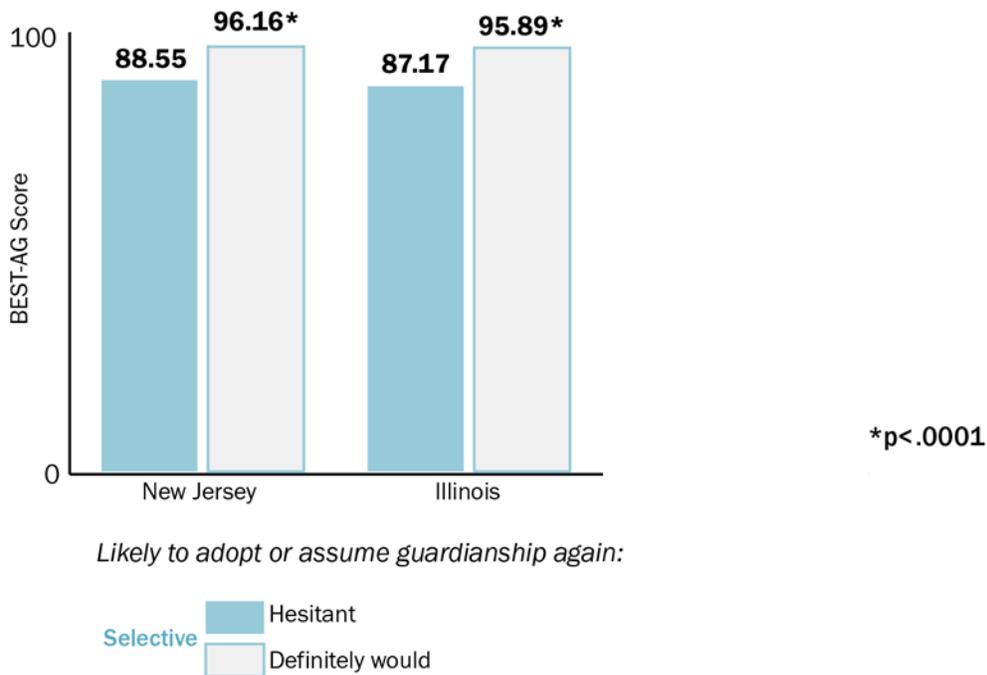


The Caregiver Strain Questionnaire-Adoption/Guardianship (CGSQ-AG) used in this project is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger, & Brickman, 1997), a measure to assess the extent to which caregivers experience additional demands, responsibilities, and difficulties 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.

BELONGING AND EMOTIONAL SECURITY TOOL (BEST-AG)

Figure 10.8. Belonging and Emotional Security Tool (BEST-AG) by Inclination to Adopt or Assume Guardianship Again

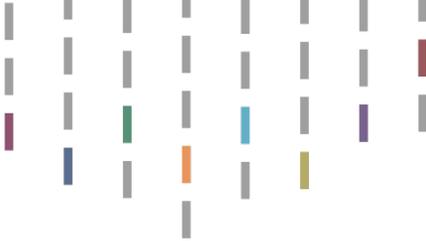


The BEST-AG, developed by Casey Family Services (Frey, Cushing, Freundlich, & Brenner, 2008), was originally designed to help social workers frame conversations about emotional and legal commitment with foster parent and youth who are unable to reunify with their family of origin. For this study, the 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 guardianship. 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 guardianship 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.”

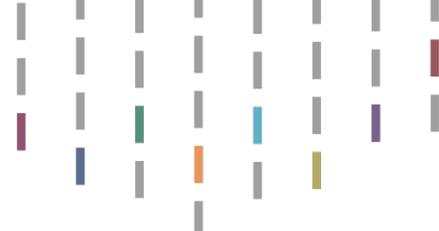
“Attachment disorder has severely impacted my daughter...She has struggled with attachment and reciprocity. I, too, have struggled with attachment to her, given her lack of reciprocity. Having worked with a therapist years ago who purportedly understood attachment disorder, my daughter and I received 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.

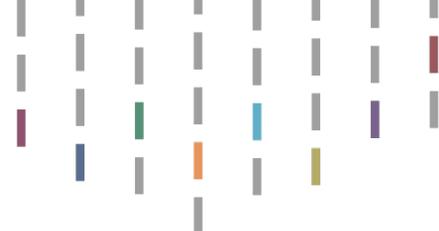
Furthermore, adoptive parents and guardians have found various ways to tell the QIC-AG project that they welcome outreach from the child welfare system after finalization. Some reported this in interviews, others in responses written in surveys, and others when they called a member of the research team 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	1.08	0.94	0.95	0.80	0.95	0.86	0.98	1.05
CHILD OF COLOR	0.81	0.30	1.20	1.03	0.94	0.78	1.29	1.09	1.06	1.15
CHILD ACHIEVED PERMANENCY AT THE AGE OF 6 OR OLDER	3.90	2.76	2.08	1.79	15.67	11.66	2.73	2.41	2.90	3.16
CHILD SPENT THREE OR MORE YEARS IN FOSTER CARE	1.05	0.77	0.70	0.60	1.13	0.94	1.04	0.91	0.95	1.03
CHILD HAD 3 OR MORE MOVES WHILE IN FOSTER CARE	1.37	1.02	3.01	2.58	1.63	1.37	1.41	1.26	1.66	1.78
NUMBER OF OBSERVATIONS USED IN MODELS		2,779		19,493		12,012		25,532		59,816

Note: HR stands for Hazard Ratio.

