

Evaluation Results from

Wisconsin

Final Evaluation Report



September 2019

Chapter 7: Wisconsin

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 (Wisconsin is Chapter 7), 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.

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Acknowledgements

The QIC-AG evaluation team would like to extend our sincerest thanks to all of the adoptive and guardianship families who participated in the project.

We also thank the many stakeholders on the QIC-AG site specific Project Management Team (PMT), Stakeholder Advisory Team (SAT) and Implementation Team (IT) who were invaluable in providing the support and direction needed to implement the study. The participants on these three teams included community consumers and providers from adoption and guardianship services; adoptive and guardianship families; representatives from private, domestic, and international adoption; key leaders across multiple systems; and the numerous support agencies and system partners.

We would like to acknowledge the staff at the Wisconsin Department of Children and Families, the site team leaders and Site Implementation Managers (SIMS) 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.

Evaluation Results from

Wisconsin

PROJECT PARTNERS

QIC-AG partnered with **Wisconsin Department of Children and Families (DCF)**

CONTINUUM PHASE

Indicated

INTERVENTION

Adoption and Guardianship Enhanced Support (AGES) was developed by the QIC-AG to provide support to adoptive and guardianship families who made contact with a service provider. By providing families with support, the project hoped that families would feel less stressed, and ultimately have increased capacity for post permanency stability and improved wellbeing.

STUDY DESIGN

Descriptive



Included **17 Wisconsin counties** (Brown, Calumet, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Menominee, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, Waushara, and Winnebago) and **3 sovereign tribal nations** (Oneida, Menomonee, and Stockbridge-Munsee Native Americans)

The target population was **families in the Northeastern Region of Wisconsin with a finalized adoption or guardianship who requested services.** Families adopting through public, tribal, private or intercountry providers, and families who assumed guardianship were all included.

RESEARCH QUESTION

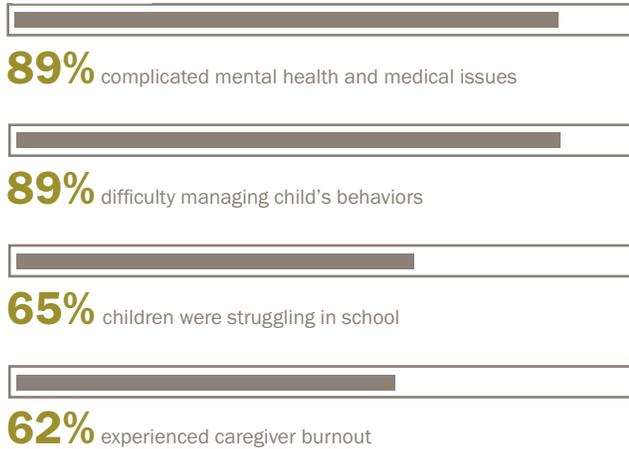
Will families with children residing in the Northeastern Region of Wisconsin with a finalized adoption or guardianship who request services from one of the identified referral sources who receive Adoption and Guardianship Enhanced Support (AGES) experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health after receiving AGES?

Findings

PARTICIPATION



COMMON ISSUES



Caregivers shared that finding appropriate, timely, and effective adoption and guardianship-competent services was difficult.

“[Prior to AGES] I couldn't get help because [my adopted son's issues are] not bad enough...Why should he have to get so bad ... if I had that help when I started seeing stuff ... we'd be seeing a different ten-and-a-half-year-old.”

FEEDBACK FROM CAREGIVERS

Support was essential! Caregivers reported feeling less stressed as a result of having an AGES Worker who listened, provided guidance and advocated on behalf of them.

“ [The AGES worker] literally saved our family...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 [the caregiver] but somehow [the AGES worker] legitimizes our issues.”

“ ...I am not feeling so overwhelmed because I feel like I have help. [The AGES worker] would do whatever's needed to be done to help reduce the stress in our family.”

CHARACTERISTICS OF AGES WORKERS

Ensuring the Right Fit. AGES workers took the time to get to know what the family needed and matched specific services with family needs.

Flexibility. AGES workers made home visits, met families where it was most convenient, and advocated at important meetings alongside the family.

Being Direct and Candid. AGES workers sometimes needed to have difficult discussions with families, in a gentle but direct manner.



The University of Texas at Austin

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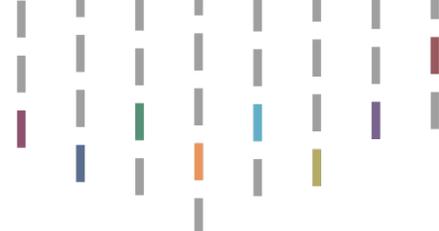
This research summary was designed by staff at the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work, in conjunction with the Jack, Joseph and Morton Mandel School of Applied Social Sciences at Case Western Reserve University.

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 Wisconsin site of the National Quality Improvement Center for Adoption and Guardianship Support (QIC-AG) designed a new model for post permanency support, the Adoption and Guardianship Enhanced Support (AGES). The development of AGES was based on input from stakeholders, including adoptive parents, guardians, and service providers. Stakeholders reported that what families in Northeastern Region of Wisconsin needed to enhance the continuum of services for adoptive and guardianship families, and ensure children and youth remained in long-term, stable homes was a new model of post permanency support.

The AGES program was located in the **Develop and Test** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. Developed by this project, at the Indicated Interval of the QIC-AG Permanency Continuum Framework, AGES was designed to support families who contacted a service provider to request services, information or support.

Intervention

The Theory of Change developed by the QIC-AG project in Wisconsin, in summation states that some adoptive parents and guardians feel ill-equipped and unsupported to meet the needs of their children, and, if provided with additional support, families would feel less stressed, and therefore have increased capacity for post permanency stability and improved wellbeing. The QIC-AG team explored several existing interventions, none of which met the specific needs, as articulated by the stakeholders and the Theory of Change. One of the key aspects of the program that stakeholders reported needing was support, rather than a particular specific intervention. Building on portions of two existing interventions, the Wisconsin QIC-AG team developed and tested a new intervention to address this gap in support.

The QIC-AG team in Wisconsin followed a careful process for the development of social work-related interventions to create AGES (Fraser, Richman, Galinsky & Day, 2009). This involved the team working to specify the problem, and creating program materials. This began with all-team sessions where program materials were reviewed and evaluated. The team was careful to examine the use of language, ensure the project would be culturally sensitive, and obtain feedback from stakeholders during the process. This process resulted in the creation of AGES, a five stage intervention.

The five stages of AGES were: Support Initiation, Assessment, Support Planning, Support Delivery, and Case Closure. The program offered individualized assessments of the families' needs and strengths; identified family-specific goals; assistance in navigating resources and services, and offered targeted advocacy. The four major types of support provided to families included: social supports, case management, parenting services, and educational-related services.

This study was a pilot test of the AGES model. Given the short timeframe associated with this study, the next study of AGES should test the program components and examine associations with the desired program outcomes.

Primary Research Question

The primary research question for the QIC-AG study was:

Will families with children residing in the Northeastern Region of Wisconsin with a finalized adoption or guardianship who request services from one of the identified referral sources who receive Adoption and Guardianship Enhanced Support (AGES) experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health after receiving AGES?

The target population included adoptions and guardianships that were finalized through public, private domestic, intercountry, or tribal authorities.

Originally, a pre-post design was selected to evaluate the AGES program. However, there was a slower than expected uptake of AGES, and few AGES participants had completed services. As such, there was not enough time to observe changes in short-term outcomes. The evaluation design was changed to a descriptive study to allow the project to learn from current and former AGES participants. The purpose of the descriptive study was to:

1. Assess adherence to the implementation protocol.
2. Describe the issues confronting families who participated in AGES.
3. Describe how issues confronting AGES-involved families were addressed.

The study used data collected by the program staff to assess adherence to the implementation protocol and used a combination of case record review and interviews with study participants to describe the issues participants were facing and the supports and services provided by AGES workers. Participant interviews were used to describe how participants felt about their experiences of AGES.

Key Findings and Discussion

The **Develop and Test** phase of intervention development should result in “a set of specific practices, program components, and intervention guidelines that do not require adjustment, have been defined well enough that others can replicate them, and show an initial improvement in outcomes that can most likely be traced to the intervention” (Framework Workgroup, p. 11). This initial test of AGES was a descriptive analysis conducted with the 32 families served by AGES found that participants reported receiving and benefiting from the key ideas that were the foundation of the AGES program. Specifically, the case file review and interviews with adoptive parents and guardians found key factors in the AGES program that were helpful to families.

Key findings from the case file reviews included:

Many families were struggling with a wide range of issues. The two most common issues were complicated mental health and medical issues (89%) and difficulty managing the behaviors of their children (89%). Most of their children were struggling in school (65%) and there was a large level of caregiver burnout (62%). AGES workers provided support and referrals to services that matched the needs of adoptive and guardianship families. A wide range of support and services were requested by families, including having available service providers who understood issues specific to families formed through adoption or guardianship, addressing families’ emotional and informational needs, obtaining referrals and navigating systems, and meeting with families who had similar experiences.

Being flexible and candid with family members and service providers made workers especially effective. In particular, the case file reviews found that AGES staff:

- **FOUND THE RIGHT FIT.** Investing the time to get to know what the family needed was critical and resulted in matching children to specific services (e.g., equine therapy, de-escalation skills) that ultimately improved family wellbeing. By providing enhanced case management, AGES workers were able to coordinate services for families and assist them in navigating different systems.
- **WERE FLEXIBLE.** To provide the right fit, AGES workers provided home visits, attended school meetings with caregivers, and even accompanied the family during visitation with the birth family. This individualized approach was an important objective in the AGES program.
- **WERE DIRECT AND CANDID.** AGES workers sometimes needed to have difficult discussions with families in a gentle but direct manner (e.g., addressing a caregiver's substance use).

Key findings from the interviews with adoptive parents and guardians:

Adoptive and guardianship families struggle like other families, but there is a uniqueness to their struggle that they discussed in the interviews. Families discussed issues with different degrees of urgency, where some issues were described as **long-term issues** and others as **urgent issues**. Long-term issues were ones that families wanted addressed or better understood but were not overwhelmed by them at the moment. Adoptive and guardianship families also struggled with **urgent issues**. **Urgent issues** were ones where families were in critical need of services for their children, but due to a variety of roadblocks, could not access those services on their own. They reported that they had tried many services prior to AGES that did not seem to work and were at a place of not knowing what to do next. When families were desperate for help, they reported feeling

like no one was there and that things might never change. These struggles, coupled with the lack of supportive services, are what made families consider ending the adoption or guardianship. The urgent issues were diverse, and often required a variety of responses and assistance from the AGES workers.

In sum, AGES participants reported increased capacity to care for their children in a variety of ways, including:

- Helping families make difficult decisions.
- Being a sounding board for families.
- Equipping families with knowledge of available resources.
- Assisting families with the set-up of those services.
- Navigating the various systems.
- Figuring out the right diagnosis and establishing the appropriate services to help with that diagnosis.

Adoptive parents and guardians indicated that the AGES workers increased their skills or capacity to manage their children's behavior and educational challenges in a variety of ways, including providing information and knowledge about available services.

Participants reported a reduction in family stress as a result of participating in the AGES program. They attributed this to the knowledge that they had someone they could go to for support, which reduced their stress levels:

"I just need to vent to somebody and then somebody telling me, 'Okay, you're a good mom, you know, a lot of his issues are trauma...' That is awesome because that's reducing a lot of my stress...Because one of the biggest things is if you're a single parent and you have to get out of the house and you're worried about even just getting to work that's a huge stress. For me, I feel like things improved in the family in general. Jaron [adopted child] is on a mood stabilizer. Two weeks ago, he said to me at our meeting with the county, 'Don't tell him [county worker], but I like him now.' It's a lot of reduced stress...I am not feeling so overwhelmed because I feel like I have help. She would do whatever needed to be done to help reduce the stress in our family."

"I would say it would be helpful because it's just having that extra support and also having that resource, I think it's valuable...I think it would be helpful to maybe expand it to allow some foster parents in as well."

One parent reported that, through the AGES program they discovered the child that they always knew was there:

"As soon as she feels like she's gonna be happy, she self-sabotages and makes it awful. So, we've never had that happy moment. And since [the help she got through AGES], it's been like she's okay with feeling happy. It makes a big difference...That child has never been happy during Christmas. The AGES program gave us our first happy Christmas ever."

One of the AGES workers reflected on why she believed AGES successfully helped so many families. She attributed this to the families who refused to give up on the idea that something could work:

“It's not working because I have the magic. It's working because they were willing to try one more time. They had someone who could help them navigate the system...I have had to play the role of looking at parents and saying, 'If you've had your child in therapy for four years and we're not making progress, maybe this isn't the best therapist.' I mean, they literally were afraid to [make a change] on their own because they were overwhelmed and burdened by this whole idea that nothing is gonna get better, I think they started to get to the point where it was like, 'I don't know that I can be open-minded. I don't know that I can try these things.'”

The families reported that the AGES workers helped them identify, locate, and access services. Similarly, caregivers affirmed the need for home visits as an important aspect of the program. Families reported that the AGES worker understood their unique circumstances, as adoptive parents and guardians, and were able to interface with service providers and gain access to services that they were unable to do on their own. These activities affirmed the importance that support played in the AGES program.

The families served by the AGES program were from one region in one state and were small in number. As such, the results from the AGES program are not generalizable to all adoptive or guardianship families. Results from outreach in Wisconsin confirmed that offering post permanency services and supports did not create a mass influx of families in need of services. Most adoptive and guardianship families are doing well with the supports and services they have. However, for a small proportion of families who engaged in services, their needs were great, and supporting them through AGES was important to them. However, a key factor in providing this support is finding workers with the right set of dedication, determination, patience and flexibility to stop, listen and support families when and how they need it. The workers believed the families when they said they were struggling. They let parents and guardians know that they understood the strength it took for these families to try “one more time,” seeking out AGES after exhausting all other options, and never giving up.

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.

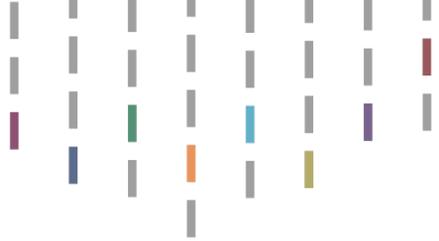
Child welfare jurisdictions interested in targeted outreach to adoptive or guardianship families may consider periodically checking in with families to assess their level of caregiver commitment and familial relationship (e.g., the parent or guardian's assessment of how well they can manage their child's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



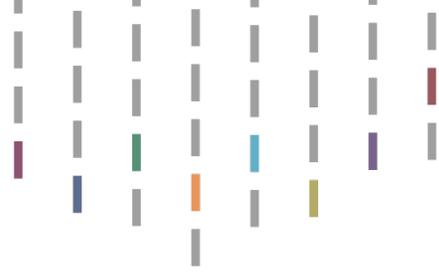
Chapter 1

Table of Contents

QIC-AG OVERVIEW	3
Background	3
QIC-AG TARGET POPULATIONS	6
Target Group 1	6
Target Group 2	7
Private Domestic and Intercountry Adoptive Families.....	7
QIC-AG CONTINUUM OF SERVICES	8
Pre Permanence.....	8
Stage Setting	9
Preparation	9
Focused Services	9
Post Permanence	9
Universal.....	10
Selective	10
Indicated Services.....	11
Intensive	11
Maintenance	11
SITE SELECTION	12
Pre Assessment.....	12
Initial Assessment.....	12
Full Assessment	13
Tribal Selection Process.....	13
IMPLEMENTATION & EVALUATION	14
Evaluation	14
Guiding Frameworks.....	15
SUMMARY	18
REFERENCES.....	19

List of Tables and Figures

Figure 1.1. National Average Monthly IV-E Funded Caseloads	4
Figure 1.2. QIC-AG Permanency Continuum	8
Figure 1.3. Prevention Framework.....	10
Figure 1.4. A Framework to Design, Test, Spread, and Sustain Effective Practice	15
Figure 1.5. National Implementation Research Network’s (NIRN) Hexagon Tool	16
Table 1.1. Site, Target Population, Intervention and Study Design	17



QIC-AG Overview

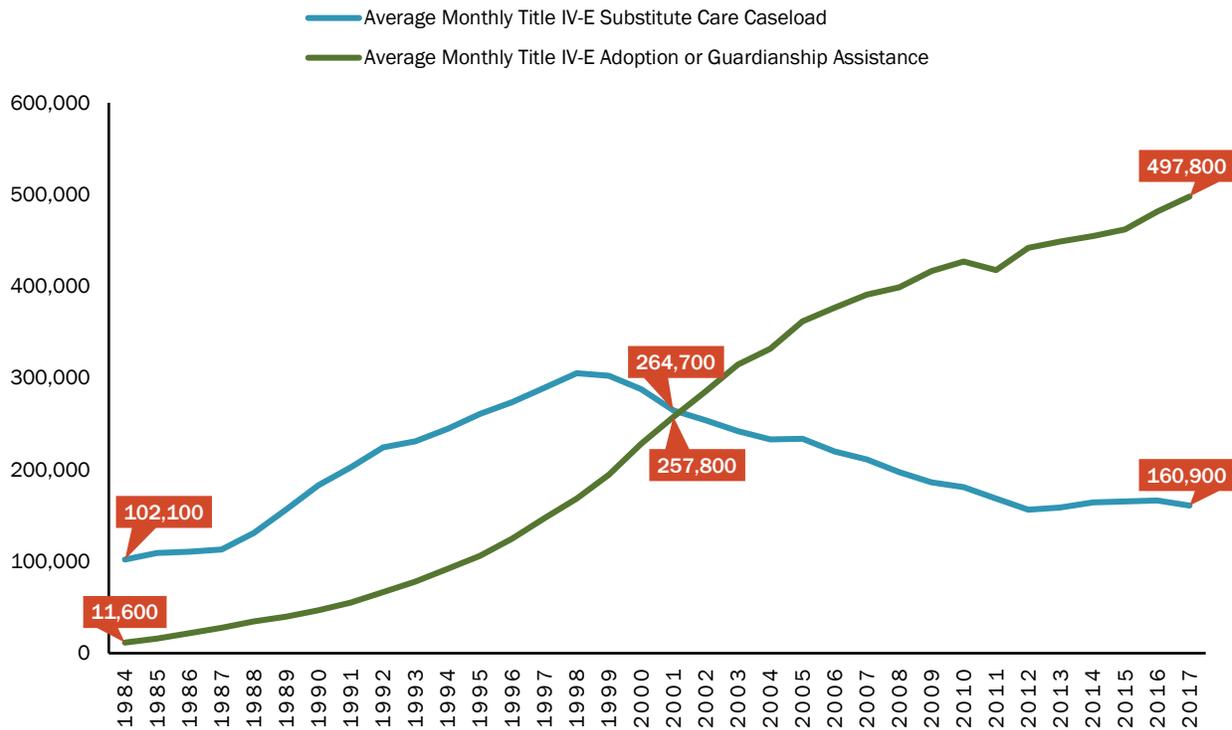
The Children's Bureau, Administration for Children and Families, and Department of Health and Human Service established the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG). In October 2014, the QIC-AG was awarded to Spaulding for Children in partnership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

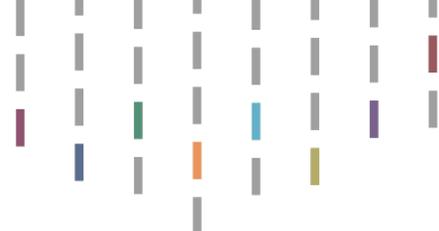


Data sources: The information on federally-funded caseloads are from the Committee on Ways and Means (CWM) of the U.S. House of Representatives and represents the average monthly Title IV-E caseloads.

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

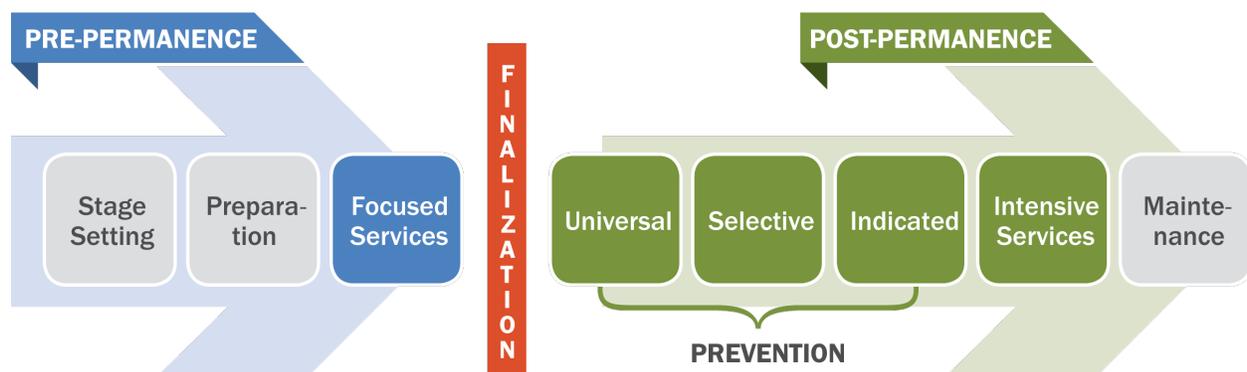
The challenges associated with providing a stable, long-term and permanent home are not consigned to adoptions and guardianships that occur through the child welfare system. Private domestic and intercountry adoptive families can also encounter post permanency disruptions and discontinuity. Children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

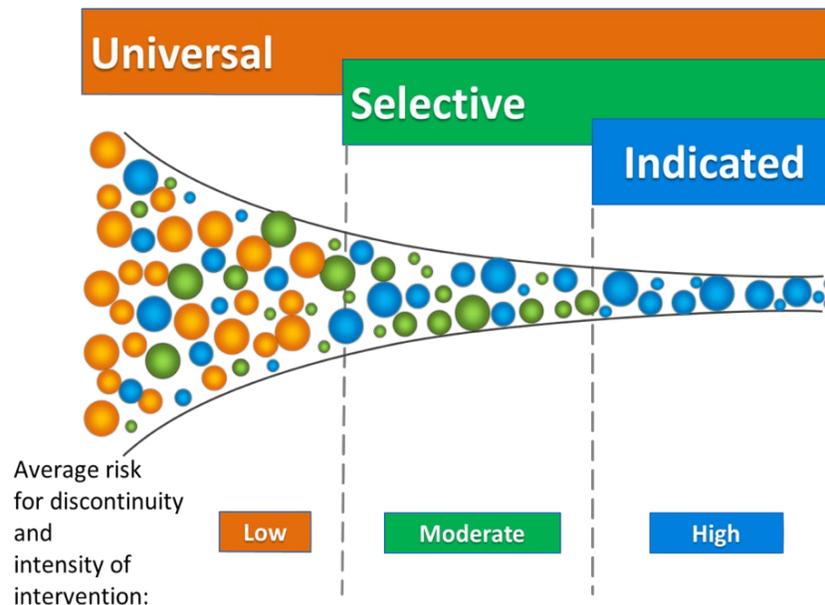
Focused Services

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).

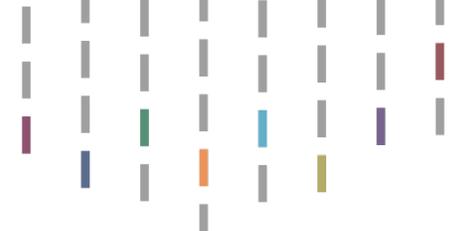
For the QIC-AG project, **Indicated** prevention efforts were defined as services that target families who request assistance to address an issue that has arisen after permanence has been achieved, but before the family is in crisis. For instance, when families call an agency with a question about a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

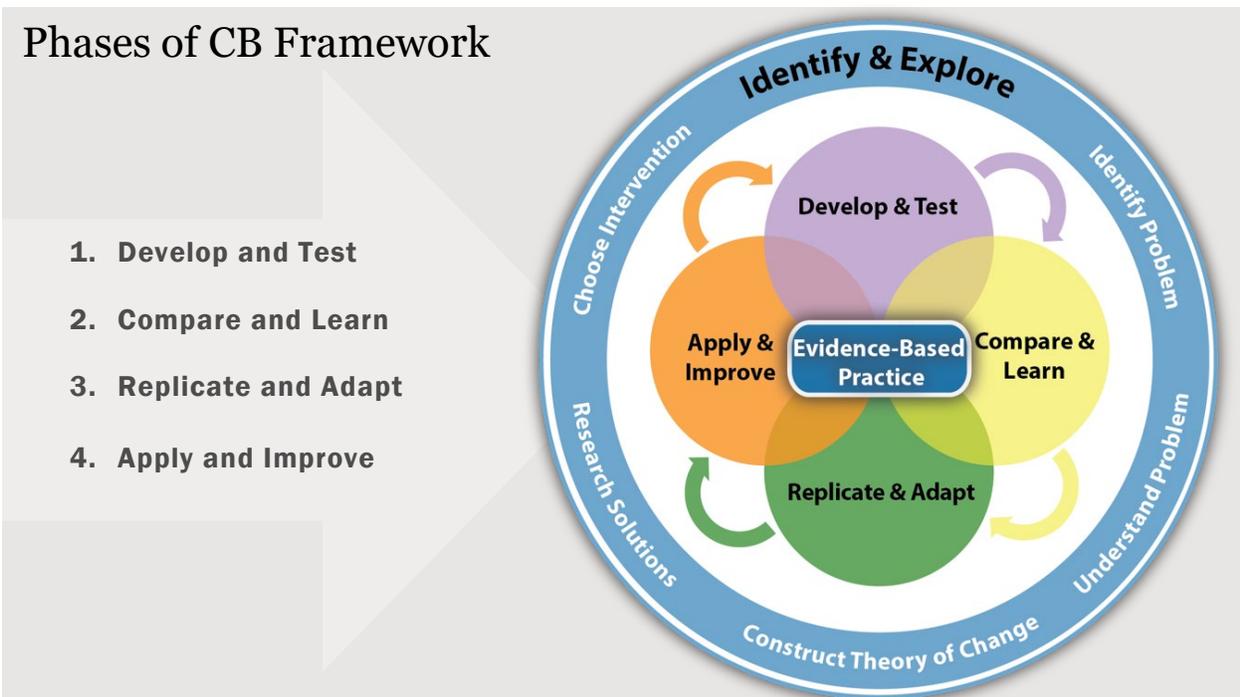
Guiding Frameworks

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

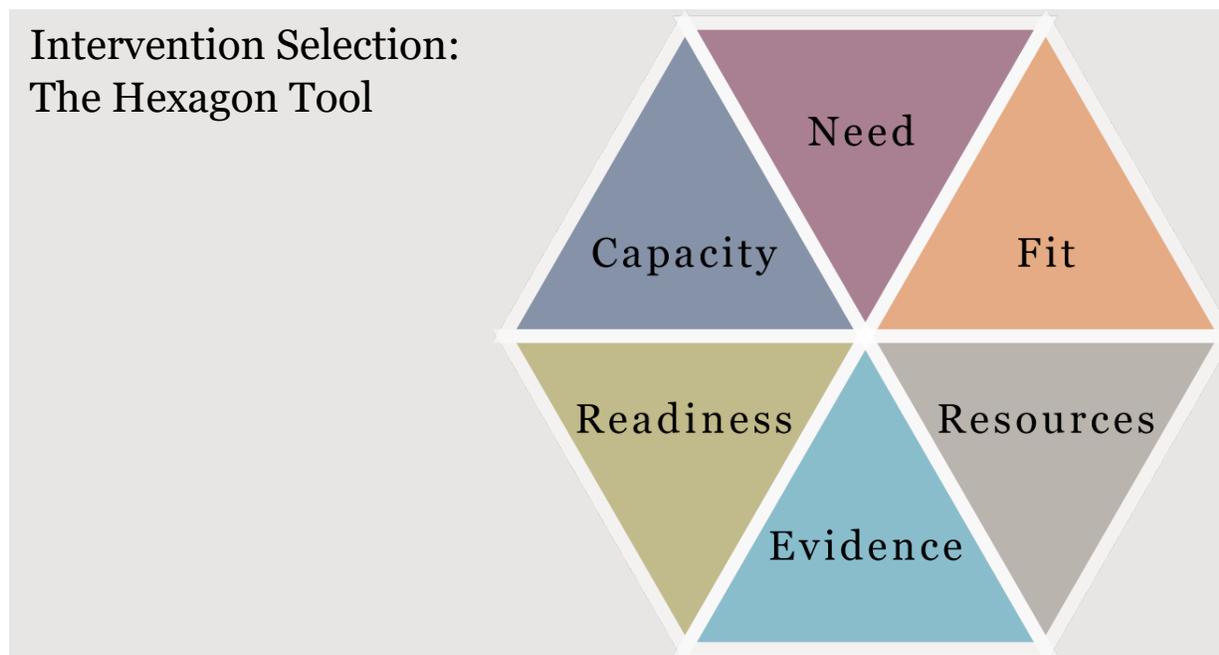


Table 1.1. Site, Target Population, Intervention and Study Design

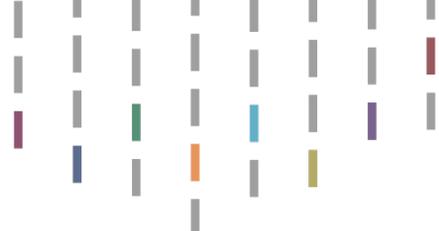
SITE	INTERVENTION	STUDY DESIGN
TARGET POPULATION: GROUP 1		
WINNEBAGO TRIBE	Family Group Decision Making (FGDM)	Descriptive
TEXAS	Pathways 2 Permanence	Quasi-Experimental
TARGET POPULATION: GROUP 2		
VERMONT	Vermont Permanency Survey	Descriptive
ILLINOIS	Trauma Affect Regulation: Guide for Education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

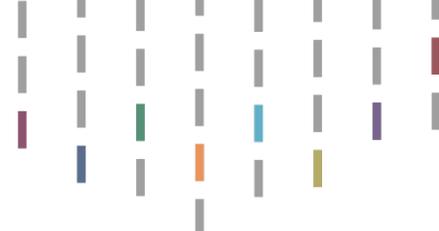
Outcomes across Target Group 2 sites are summarized in the final chapter, the **Cross-Site Evaluation**. The QIC-AG evaluation team also conducted a **Cost Evaluation** for each site. These findings are embedded in each site report.



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 7

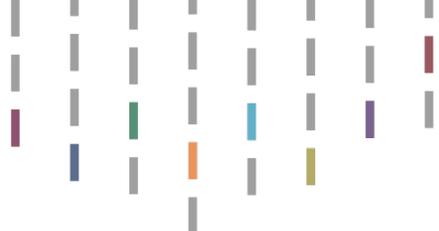
WISCONSIN: ADOPTION AND GUARDIANSHIP ENHANCED SUPPORT (AGES)

Table of Contents

SITE BACKGROUND	6
National Data: Putting Wisconsin in Context	7
QIC-AG Permanency Continuum Interval	10
PRIMARY RESEARCH QUESTION	11
Target Population	11
Intervention	12
Outcomes	14
Logic Model	15
EVALUATION DESIGN AND METHODS	16
Procedures	16
Measures	20
Missing Data	21
FINDINGS	22
Sample and Participant Profile	22
Process Evaluation	25
Limitations	44
COST EVALUATION	46
Cost Evaluation Approach	46
Assumptions, Constraints, and Conditions	46
Cost Estimation	47
Cost calculation	51
Sensitivity analysis	51
Cost Evaluation Summary	52
DISCUSSION	53
REFERENCES	55
APPENDIX	57

List of Figures and Tables

Figure 7.1. Wisconsin Foster Care Entry Per Capita Rate (2013 – 2017).....	7
Figure 7.2. Median Length of Stay for Children in Foster Care as Measured in Months.....	8
Figure 7.3. Wisconsin Caseloads.....	9
Figure 7.4. Wisconsin QIC-AG Permanency Continuum	10
Figure 7.5. Stages in Intervention Development.....	12
Figure 7.6. Wisconsin Logic Model	15
Table 7.1. AGES Stages: Project-Defined Goals	17
Table 7.2. AGES Assessments	18
Table 7.3. AGES: Problems or Issues.....	19
Figure 7.7. AGES Project Timeline	23
Figure 7.8. AGES Project Case Flow	24
Figure 7.9. Number of Children Served by AGES, by Type of Adoption or Guardianships	25
Table 7.4. Time to Meet Key AGES Milestones for Families Served by AGES	26
Figure 7.10. Mean Responses to AGES Screening Question	27
Table 7.5. Scores on AGES Measures.....	28
Table 7.6. Type of Issues and Problems Addressed by AGES.....	29
Table 7.7. Support Types and Families Who Received Individual Support Types	30
Table 7.8. Costs for Wisconsin	48
Table 7.9. Sensitivity Analysis: Adjusted Costs for Wisconsin.....	52
Table 7.10. Mean Responses to AGES Screening Questions	58
Table 7.11. Case Review: Issues AGES Participants Were Confronting.....	59
Table 7.11. Case Review: Issues AGES Participants Were Confronting Continued.....	60



Site Background

The Wisconsin Department of Children and Families (DCF) administers a broad range of human service programs to improve the economic and social wellbeing of the state's children, youth and families. With the exception of Milwaukee, Wisconsin's child welfare system is a county-state supervised system, and tribal-administered; Milwaukee's child welfare system is directly administered by DCF. DCF has a number of Divisions and Bureaus responsible for overseeing children and family services, including foster care and adoption services, and child abuse and neglect investigations.

The Department engages with a number of groups and key constituencies to reduce the risk of child abuse and neglect and support and preserve families. Wisconsin's Adoption Program is part of DCF's collective mission. Post permanency services are delivered by Post Adoption Resource Centers (PARC) throughout the state. The PARCs are located in Green Bay, Stevens Point, Milwaukee, Madison, Eau Claire, and La Crosse. They provide a wide variety of post permanency referral services including respite, crisis intervention, family counseling, and support groups. In addition, Wisconsin's Foster Care and Adoption Resource Center (FCARC) provides information and materials on foster care and adoption (Wisconsin DCF website, 2018; Wisconsin Annual Progress and Services Report, 2017).

In an effort to better understand the needs of the adoption and guardianship population being served, the Wisconsin QIC-AG site team met with families as well as the professional staff who provided services to these families. A number of gaps in support and services were identified in meeting the needs of some adopted children and their families including addressing the families' emotional, informational and/or companionship needs; finding service providers with experience working with families formed through adoption or guardianship; obtaining referrals; navigating systems, and; having opportunities to meet other adoptive and guardianship families with similar experiences.

To address the concerns of families who expressed feeling ill-equipped, unsupported and unprepared to meet the emerging needs of their children after permanence occurred, the QIC-AG Wisconsin team set out to design a new intervention. The Theory of Change supposed that adoptive parents and guardians who felt ill-equipped and unsupported to meet the needs of children in their homes may result in discontinuity. By offering a prevention program that included additional services and support that helped families address the needs of their children, the hope was that adoptive and guardianship families would feel less stressed, and therefore have increased capacity for post permanency stability and improved wellbeing.

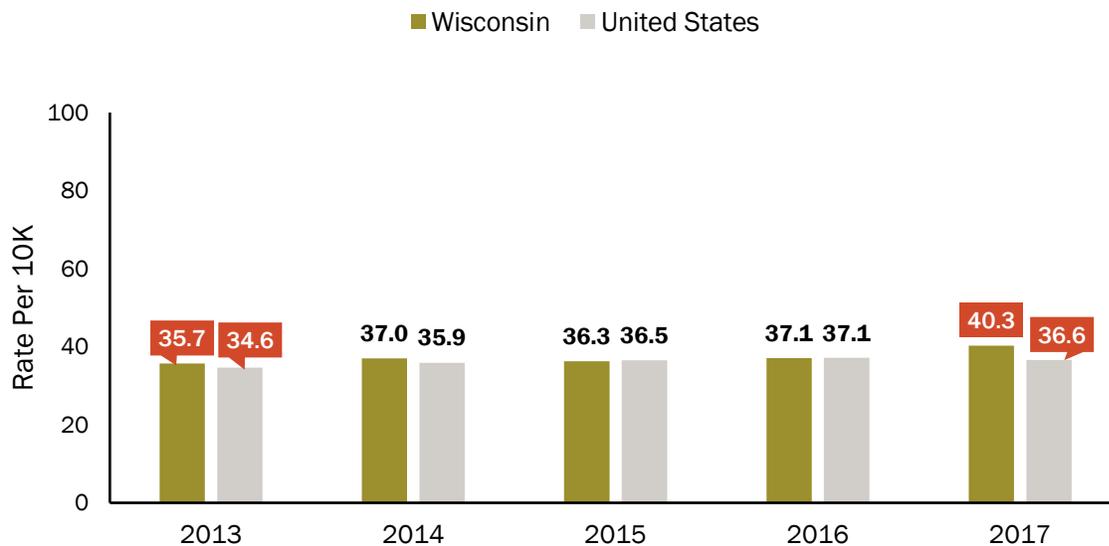
The QIC-AG project in Wisconsin had strong buy-in from the DCF leadership team, including the Division Administrator and Bureau Director and also from the local county and tribal leaders in the Northeastern Region. Three teams, the Project Management Team (PMT), the Stakeholder Advisory Team (SAT) and the Implementation Team helped design and implement the AGES program. These teams also included current service providers, including the State Permanency Consultants (SPC) and Regional Supervisor and the PARC and FCARC providers in the Northeastern Region.

National Data: Putting Wisconsin in Context

The data in this section is provided to put the Wisconsin QIC-AG site in context with national data. By comparing data from Wisconsin to that of the nation we are able to understand if Wisconsin is a state that removes more or fewer children than the national average, and compare the state's rate of children in foster care and median lengths of stay of children in foster care 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.

As displayed in Figure 7.1, between Fiscal Years 2013 and 2017, the rate¹ of children entering foster care in both Wisconsin and the U.S. increased. Between 2013 and 2017, the state's foster care entry rate increased from 35.7 per 10K (4,668 children) to 40.3 per 10K (5,175 children). This per capita rate was higher than the per capita rates for the U.S. The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. In other words, more children, per capita, entered foster care in Wisconsin than in the U.S.

Figure 7.1. Wisconsin Foster Care Entry Per Capita Rate (2013 – 2017)

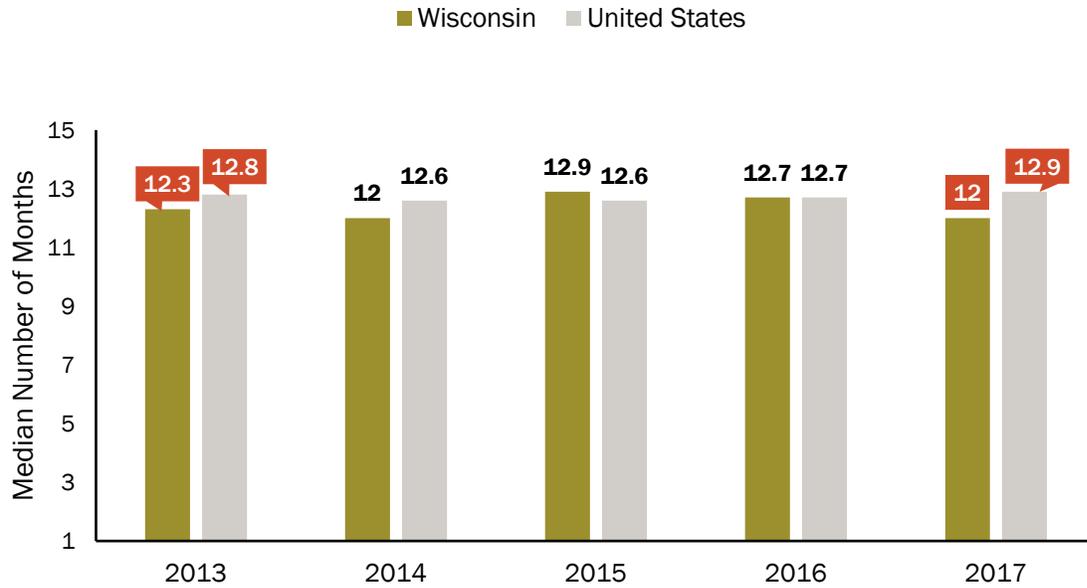


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, <https://cwoutcomes.acf.hhs.gov/cwodatasite/>

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

Between 2013 and 2017, the median length of stay for children in foster care on September 30 (shown in Figure 7.2) were similar and fairly constant for Wisconsin and the U.S. The length of stay decreased in Wisconsin from 12.3 months in 2013 to 12.0 months in 2017 while in the U.S. it increased slightly from 12.8 months in 2012 to 12.9 months in 2016.

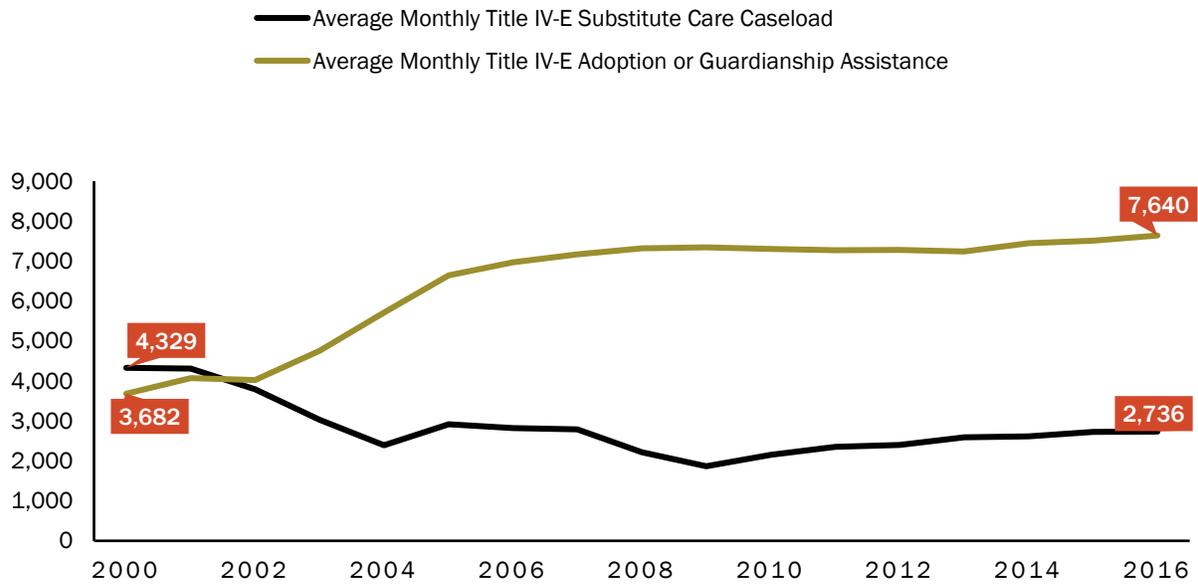
Figure 7.2. Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)



Data Source: United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Bureau, <https://cwoutcomes.acf.hhs.gov/cwodatasite/>

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 7.3, the number of children in Wisconsin in IV-E funded foster care and the number of children in IV-E funded adoptive homes were approximately the same in 2000 (4,329 and 3,682 respectively), yet in 2016 these numbers have diverged. In 2016 there were 2,736 children in IV-E funded substitute care and 7,640 children in IV-E funded adoptive or guardianship homes.

Figure 7.3. Wisconsin Caseloads



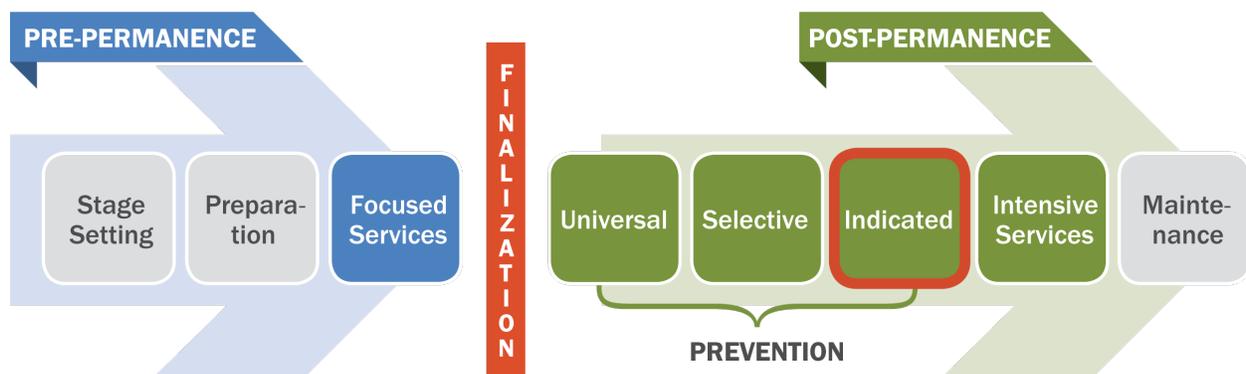
Data sources: Title IV-E numbers: U. S. Department of Health and Human Services / Administration for Children and Families, compiled data from states' Title IV-E Programs Quarterly Financial Reports, Forms IV-E-1 (for years prior to 2011) and CB-496 (for 2011 and later).

QIC-AG Permanency Continuum Interval

The QIC-AG Wisconsin project implemented the AGES program in the **Indicated Interval** of the QIC-AG Permanency Continuum Framework. **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.

Figure 7.4. Wisconsin QIC-AG Permanency Continuum



Primary Research Question

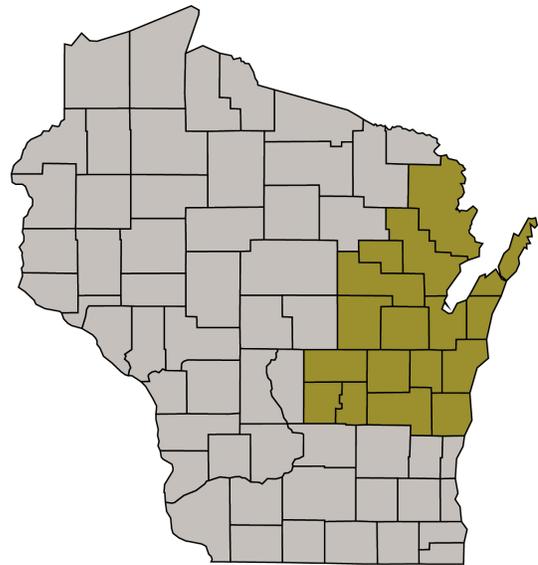
The well-built research question using the Population, Intervention, Comparison Group, Outcome (PICO) framework (Richardson, Wilson, Nishikawa & Hayward, 1995; Testa & Poertner, 2010) was:

Will families with children residing in the Northeastern Region of Wisconsin with a finalized adoption or guardianship who request services from one of the identified referral sources (P) who receive Adoption and Guardianship Enhanced Support (AGES) (I) experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health (O) after receiving AGES?

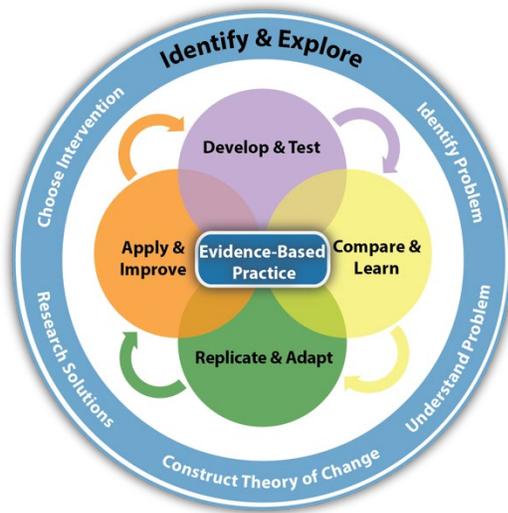
Each component of the PICO is described below. For Wisconsin, a pre-post test design was originally planned, but this had to be changed to a descriptive study only, in the **Develop and Test** phase of evidence-building.

Target Population

The target population for the AGES project was families in the Northeastern Region with a finalized adoption or guardianship who requested services. Families adopting through public, tribal, private or intercountry providers, and families who assumed guardianship were all included in the target population. Participation was voluntary and included 17 counties (i.e., Brown, Calumet, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Menominee, Oconto, Outagamie, Shawano, Sheboygan, Waupaca, Waushara, and Winnebago) and three sovereign tribal nations (i.e., Oneida, Menomonee, and Stockbridge-Munsee Native Americans). Adoptive and guardianship families were not eligible if their needs exceeded the scope of the program such as if the family requested the child be removed, felt they could not manage the child's behavior or that others in the family were in danger. It was estimated that approximately 70 families would be served by AGES each year.



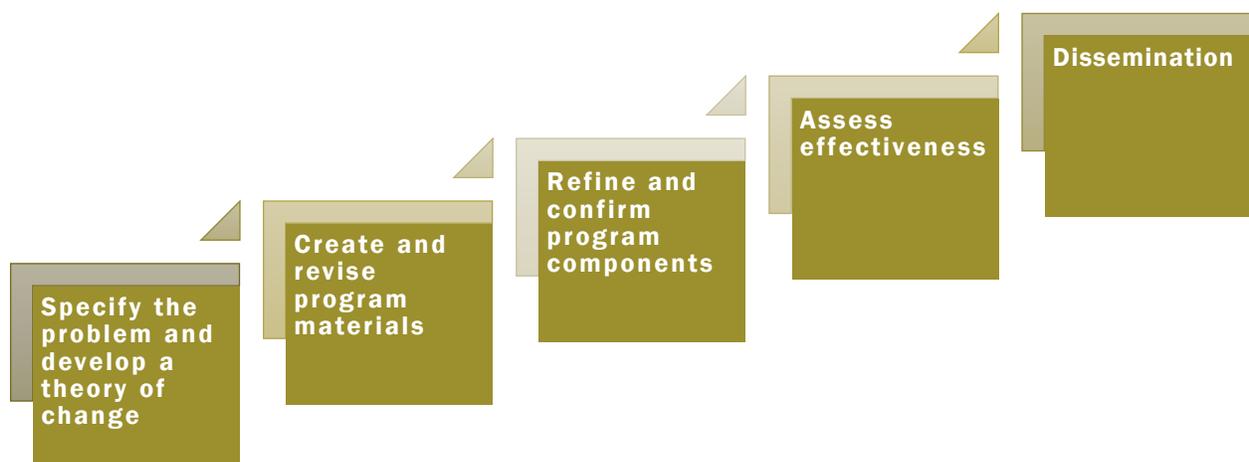
Intervention



The Theory of Change developed by the QIC-AG project in Wisconsin states that some adoptive parents and guardians feel ill-equipped and unsupported to meet the needs of their children. These families feel ill-equipped and unsupported because there are emerging issues that at the time of finalization may have been within the caregiver’s capacity to address, were not present, or were not causing familial stress. However, post permanence, after child welfare oversight has ended, these families are doing the best they can to meet the needs of the child but feel it may not be enough. Left unaddressed, these issues may result in discontinuity. This Theory of Change supposed that by providing families with support, families would feel less stressed, and therefore have increased capacity for post permanency stability and improved wellbeing.

The QIC-AG team explored several existing interventions, none of which met the specific needs, as articulated by the stakeholders and the Theory of Change. Building on portions of two existing interventions, Pennsylvania’s SWAN Post Permanency Services program and the Success Coach model from Catawba County, North Carolina, the Wisconsin team developed the Adoption and Guardianship Enhanced Support (AGES) program to address this gap. According to *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*, AGES was in the **Develop and Test** phase of intervention development.

Figure 7.5. Stages in Intervention Development



Adapted from: *Intervention Research: Developing Social Programs* by Fraser, Richman, Galinsky & Day, 2009

The QIC-AG team in Wisconsin followed a deliberate process for the development of social work-related interventions to create AGES (Fraser, Richman, Galinsky & Day, 2009). As depicted in Figure 7.5, the first step in this process was to deliberately and intentionally specify the problem to be addressed and to develop a Theory of Change. The next step was to create program materials.

This began with all-team sessions where program materials were reviewed and evaluated. The team was careful to examine the use of language and ensure the project would be culturally sensitive. A draft manual was developed and submitted to stakeholders for review and comment. This study was the pilot testing of the AGES model. Given the short time-frame associated with this study, the next study of AGES should test the program components and examine associations with the desired program outcomes.

To ensure that AGES was effectively delivered, AGES workers participated in a number of trainings, including:

- Training in Confirming Safe Environments
- CANS Training – (more specifics in AGES Manual of what is expected)
- Case Practice with American Indian Tribes
- Trauma-Informed Practiced – Trauma-Informed Practice Web-Based Module
- This training should be completed prior to the two-day Trauma-Informed Practice classroom training.
- Motivational Interviewing
- Engagement Tools
- Other Adoption Competent and Specific Trainings (from PARC and FCARC).

ADOPTION AND GUARDIANSHIP ENHANCED SUPPORT (AGES)

AGES was delivered in five distinct stages: Support Initiation, Assessment, Support Planning, Support Delivery, and Case Closure. While each of these phases is described as distinct and separate, in practice, these phases intersected and at times even blended.

Stage 1: Support Initiation

Strong engagement with families is a critical component and was the foundation for the relationship between the worker and the family throughout service delivery. This began with the family being screened into AGES and the assigned worker making the initial phone and contact with the family. Developing trust between client and worker facilitated the assessment process.

Stage 2: Assessment

During the assessment phase, the AGES worker sought information to understand the presenting problem, the strengths the family possessed, the ongoing needs of the family, and necessary linkage to services. The results of the assessment guided the development of goals for the Support Plan. The AGES worker worked with the family to complete the assessments within the first 30 days, with re-assessment approximately every 6 months.

Stage 3: Support Planning

The family strengths and needs identified in the assessment process provided the framework for developing the Support Plan. The AGES worker worked with the family to develop the plan and establish goals that were Specific, Measurable, Attainable, Realistic, and Timely (S.M.A.R.T. goals).

Stage 4: Support Delivery

Support delivery included using a family-centered approach aimed at enhancing knowledge and skills, parental resilience, social connections, and relationships. AGES also provided service coordination to strengthen needed supports to the family and remove barriers in accessing that support. During the course of providing AGES, goals were discussed at each family visit and documented in a case plan. In addition, progress and barriers to achieving the goals were assessed, with family input, at family visits.

Stage 5: Case Closure

Family participation in AGES was voluntary and could be terminated at any time the family chose. Families received services if there was an identified need and goals in the Support Plan remained unmet. The decision to close a case was a mutual decision between the family and the AGES worker. This decision included the progress towards, or successful achievement of, the S.M.A.R.T. goals.

Outcomes

The site-specific short-term outcomes for AGES were:

- Increased proportion of caregivers who felt equipped to address the needs of the children in their home
- Increased levels of social support
- Increased caregiver commitment
- Decreased in child behavioral problems

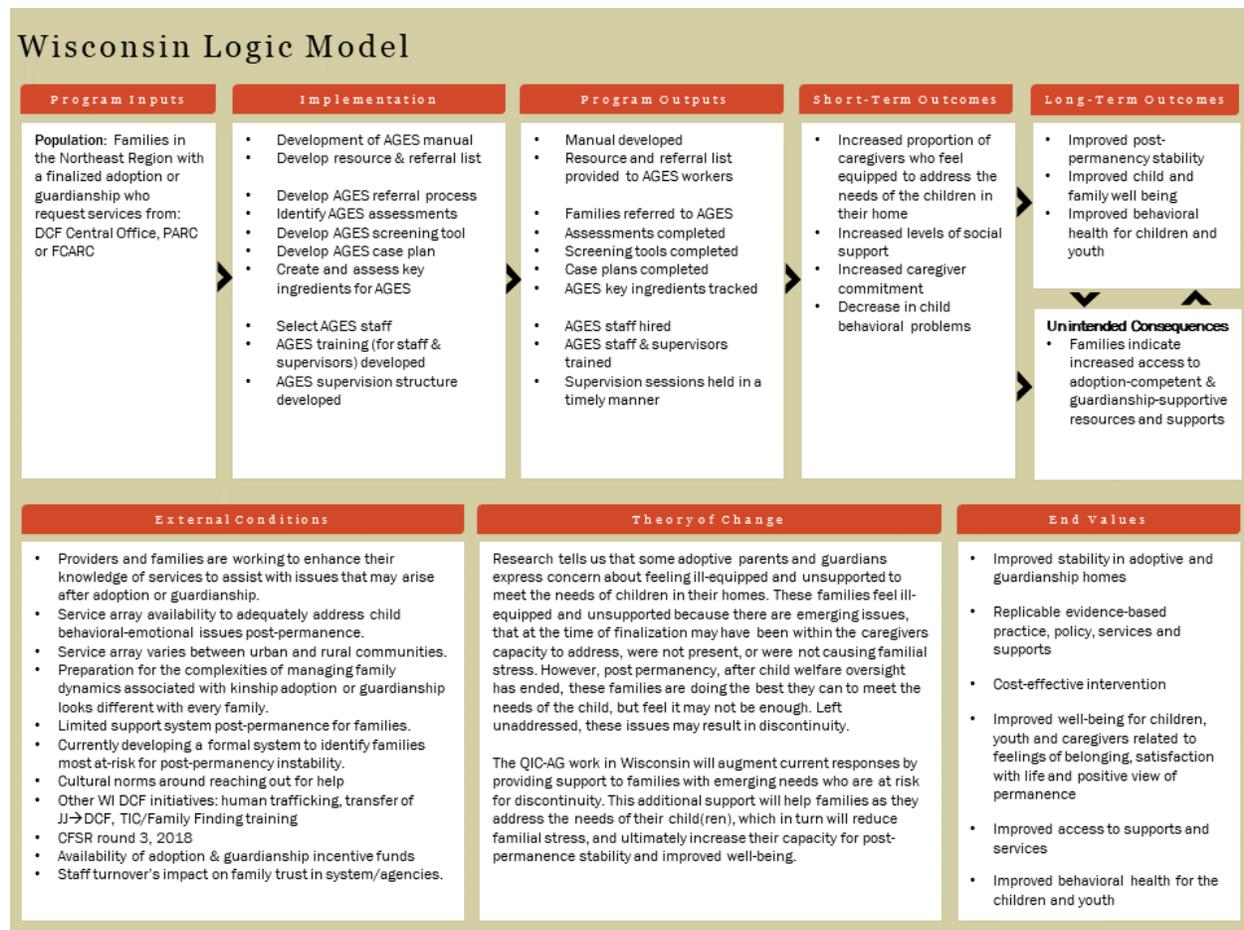
The project's long-term outcomes, set *a priori* by the funder were:

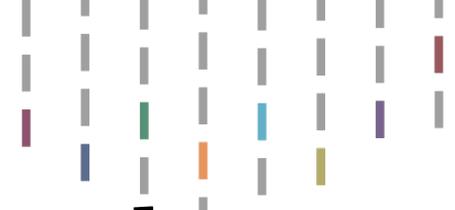
- Improved post permanency stability
- Improved child and family wellbeing
- Improved behavioral health for children and youth

Logic Model

The Logic Model (Figure 7.6) 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. The model also identifies the core programs, services, activities, policies, and procedures that were studied as part of the process evaluation, as well as contextual variables that may affect their implementation.

Figure 7.6. Wisconsin Logic Model





Evaluation Design and Methods

Originally, a pre-post design was selected to evaluate the AGES program. However, there was a slower than expected uptake of AGES, and few AGES participants had completed services. As such, there was not enough time to observe changes in short-term outcomes. The evaluation design was changed to a descriptive study to allow the project to learn from current and former AGES participants. The purpose of the descriptive study was to:

1. Assess adherence to the implementation protocol.
2. Describe the issues confronting families who participated in AGES.
3. Describe how issues confronting AGES-involved families were addressed.

The study used data collected by the program staff to assess adherence to the implementation protocol and used a combination of case record review and interviews with study participants to describe the issues participants were facing and the supports and services provided by AGES workers. The evaluation design and protocol were reviewed by the Institutional Review Board (IRB) at the University of Wisconsin-Milwaukee (UWM). This project involved electronic data collected by DCF and its partner agencies and shared with the evaluation team. A secure file-sharing site was used by DCF to share information with the evaluation team.

Procedures

USABILITY TESTING

During usability testing, the program outputs, listed in the Logic Model, were tracked. As a result of usability testing, the AGES manual was revised, and the timing of some of the AGES phases were adjusted to more accurately reflect the time it took to implement the various tasks associated with each phase.

RECRUITMENT

Training of staff at the points of contact for adoptive parents and guardians (staff at the PARC in the Northeastern region, FCARC, and the DCF Central Office) included assessing families to ensure they were in the 'Indicated' level of need. To assess this, staff were instructed that, for example, if a family called to inform the system of a new address, or asked about the timing of a training, or other calls for information only, they did not need to screen the family for AGES. However, if a family expressed that they were having some difficulties or struggles, staff were asked to talk with the family about participation in AGES.

In addition, a recruitment brochure was developed describing the program’s goals and eligibility requirements. Recruitment efforts consisted of distributing the brochures and presenting AGES to different groups that were in contact with eligible families. Families who contacted one of the agencies were screened and tracked by agency staff.

Tracking of AGES Stages

The tracking of AGES stages, and project-defined goals for critical steps, are detailed in Table 7.1.

Table 7.1. AGES Stages: Project-Defined Goals

KEY AGES STEP	DEFINITION	GOAL
CALL TO REFERRAL	Time from the initial call from the family to the referral for screening	Same day
REFERRAL TO SCREENING	Days from referral for screening to the date screening occurred	1 business day
SCREENING TO ASSIGNMENT	Days from screening occurring to date family assigned to a worker	3 business days
ASSIGNMENT TO ATTEMPTED CONTACT	Days from assignment to initial contact attempted by worker	3 business days
ASSIGNMENT TO SUPPORT INITIATION	Days from assignment to successful contact	3 business days
SUPPORT INITIATION PHASE	Days from first contact to first face-to-face visit	5 business days
ASSESSMENT PHASE	Days from assessment start (first face-to-face) date to the assessment end date (CANS approval)	30 calendar days
SUPPORT PLANNING PHASE	Days from support planning (CANS approval) start date to end date (Support Plan approval)	45 calendar days
REASSESSMENT	Months from initial assessment to reassessment	6 months
UPDATED SUPPORT PLAN	Months from completion of first support plan to updated support plan	6 months
TIME TO CASE CLOSURE	Months from case opening to case closing	No established goal

The project developed a series of tools intended to inform the process of support delivery (see Table 7.2). These assessments served two purposes: they informed the service delivery and they served as the pre-measures for the research study.

Table 7.2. AGES Assessments

ASSESSMENT TOOL	AREA ASSESSED	COMPLETED BY
FAMILY ADAPTABILITY AND COHESION EVALUATION SCALE (FACES) III	Assesses cohesion and flexibility	1 per family member completed by each member who is able
BEHAVIOR PROBLEM INDEX (BPI)	Measures frequency of behaviors and captures change over time	1 per child completed by each caregiver
BELONGING AND EMOTIONAL SECURITY (BEST)	Assesses child's belonging to family	1 per child completed by each caregiver
FUNCTIONAL SOCIAL SUPPORT QUESTIONNAIRE (FSSQ)	Measures strength of family's social supports	1 per caregiver
CAREGIVER STRAIN	Caregiver Strain	1 per child completed by each caregiver
CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) TOOL	Strength and Needs of the child and caregivers	1 per child completed by the AGES worker

Case File Review

The purpose of the case review was to analyze records written by the AGES workers between April 2017 and April 2019. The objectives of the case review were to:

- 1) Identify problems or issues confronting families who participated in AGES
- 2) Explain how AGES workers addressed problems or issues
- 3) Describe the reasons why AGES cases were closed

Between January 2019 and May 2019, two members of the QIC-AG evaluation team analyzed the case records related to the receipt of AGES services. The case records included case notes, support plans, intake and assessment data. All identifying information was redacted by the QIC-AG Wisconsin team. Data was organized in an Excel spreadsheet that included: the family's pseudonym; start and end date of the record; family's description; children or youth's age; caregiver's employment status; problems or issues; Support Plan completion; how problems or issues were addressed, and; reasons for case closure.

It was evident from the beginning of the case review that the problems or issues documented in the records were both numerous and varied. Therefore, 10 categories were developed to summarize the problems or issues identified by the reviewers (see Table 7.3):

Table 7.3. AGES: Problems or Issues

PROBLEM OR ISSUE	DEFINITION
COMPLICATED MENTAL HEALTH OR MEDICAL HISTORIES	Child or youth’s mental health or medical diagnosis
DEVELOPMENTAL ISSUES	Child or youth’s physical, mental, emotional, cognitive and development
DIFFICULTY IN MANAGING BEHAVIORS	Child or youth’s conduct challenging for caregivers
LACK OF CAREGIVER SUPPORT	Caregivers requesting support
CAREGIVER FATIGUE OR BURNOUT	Caregivers are stressed
PROBLEMS AT SCHOOL	Child or youth have educational needs
CONFLICTS WITH SIBLINGS	Problems or issues occurring among siblings
SOCIAL ISOLATION	Caregiver, child, or youth’s need for socialization
OTHER FAMILY INVOLVEMENT (BIO FAMILY)	Conflicts with birth family
OTHER ISSUES	All other problems or issues not listed

To ensure accuracy, the researchers reviewed the same 20 case records, checking each other’s work for discrepancies at three different time intervals until differences were resolved. The reviewers then divided the remaining case records and analyzed them separately. The first part of the case review focuses on the records that had Support Plans and addressed the first two objectives. The second part of the case review includes all case records and addresses the third objective (reason for case closure).

Interviews

To further explore whether AGES equipped families with the support they needed to strengthen their capacity to care for their children, interviews were conducted with adoptive parents and guardians who participated in the AGES program. The interviews sought to:

1. Describe the issues confronting families who participated in AGES.
2. Describe how issues were addressed by the AGES workers.

Prior to contacting participants, the entry point staff discussed with adoptive parents and guardians whether they were interested in participating in the interviews. Once the families expressed interest in being interviewed, the families’ contact information was provided to researchers. AGES families were contacted via letter, email, and/or phone. Interviewers provided families with an explanation of the reason for the interviews along with a detailed consent form.

In-depth interviews were conducted with caregivers at two time points: (1) During usability testing, and (2) in early 2019, at the end of the evaluation period (between January and March 2019). A total of 21 of the 32 families served by the AGES program were interviewed by the QIC-AG evaluation team. Five families were interviewed at both time periods.

The University of Wisconsin Institutional Review Board approved a detailed consent form, describing the risks and benefits to participating in the phone interview, items asked on an interview guide, and a letter to potential study participants explaining the reasons for conducting the interview. Data was collected using a 25-item interview guide. Participants received a \$25 gift card for their participation in the interviews.

Using grounded theory (Charmaz, 2014; Eaves, 2001), questions on the interview guide were asked and refined as the interviews proceeded. Interviews were recorded and transcribed verbatim. Data analysis consisted of reading the interviews line by line multiple times and verifying open coding by two researchers. Axial coding was then used to create subcategories followed by selective coding that integrated and refined the theory. Categories and themes identified through coding were used to create hypotheses that reflected the participants' experiences.

To further clarify the understanding of the program by the evaluation team, the researchers met with the AGES workers to gain insight and clarity on the support they provided to families. We explored their experiences working with adoptive and guardianship families. They reflected on the successes and challenges associated with their work. They also reflected on the factors they believed contributed to their ability to connect and engage with families.

Measures

During the initial assessment phase, the following measures were collected by the AGES workers, completed by the families they served.

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 is not true, sometimes true, or often true. Scores on the BPI range from 0 to 56, where higher scores indicate a child may be exhibiting more difficult behaviors. The BPI contains two subscales: the BPI Internalizing Subscale (11 items) and the BPI Externalizing Subscale (19 items) which are used to measure a child's tendency to internalize problems or externalize behaviors.

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

The BEST-AG, developed by Casey Family Services (Frey et al., 2008), was originally designed to help social workers guide conversations around emotional and legal commitment with foster parents and youth who are unable to reunify with their family of origin. For this study, the BEST was adapted and used with families 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).

Caregiver Strain Questionnaire – FC/AG22

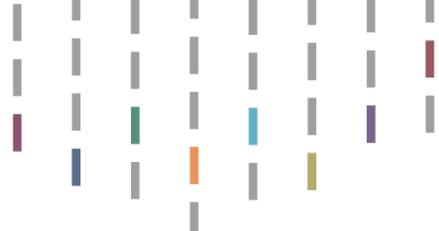
The Caregiver Strain Questionnaire-Adoption/Guardianship Form (CGSQ-FC/AG22) is an adapted version of the Caregiver Strain Questionnaire (Brannan et al., 1997). This 22-item measure is a self-report measure that assesses the extent to which caregivers experience additional demands, responsibilities,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

Functional Social Support Questionnaire (FSSQ)

The Functional Social Support Questionnaire (Broadhead, Gehlbach, DeGruy, & Kaplan, 1988) measures an individual's perception of the amount and type of personal social support. It includes eight items with the options of 1-5 (1 being much less than I would and 5 as much as I would like). Thus, higher scores reflect higher perceived social support.

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 and Participant Profile

Participants who were engaged in the AGES program between March 2017 and January 2019 were included in this study. Participant outcomes were tracked through April 2019. The evaluation also sought to determine to what extent the preliminary findings from the AGES program showed that the program met the initial desires of the program as outlined in the Wisconsin QIC-AG Theory of Change. The Theory of Change states that some adoptive parents and guardians feel ill-equipped and unsupported to meet the needs of their children. These families feel ill-equipped and unsupported because there are emerging issues that at the time of finalization may have been within the caregiver's capacity to address, were not present, or were not causing familial stress. However, post permanence, after child welfare oversight has ended, these families are doing the best they can to meet the needs of the child but feel it may not be enough. Left unaddressed, these issues may result in discontinuity. This Theory of Change supposed that by providing families with support, families would feel less stressed, and therefore have increased capacity for post permanency stability and improved wellbeing.

PROGRAM REFERRAL TIMELINE

From March 2017 to January 2018, of the 77 families who called one of the three entry sites, and met the criteria for AGES², the calls came from the following sources.

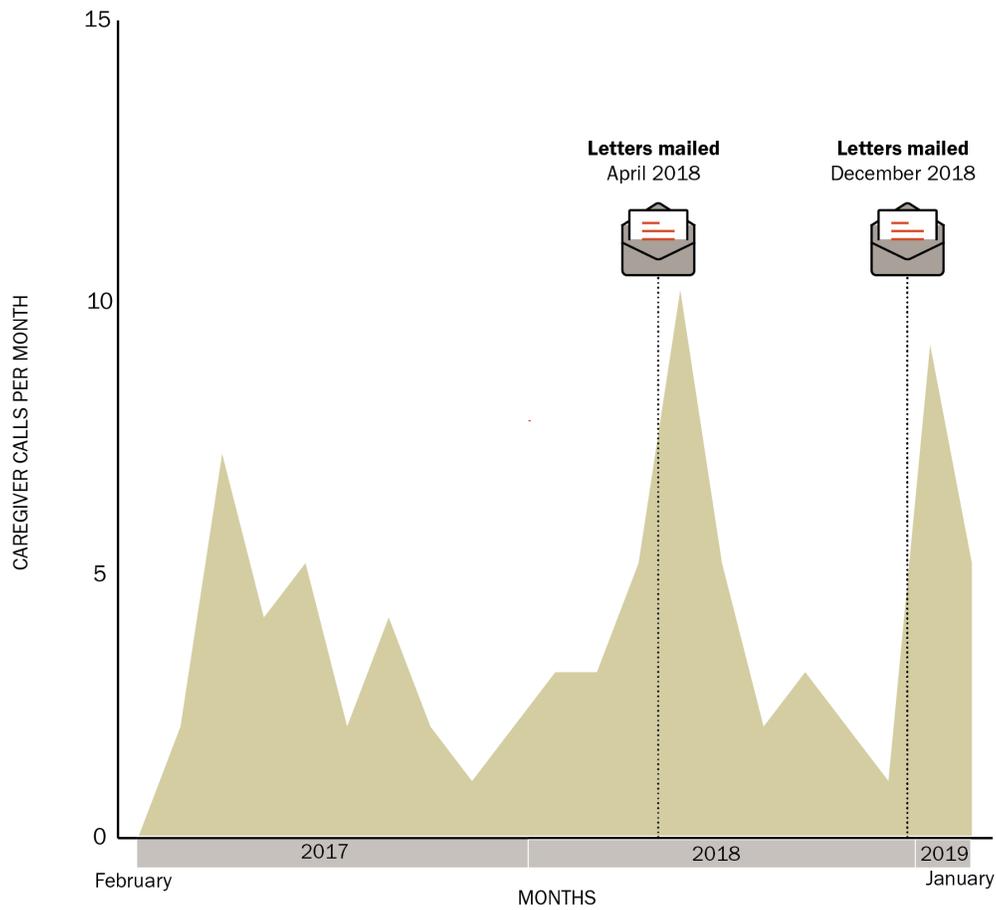
- 73% (56) PARC
- 22% (17) DCF Central Office
- 5% (4) FCARC

This was a lower number of calls than had been expected. Figure 7.7 depicts the number of calls, by month, during the project period. To increase enrollment into the program, DCF and AGES supervisors conducted two recruitment mailings to prospective adoptive parents, guardians and pertinent agencies (depicted by dotted lines in Figure 7.7). An increased number of calls was observed after each of the mailings.

Two AGES workers staffed the AGES program. Staff changes are noted in Figure 7.7, service dates are shown across the bottom. Lower than expected calls may have been hampered by staff changes and uneven recruitment efforts. For instance, letters did not go out to families until staff was in place to serve families who responded. There were several months early-on in the roll-out of AGES where only one AGES worker was responsible for serving families, and decisions were made to delay outreach letters until adequate staff was in place.

² There were additional calls made to the entry points, but they were screened out because the family was not expressing a need for services. Many of the calls to the entry points are for information only (e.g., time and location of a training, updated address information) and therefore not recruited for AGES.

Figure 7.7. AGES Project Timeline

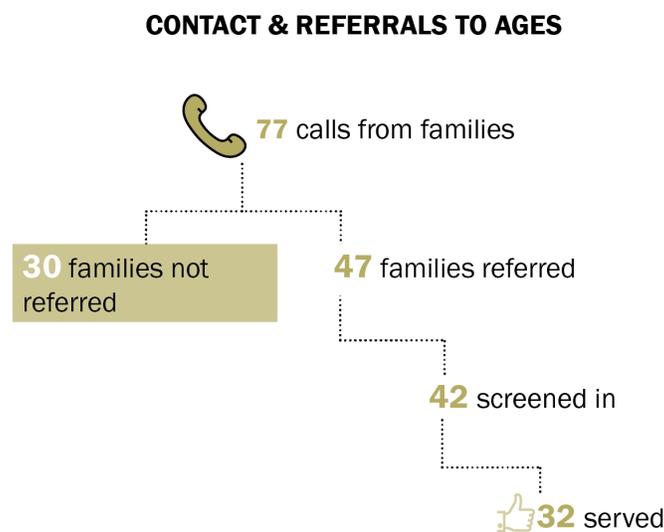


At the start of the enrollment period for the Wisconsin project, there was a concern that the project staff might not be able to serve all the families who wanted services. In what was referred to as ‘the floodgates opening,’ the project staff worried they would be overwhelmed with requests for services. This concern was based on interactions staff had with adoptive and guardianship families in the past, and the difficult stories they had heard from these families. Rather than being overwhelmed by requests, the agency ended up sending letters to families alerting them of the AGES program, seeking additional program participants. At no point in the program did staff feel that they were flooded with requests for services.

PROFILE OF AGES FAMILIES

Seventy-seven adoptive and guardianship families called one of the three entry points and met the criteria for AGES. Of those families, 47 were referred for screening and 5 were screened out, leaving 42 screened in. Once screened in, 10 families closed prior to completing the assessment phase. (Note: For the purposes of the evaluation, if the initial assessments were not complete, families were not counted as served.) Typically, the assessments were not completed because the family exited the program before completing them. This occurred because it was determined that the family was not eligible, a decision that was made after initial screening, and closed. Or, because the family decided they did not need AGES, or simply stopped communicating with the program. This resulted in a total of 32 families served by the AGES program (see Figure 7.8) including those served during the usability testing phase of the evaluation³.

Figure 7.8. AGES Project Case Flow

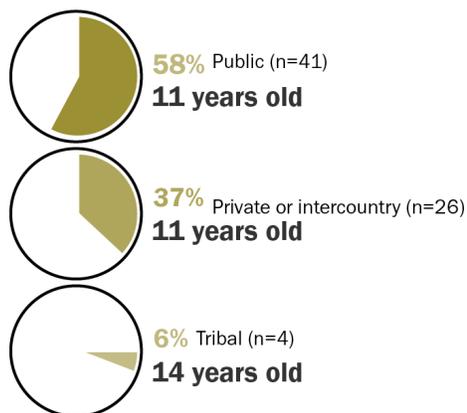


The 32 families served had a total of 71 adoptive or guardianship children. The types of adoption or guardianship children served by AGES was: 58% public adoptions or guardianships, 37% private or intercountry adoptions or guardianships, and 6% (one family) tribal adoptions or guardianships (Figure 7.9). Two families adopted or assumed guardianship through both public and private agencies.

³ For the families who were not referred to the ages program (30 families noted in Figure 7.8), the reasons for not being referred, and the number of families who had this reason were: 4 families wanted the child to move; 7 families had cases open with child welfare, juvenile justice, or child protective services; 12 families had current foster parent licenses; 8 children were living away from the family; and 12 families were not interested in participating. Please note that this sums to more than 30 because one family could have multiple reasons that the child was not referred.

Figure 7.9. Number of Children Served by AGES, by Type of Adoption or Guardianships

Type of Adoption or Guardianship & Average Age at Initial Call



In Wisconsin, there are two statutes under which a guardianship can occur. Chapter 48.977 requires the involvement of child welfare and has different expectations if the family chooses to try to dissolve a guardianship. Chapter 54 does not require the involvement of child welfare and a family can obtain guardianship of a child in family court; they are sometimes referred to as a family court guardianship. However, Chapter 54 guardianship can also be granted through child welfare. Hence, the definitions of guardianship are complicated. Furthermore, the financial support available to families varied by statute. All types of guardianship families were included in this project. The specific definitions of guardianship used by the Wisconsin Department of Children and Families (DCF) staff are in the Appendix.

Process Evaluation

ADHERENCE TO THE AGES PROTOCOL

The AGES program was developed to progress through five stages. Each stage had a list of specific activities. Time to accomplish key steps were tracked and are reported below. This summary is based on the records of the 25 families served by AGES *after usability* when time frames were readjusted.

Adherence to the implementation protocol is detailed in Table 7.4 below. While many of the time frames established for the program worked, a few tasks required more than expected time to complete.

- Referral to screening: On average, 1.36 days, rather than one day, with a few referrals extending up to three days.
- Assignment to support initiation: This was set at 3 days; however, it took up to 12 days for some families to find a time to meet. Often during this time, the worker was attempting to reach the family, by email and phone, before an actual meeting occurred.

- Assessment phase: While it was initially thought that this would take 30 days, on average, it took 33.21 days, and in some cases, the process took up to 60 days.
- Support planning phase: The goal was 45 days, yet this took, on average, 52 days, and up to 101 days.
- Time to reassessment: The goal was 6 months; this took between five and seven months to complete. However, it should be noted that at the time data collection ended, only 12 families had reached this milestone.
- Support plan updates: While the goal was 6 months, this took six to seven months to complete for the 8 families whose plans were updated during the observation window.
- Case closure. Of the 10 cases that had closed at the time of data collection ended (and after usability), they closed, on average, at 6.20 months, and ranged from two to ten months.

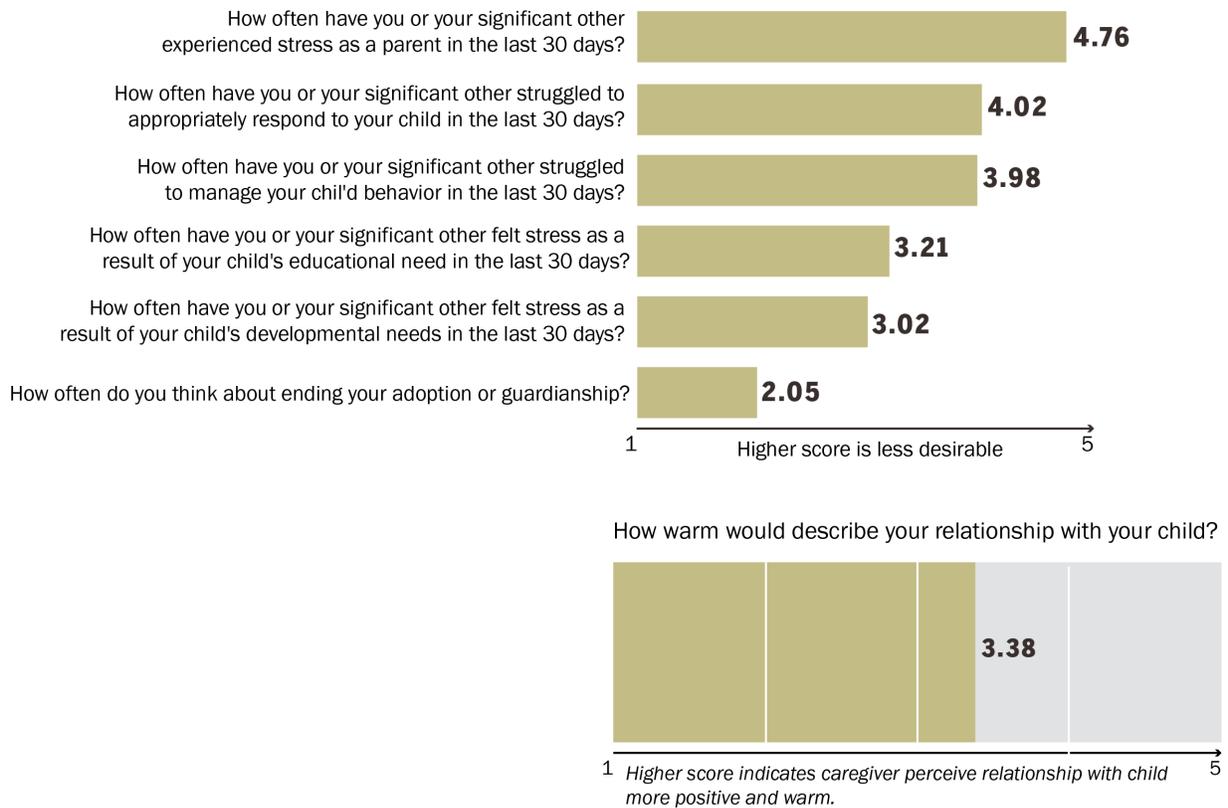
Table 7.4. Time to Meet Key AGES Milestones for Families Served by AGES

MILESTONE	PROJECT GOAL	PERCENTAGE WHO MET GOAL	AVERAGE TIME TO ACHIEVE GOAL
Initial call	Same day	96%	0.04 days
Referral	1 day	60%	1.36 days
Screening	3 days	100%	0.16 days
Attempted contact	3 days	96%	0.80 days
Support initiation	3 days	60%	3.12 days
Support initiation phase	5 days	80%	3.60 days
Assessment phase	30 days	54%	33.21 days
Support planning phase	45 days	37%	52.26 days
Time to reassessment	6 months	42%	6.15 months
Time to updated support plan	6 months	0%	6.39 months
Time to case closure	no goal		6.20 months

SCREENING AND INTAKE

At the time of initial screening, families were asked a series of questions related to their familial relationships. Results from those questions are summarized in Figure 7.10 (and detailed in Table 7.10 in the Appendix). These questions were asked at the family level – one response per family. Responses to these questions were all on a 5-point scale.

Figure 7.10. Mean Responses to AGES Screening Question



Results of the assessment data and screening questions are summarized below. Please note that parents or guardians were asked to assess each child in their home at the time of initial intake. Results for multiple children per family are included, and results for birth children were not included.

Table 7.5. Scores on AGES Measures

ASSESSMENT DATA	N	SCALE RANGE	MEAN	SD	MIN	MAX
<i>ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN</i>						
BEHAVIOR PROBLEM INDEX (BPI)	71	0-56	28.44	12.92	1	51
BPI -- EXTERNALIZING	71	0-38	19.99	9.42	1	36
BPI -- INTERNALIZING	71	0-22	9.76	4.95	0	20
CAREGIVER STRAIN QUESTIONNAIRE (CGSQ-FA)	71	1-5	3.35	0.79	1	5
OBJECTIVE STRAIN	71	1-5	3.97	0.83	2	5
SUBJECTIVE STRAIN	71	1-5	2.84	0.82	1	4
<i>ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN</i>						
BELONGING AND EMOTIONAL SECURITY (BEST-AG)	71	20-100	85.01	10.43	49	100
BEST-AG CLAIMING	71	7-35	31.99	3.14	21	35
BEST-AG EMOTIONAL SECURITY	71	13-65	53.03	7.94	24	65
FUNCTIONAL SOCIAL SUPPORT QUESTIONNAIRE (FSSQ)	33	10-50	28.30	7.18	12	40

CASE RECORD REVIEW

AGES case records were analyzed with three objectives in mind: (1) Identify problems or issues confronting families who participated in AGES; (2) Explain how AGES workers addressed problems or issues, and; (3) Describe the reasons why AGES cases were closed. The first two objectives of the case review focused on 26 case records that included Support Plan. The third objective of the case review included the 32 case records of families who were served by the AGES program.

Objective #1: Identify problems or issues confronting families who participated in AGES.

The case review identified the problems or issues confronting the 26 families who had Support Plans written. Two qualifications need to be made prior to addressing this objective. First, the goal of the AGES program was to view families holistically rather than through a problem-oriented lens. The families' strengths, as well as problems or issues, were documented in the records. Secondly, while this section describes problems or issues separately, they did not exist in a vacuum and were often interconnected. It was clear from analyzing the records that an identified problem or issue triggered a number of other problems in its wake.

Table 7.6 lists problems or issues documented in the records reviewed. A more detailed description of these issues can be found in the appendix (Table 7.11).

Table 7.6. Type of Issues and Problems Addressed by AGES

PROBLEMS OR ISSUES	26 FAMILY CASE RECORDS
COMPLICATED MENTAL HEALTH OR MEDICAL HISTORIES	23 (89%)
DIFFICULTY IN MANAGING BEHAVIORS	23 (89%)
PROBLEMS AT SCHOOL	17 (65%)
CAREGIVER FATIGUE OR BURNOUT	16 (62%)
DEVELOPMENTAL ISSUES	14 (54%)
OTHER ISSUES	12 (46%)
OTHER FAMILY INVOLVEMENT (BIRTH FAMILY)	8 (31%)
CONFLICT WITH SIBLINGS	7 (27%)
SOCIAL ISOLATION	4 (15%)
LACK OF CAREGIVER SUPPORT	2 (8%)

Objective #2: Explain how AGES workers addressed problems or issues.

To understand how the AGES workers addressed the families' problems or issues, the evaluation team compared the 10 major problems or issues described in the previous objective with the different types of supports the 26 families received in their Support Plans. A detailed account of the services provided to each of the 26 families was beyond the purview of this review. However, this section will briefly describe the different support types, their relationship to the families' problems or issues, and the three themes that may explain how the AGES workers addressed the problems or issues confronting the families.

As described in the AGES manual, developing a Support Plan is a dynamic, collaborative process between the family and the AGES worker. After family assessments were completed, goals and respective support and services were identified to address the needs of each child, caregiver, and family. Table 7.7 lists the types of support and services that AGES workers provided and the percentage of support types each of the 26 families received.

Table 7.7. Support Types and Families Who Received Individual Support Types

TYPES OF SUPPORTS IN SUPPORT PLAN	FAMILY-LEVEL SUPPORT PLANS (N=26)
INDIVIDUAL THERAPY	23 (89%)
CASE MANAGEMENT	16 (62%)
PARENTING SERVICES	13 (50%)
RECREATIONAL ACTIVITIES	13 (50%)
FAMILY THERAPY	12 (46%)
EDUCATIONAL ASSESSMENT	10 (35%)
SOCIAL SUPPORTS	8 (31%)
BASIC HOME MANAGEMENT	7 (27%)
DEVELOPMENTAL, PSYCHOLOGICAL OR PSYCHIATRIC ASSESSMENT	3 (12%)
OTHER	8 (31%)

Examples of the types of supports summarized above include:

- Individual Therapy (individual in-home therapy, equine therapy);
- Case Management (caseworker advocacy, service coordination);
- Parenting Services (skill development with communication, empathy);
- Recreational Activities (afterschool or sports program);
- Family Therapy (familial analysis);
- Educational Assessment (guidance on navigating school systems, obtaining the Individual Evaluation Program - IEP);
- Social Supports (emotional, psychological support);
- Basic Home Management (parenting advice, time management);
- Development, Psychological or Psychiatric Assessment (neuropsychological evaluations, mental health hospitalizations), and;
- Other (mentoring, spiritual-cultural supports).

Support Plans included 15 different types of supports that were consolidated into 10 support types (due to low percentages of some supports). The most frequently cited type of support families received was : Individual Therapy (89%) followed by Case Management (62%), Parenting Services (50%), Recreational Activities (50%), and Family Therapy (46%). The Support Plans closely reflected the problems or issues reviewed in the first objective. For example, records indicated the highest percentage of problems or issues were Complicated Mental or Medical Health Histories and Managing Behaviors. This corresponded to the highest percentage of support type or Individual Therapy. Next was documented problems or issues requiring different types of services, and the next highest support type was Case Management.

In analyzing the records, three themes emerged illustrating how AGES workers addressed problems or issues confronting families: 1) The Right Fit, 2) Flexibility, and 3) Being Direct and Candid. These themes are not exclusive from one another but rather interconnected.

1. The Right Fit

Social workers require in-depth knowledge and skills to best serve and support adopted and guardianship children, youth and their families. AGES workers offered families a broad range of case management services that included individualized assessments, advocacy, referrals, navigation and coordination of services. What was apparent in analyzing the case records was the number of instances where children, youth and their families were matched with supports and services that specifically addressed their needs.

Ensuring that families are connected appropriately to needed services is no easy accomplishment considering Wisconsin, like many other states, have limited trauma-informed care or specialized behavioral treatment modalities. The record review indicated workers either had knowledge of and/or investigated different resources to find the “Right Fit” of supports and services for families and individual family members. If one type of service did not meet the family’s need, another was tried. Examples included: finding a counselor who taught de-escalation skills (“Stop Therapy”). The case records reported that the family experienced decreased stress as a result of the services, stress that was debilitating the family.

Another example was connecting a child with equine therapy and the case notes reflected a dramatic improvement in the child’s behavior. Other examples of services include: referring a set of adoptive parents who were separated while in the AGES program (and considering divorce) to resources that met their individual needs; (after obtaining appropriate releases) consulting and collaborating with therapists, county social workers and even probation officers to ensure appropriate care was being delivered; connecting guardian caregivers to Kinship Care funding for their guardian children and youth to participate in particular recreational activities; reaching out to members of one adoptive parent’s church members for support. The AGES workers made referrals to providers who had experience working with families formed through adoption or guardianship facilitated families receiving services that were the right fit.

The above examples are just a few ways the workers identified the unique needs of adoptive and guardianship families and individual family members (including birth siblings) and connected them with the support and services that fit those needs. If the supports and services were not benefitting them or circumstances changed within the family, different services or supports were explored. If the workers could not find a resource, support, or service, notes indicated they acted as a place holder until the resource or service could be located. Records also showed that if families were not provided the services they needed for an extended length of time, the effects on families could be detrimental and could pose a risk to the stability of the adoptive or guardianship family.

While it was vital for workers to connect family members with the “Right Fit” of services and support, workers themselves played an important role in families and family members accepting that help and support. Caregivers were often “frustrated” and “ready to give up,” but seemed to have benefited from the support of the AGES workers.

2. Flexibility

To provide the “Right Fit” of services and support to meet the families’ needs, case notes show worker flexibility was an important factor. This individualized approach was an important objective in the AGES program. For example, in addition to meeting caregivers and family members in their home, workers met families in therapists’ offices, parks, schools, and restaurants or cafes accommodating the families’ schedules, availability, and needs. Case notes indicated if appointments were missed, AGES workers continued to reach out to families. Appointments were scheduled and rescheduled through emails, phone calls, and text messages. In some case notes, caregivers responded to worker emails and updated them about how the family was doing.

The number of problems or issues among families was often numerous and Support Plans were updated depending on the priorities of the families. Case notes indicate solutions to problems came from family members themselves rather than formula-like answers from workers. The way family meetings were structured was also flexible and according to individual families. For example, some adoptive and guardianship families preferred the worker meet with children and caregivers individually and then come together as a group; other families met with the worker altogether and not individually. And for some meetings, the AGES worker only met with the parent or guardian, again taking direction from the family themselves.

AGES workers’ flexibility also extended to their availability in accommodating adoptive and guardianship families’ needs. For instance, one worker attended and supported a guardian family during their visitation with birth parents. Case notes also revealed some workers were flexible in the creative sense. For example, one adoptive parent had difficulty setting limits with her children. To help her, the worker wrote out rules and expectations for the children and called it “The Respect Project” which sounded less threatening and punitive. In another family, a worker brought the family donuts making a special point to bring a favorite kind of donut to one family member who was difficult to connect with. Flexibility and individualized support seemed to be important ingredients in both workers providing services and families accepting them.

3. Being Direct and Candid

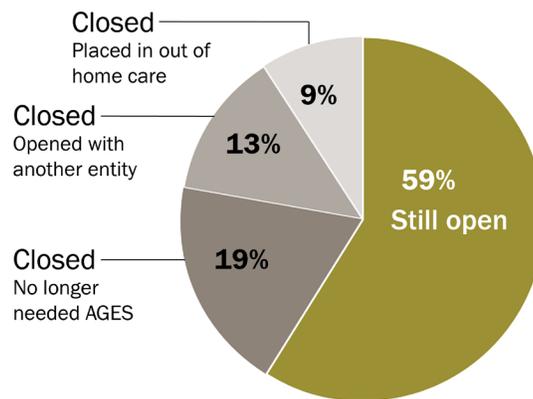
The third theme that ran through the cases was AGES workers being direct and candid not only with family members but also with other service providers. According to the notes, workers wrote that they communicated with families honestly and directly albeit in a gentle manner. For example, one adoptive parent wanted to take a class outside of the state and the worker wrote that she redirected the parent and suggested that she “focus on the issue at hand.” When caregivers themselves had problems such as alcohol abuse or were punitive with their children, workers were honest about how the caregivers’ behaviors were affecting their families and provided services and resources that addressed their issues. Responses by caregivers documented in the notes indicated that direct communication from workers was effective and appreciative. However, being candid at times was sometimes not well received. In those circumstances, workers processed feelings in ensuing meetings taking a different yet still honest approach.

Records also indicated workers were upfront with other service providers. When professionals were not providing services in the best interest of a family, workers spoke with those providers on behalf of the family. For example, in one case note, the worker spoke with a child’s therapist about the child’s needs repeatedly. After the therapist continued to not adequately address the child’s needs, the worker advocated for the family to switch to another therapist; subsequently the new therapist correctly diagnosed the child who was then able to obtain intensive services for his condition. In addition, case notes revealed straightforward discussions between workers and their supervisors particularly with questions regarding the family’s eligibility for continuing services in AGES; workers advocated that cases stay open until families were securely connected with the outside programs and services they needed.

Objective #3: Describe the reasons why AGES cases were closed

Altogether 32 families were served by the AGES program during the evaluation period. At the end of the evaluation period (March 2019) their status was as follows:

The status of 32 families served at the end of the evaluation period:



- **59% (19) were still opened and receiving services.** The families in this category will continue to receive services, as needed, after the end of the evaluation period.
- **19% (6) families closed because their goals had been met, or they no longer needed services.** The families in this category reported doing well, and that AGES had helped them get through difficult times. For example, one family reported that their entire family was in a better place and feeling less socially isolated. Another family reported that their youth had learned to control his anger and was more socially engaged. Another parent reported positive changes within their home, relationships and as a family unit. Yet, another family had more of a mixed-bag outcome, stating that the information they had received as part of AGES was helpful, but they were still had some familial struggles and issues to continue to work through.
- **13% (4) closed because the child or youth had a case opened with another entity.** These families were in need of continued services, but because their children needed services provided by the county (Child Welfare/Child Protection or Youth Justice), the AGES program was no longer available to them. In these cases, the AGES worker kept these cases open and intervened on the families’ behalf until they were connected to the services they needed. Although it may appear as a “poor outcome” the AGES workers provided a very important service to these families.

- **9% (3) families closed because their child was placed in out of home care, or returned to the care of the birth parent.** AGES workers often identified families who had complex issues, but the families were unsuccessful in connecting to a higher level of support, even after multiple attempts with county social workers, police, etc. The AGES workers noted that two of these parents or guardians stated that they were ready to end the adoptive or guardianship relationship from the start of the program. For these families, perhaps AGES was not the right intervention. However, the AGES workers helped these families to make the best of a difficult situation.

INTERVIEWS WITH AGES PARTICIPANTS

The purpose of the interviews was to understand from the adoptive parent or guardian's perspective, what issues they were facing when they began the AGES program, and how AGES addressed these issues. The research team conducted interviews (typically lasting 45 to 60 minutes). After the interview, the team reviewed the transcripts from the interviews, coded what was reported in the interviews, and then summarized the themes that emerged from the interviews. The section summarizes what families told the evaluation team about the AGES program.

Of the 32 families served by the program, 21 (66%) were interviewed by the QIC-AG evaluation team. At the time of the interviews, some families had completed the program and others were still receiving services. A summary of the types of struggles AGES-involved families experienced are summarized below. This is followed by a summary of how families reported that issues were addressed by AGES.

Why were the families struggling?

Adoptive and guardianship families struggle like other families, but there is a uniqueness to their struggle. Many families come to adoption and guardianship for a variety of reasons, such as infertility, wanting a bigger family, wanting to parent a specific child, and not wanting to see a relative enter the foster care system. Once they realize that love is not enough to overcome problems, they begin looking for resources, support, and help. Some families had long-term issues (e.g., how to respond to questions related to birth families or navigate the world with an adopted biracial child). Some families engaged with AGES with more urgent issues (e.g., having children kicked out of school, behavioral issues, and mental health diagnosis) that left them wondering how to best help their children. Families reported different types of struggles within the same family. Their experiences are summarized below.

Long-Term Issues

Long-term struggles were those that were concerning to families and needed addressing. They did not lack importance or overwhelm families at the moment. Long-term issues often consisted of questions that adoptive parents and guardians had about how to discuss or explain difficult things to their children. This included, for example:

How to handle children's questions about birth parents:

"Her medical stuff I've got covered. I would say that's an easy part to deal with. That part is easier to wrap my head around. The tougher part is how to answer her questions or issues about who her dad is...I don't really have anything to give her because she was a safe-haven...all she knows is that I came to the hospital to [adopt] her."

"Since our sibling group does not see their birth mom, the oldest does have a lot of questions – 'Where is my mom? What is she doing? How come we can't see her? How come our brother gets to see his birth mom and we can't?' And so, some of his challenging behaviors might be because of that, too."

How to set boundaries with extended families (i.e. negotiating visitations, and how to assume primary caregiver role when parents are still in the picture):

"To be grandma and then also guardian was also a very stressful thing. And I think just talking to her and seeing whether I was doing what I felt was right and having someone on the outside looking at it and saying you could do this instead of that helped...Had it been much sooner it probably wouldn't have been as long of a struggle but because that [AGES] wasn't available, I had to search these things on my own."

Raising bi-racial children as White parents in predominantly White settings:

"I struggle with the Black kid being raised in a White family in a White community in a White school. He seems to be okay with it, but I struggle with whether or not we're doing him a disservice."

"My daughter is biracial. She was pretty much oblivious to the whole race thing until middle school. Then it was like: 'Oh, I'm being raised by a White family and I'm part Black. I don't know anything about that.'"

Note to the reader: Pseudonyms (fake names) are used throughout this report, and agency or service provider names and locations concealed, to protect the confidentiality of the AGES participants.

Urgent Issues

The adoptive and guardianship families who were struggling with urgent issues reported that they had tried many services prior to AGES and were at a place of not knowing what to do next. The urgent issues were diverse, and often required a variety of responses and assistance from the AGES workers. Examples of urgent issues are provided below:

How to parent a child who has complex trauma:

“Behavior is the biggest issue. They are continuing to get worse. We're dealing with a child that has no sense of time, no sense of danger... As he gets older it's getting worse. He has several different diagnoses, nobody really told us how to help him... So, knowing the problem or knowing the diagnosis is fine, but okay now what do we do?”

Caregivers reported difficulty in addressing difficult behaviors from their children that were urgent issues. Difficult behaviors were described broadly, and sometimes more specifically, for instance issues related to destroying property, assaulting others, and problematic issues at school. Parents and guardians expressed concern about the impact of these issues on the entire family. Examples of these issues are:

“We were getting to our wit's end...It's like all is going bad with him right now, the youngest one. We don't know what else we can do. The major challenges we're having, behavior is the biggest one.”

“I've been trying to get her help. I've called the police a million times. They come here, and by the time they get out to our house, because we live so far out...she's all calmed down and sitting on the bench. And, you know, she's a beautiful kid. She's very cute and smiley, and she can be very, very sweet.”

“Lately, I have been getting frequent phone calls from school and not only just for [CHILD's NAME]. Now some of this has kind of transferred to all of the kids. So that was the main reason for calling [AGES] – the oldest [child's] behavior issues and some of the youngest ones...now all four of the kids are contributing to the difficulties at school.”

“She does okay in the community...She can keep a lid on it while she's in the community, but everything is saved until she gets home. You never – never, literally never, know what's going to set her off ...She has threatened to stab us...I found a note – I found a knife in her room.”

Parents and guardians also described the acute stress associated with difficulties addressing the needs and priorities of adoptive children and birth children and sought help integrating all their children into their family. An example of this:

“We have extra stress as she was diagnosed with a medical condition...Our older kids were not especially supportive. They were supportive of the adoption when it happened, but they just were really not connecting with their adopted siblings. There was a lot of stress in our family and we tried a lot of different things through medical professionals, through going to classes and things like that. We contacted AGES because I was just at a point where I felt like I would take any help that was available.”

Families also reported the stress associated with trying to get the correct diagnosis and services for their children. This stress was particularly acute when addressing their children's mental health

diagnosis (e.g., Reactive Attachment Disorder [RAD], Obsessive-Compulsive Disorder [OCD], Asperger syndrome), and other major health challenges:

“He has huge anger issues, which has been probably our most difficult thing. And even on medication we were doing all right for a while, and the last few weeks he's been having more trouble at school...I can't even wrap my head around it some days. I can't even believe that anybody that little has so much rage in him.”

“She doesn't know [about her diagnosis] yet. You know that's a huge bridge to cross for us...we've put it off just because she has all these other health issues and she's just so bummed about them. She's so down on herself. So, we've got to find the right counselor.”

Parents and guardians also reported that their familial stress had led to strained parental relationship and that they needed assistance addressing relationship or loss of a relationship:

“I often say things could've gone so differently had AGES been in our world a year after we adopted...A lot of my divorce is because I adopted the kids with my ex-husband...If I would've let him, he would've wanted to rehome the kids. And of course, I was not on board with that...that was what started our separation then divorce. He couldn't handle it and I refused to throw my kids away.”

After suffering for long periods of time, parents and guardians reported that they considered ending the adoption or guardianship and removing their children from their home permanently. By the time families were engaged with AGES, particularly the families with the urgent needs that they have been trying to address for a long time, some families were at the brink of discontinuity or had seriously considered it. These families were hoping that AGES could help.

“I have seriously considered ending the adoption. I hate to say that. It will rip my heart out because he is family. I've raised him since he was a baby...He is disrupting the whole family...I was told by a counselor we went to see before we made our final decision to adopt the two boys...that we [should] not adopt these boys, especially Trace because he'd end up being institutionalized by the time he was 18. I kept telling them they were crazy. I'm not going to believe that, but it's starting to hit home. I started to realize that could be a possibility.”

“I have [considered ending the adoption or guardianship]. When I am in such stressful mood, I have said, ‘I don't know what more I can do to help this child.’ And then, I'll take a look at it and I go, ‘I can't...’ So I have thought about it.”

In sum, parents and guardians spoke of the issues they were facing in terms of how much stress they were struggling with. In other words, some issues were discussed with a great sense of urgency while others needed addressing more long-term. These more long-term issues with a lesser sense of urgency are often part of training for staff working with adoptive and guardianship families (e.g., negotiating relationships with the birth family, issues related to transracial adoption).

For the more urgent issues, families reported having tried a myriad of things that did not seem to work. They were in urgent need of services that could help their children, but because of a variety of roadblocks, they could not access those services on their own. When families were desperate for help, they reported feeling like no one was there. Still, other families were left feeling like things might never change. These struggles coupled with the lack of supportive services is what made families consider ending the adoption or guardianship.

How were issues addressed by AGES?

Adoptive parents and guardians reported that, just as the issues they were facing were complex and diverse, the ways in which they benefited from participation was also diverse. The various ways in which AGES helped families address the issues they were facing are summarized below.

One of the primary outcomes of AGES was to increase the level of social support available to families. Adoptive parents and guardians reported that the AGES workers served as a source of support to them and to their families during their involvement in services. The AGES worker often became a person that they could talk to about their child and seek advice on how to handle particular situations.

“I have friends who have adopted children, but not through the foster care system ... I was looking more for...extra support to figure out that this is just a normal four-year-old or three-year-old issue or is this something I need to address.”

“I told her [the AGES worker] the plan, the medications, so I could bounce everything off of her and she kind of made sure I was checking all the boxes...it was awesome to have her.”

“I had her kinda like my personal caregiver or overseer of everything, because me deciding, ‘Oh, should I do that, should I not? ... Which should I do first?’ I can just email her and she'd tell me...[that has been] awesome.”

Support was also provided in terms of modeling parenting interactions, as described by this parent:

“She [the AGES worker] was listening to him [the child] but would put him in his place too. She'd be like, ‘Steve, really?’ He'd be making up these excuses about why he did stuff, and she'd be like, ‘Steve, stop!’...He respects her and he likes her because he's held accountable with her.”

Parents and guardians also reported that AGES helped them understand different strategies to use with children who have experienced trauma and loss associated with adoption or guardianship. They also illuminated how parenting strategies that worked with their other children (including birth children) were not working with the child they were currently struggling to parent, as suggested by one parent who was looking for new parenting strategies:

“We felt like we were super parents because we have adult children that are really well-adjusted and by society's standards, very successful...Derrick has challenged us to the core of our being. He has figured out how to play one parent against the other. Even though we know that's happening, we let it happen, so I don't think we are as good of parents as we thought we were.”

AGES participants also reported that the program helped them improve communication and relationships within their family. Specifically, they said that AGES helped build bridges between family members by focusing on the family unit (including all children), not just the child who was experiencing issues. This included working on issues between parents who were struggling in their marital relationship. They also worked with children to help them see the parental perspective, when appropriate. Some examples:

“[The AGES worker] cares about our whole family and not just Hugh. Because Hugh gets all the attention and other kids don't... She found a counselor for [my non-adopted child].”

“I think it was good for me because my husband, who stepped into this family, a ready-made family...from being single and never been married before to, ‘Bam, now I've got three kids’... I was always taking care of everything, and I always have taken care of everything...So just letting me say, ‘Hey, I need help. Can you run and get them from wherever they are tonight?’ and not feeling bad that I had to ask. That's been much better...she [the AGES worker] was a godsend.”

“She [the AGES worker] gave [our children] other ways to look at us as their parents. You know, different stressors that your parents have and just try and understand a little more, what's going on with them before you react...They listened and gave feedback as well. It was really great.”

Parents and guardians also reported that the AGES workers helped by confirming and validating their feelings, something that they reported others in the community (service providers) did not always do. This was particularly important for families who had been struggling for a long time and not able to find services and supports that adequately met their needs.

“[The AGES worker] was the first person that ever sat down with me and said, ‘Yeah, he really does have some issues here’ and believed me. Even doctors, they see him, what, for ten minutes. She saw firsthand a couple times, you know, like him doing something stupid, right in front of her...Just an understanding that I know what I'm talking about, I know there's something up with my kid.”

AGES workers helped parents and guardians prepare for important meetings with the school or service providers. Participants reported that this helped them feel better prepared and ‘heard’ when they articulated the needs of their children to service providers. In these situations, the AGES worker served as an advocate for the family or serve to legitimize the families’ concerns as schools and service providers often discounted or dismissed any information that came from the parents. Some examples:

“If I need help finding something or putting my thoughts together like when we are going to meetings with the county or the school, she helps me get the stuff I need or get the thoughts together and the goals and then she'll often speak-up some if she feels necessary to add something.”

“[The AGES worker] literally saved our family...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 the 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.”

“[The AGES worker] came for the IEP and sat down and said, ‘Look, you're gonna start taking this family seriously and you're gonna help them.’ Once we had any kinda backup, then everyone's like, ‘Oh yeah, we'll definitely – we're on board. We'll help. Sure.’ When it wasn't that at all before.”

The advocacy and support was child- and family-specific, and the knowledge the AGES worker had of the family situation was critical. For example, a guardian reported the following support provided

by the AGES worker regarding a teacher who had acted inappropriately towards her, and a parent reported how the AGES worker backed her up at a school meeting:

“I was horrified because she [the teacher] had printed that point sheet out with the teacher's nasty note [about the parent] at the bottom. She had that sitting right on top of her books. I'm like, ‘Oh my God.’ But you know what? The special education teacher actually looked at her [AGES worker] said, ‘Oh, yeah, about that.’ So ever since then, she knows not to be writing negatives things to me...knowing that [the AGES worker] is going to see everything I send her from school, that makes the special education teacher on high alert...that was awesome.”

“When we would go to meetings at school, they're like, ‘Why don't you have him do his homework at the kitchen table?’ and right away she pops up, ‘Oh, no, no, no, that is not a good idea.’ That helps because otherwise it's me saying to these people that have never been in my house, ‘Oh, no, the kitchen table won't work’. I mean, like somebody says, ‘Well, why don't you just do this with him?’ she can pipe up and say, ‘Oh, yeah, we've tried that.’ It helped. It made me look like I knew what I was talking about especially if he entered a new school and I didn't have a relationship with those teachers yet, that was really helpful. I just loved her being there.”

AGES involvement also impacted the services families received in practical terms, such as shortening the wait time for services or helping the family figure out the right diagnosis, therapy, and services for their child:

“So, once we got the new diagnosis, and with the help of [the AGES worker], she was able to get us in the door of places. Everyone's like, ‘Oh, it's gonna be a four-month wait,’ and, ‘Oh, well, maybe I'll send you over here instead.’ She was like, ‘Nope.’ She called and she's like, ‘You're seeing these people and you're going to help them.’ And then people let us in and helped us. Whereas before it's like we would try so hard to get people to help us and they would just tell us, ‘No, we can't. You called the wrong number. Call this number. Try that.’”

“It's been amazingly smooth sailing since then because we have the right diagnosis and we're doing the right treatment for our kid...Now she works with her autism therapist. They come out to the house. They do in-home therapy with her. And she's a totally different kid.”

In sum, AGES participants reported increased capacity to care for their children in a variety of ways, including:

- Helping families make difficult decisions.
- Being a sounding board for families.
- Equipping families with knowledge of available resources.
- Assisting families with the set-up of those services.
- Navigating the various systems.
- Figuring out the right diagnosis and establishing the appropriate services to help with that diagnosis.

Adoptive parents and guardians indicated that the AGES workers increased their skills and ability to manage their children's behavior and educational challenges in a variety of ways, including

providing information and knowledge about available services increased family's capacity to care for their children.

"As parents we were unaware of what there is available for us and her knowledge of all of the resources was pretty eye-opening. [The AGES worker's] list was extensive, and we looked into each one and we're going to use that as a resource when we need it. Right now, we don't really need too much because things are [on the] mountain top, but we're not blind to the fact that things can change at any time, but we have this list of resources now."

"It's a great support, finding out knowledge about different services that are out there that nobody ever even told me were out there. You know and how to get connected with those services and what kind of insurance and different things you have to have."

Participants reported a reduction in family stress as a result of participating in the AGES program. They attributed this to knowing that they had someone they could go to for support reduced their stress levels:

"I just need to vent to somebody and then somebody telling me, 'Okay, you're a good mom, you know, a lot of his issues are trauma...' That's reducing a lot of my stress... It's a lot of reduced stress...I am not feeling so overwhelmed because I feel like I have help. She would do whatever needed to be done to help reduce the stress in our family."

"It's just having that extra support and also having that resource, I think it's valuable...I think it would be helpful to expand it to allow some foster parents in as well."

One parent reported that, through the AGES program, and correct diagnosis, they discovered the child that they always knew was there:

"As soon as she feels like she's gonna be happy, she self-sabotages and makes it awful. So, we've never had that happy moment. And since [the help she got through AGES], it's been like she's okay with feeling happy. It makes a big difference...That child has never been happy during Christmas. The AGES program gave us our first happy Christmas ever."

One of the AGES workers reflected on why she believed AGES successfully helped so many families. She attributed this to the families who refused to give up on the idea that something could work:

"It's not working because I have the magic. It's working because they were willing to try one more time. They had someone who could help them navigate the system...I have had to play the role of looking at parents and saying, 'If you've had your child in therapy for four years and we're not making progress, maybe this isn't the best therapist.' I mean, they literally were afraid to [make a change] on their own because they were overwhelmed and burdened by this whole idea that nothing is gonna get better, I think they started to get to the point where it was like, 'I don't know that I can be open-minded. I don't know that I can try these things.'"

When families discussed the end of the AGES program, many families were dismayed, dumbfounded, and disheartened by the possible ending of the program. The following quotes are examples of the impressions of AGES from those served by the program:

"It was really hard - I mean, we heard that they're gonna be discontinuing the program...And it really surprises me because it saved our family. If we wouldn't've had

her [AGES worker] come out, we wouldn't be the family we are now. It literally saved us.”

“[The AGES worker is] absolutely necessary because the system is very difficult. Both my husband and I are in the medical field and we still had trouble...Without [the AGES worker's] help, I don't know how people do it.”

“I would just clone my worker. She's just so nice. And she is one of a kind. I think with all her experience...she was just amazing. Better than anyone we've ever had.”

“You feel like you're alone ... you know that other people do have family struggles, but sometimes you just feel alone...Having her just to talk to has been nice...Knowing somebody is out there that knows about what's going on and is, you know, trying to help is helpful.”

Suggestions from Parents and Guardians for Next Steps

There were a number of recommendations that families suggested, more generally, for help in families formed through adoption or guardianship, summarized below.

Provide services earlier, to all adoptive and guardianship families

Adoptive parents and guardians who were interviewed indicated that they wished that services were available when families 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. One parent believed that had services been available earlier, she might not have gotten divorced. Other families feel that their children may not have been hospitalized or ended up back in the county system.

Some parents and guardians could not understand why services and support ended once their children were adopted or in guardianship. One family recalled being “given numbers and a file folder of stuff” for her child adopted internationally, but “nothing” for her other child adopted through the public child welfare system. The parent expressed a desire to have had access to services for both children earlier. One parent indicated that she could not get help because her son was not bad enough. She wished that she had access to services when she first started seeing troubles.

“I couldn't get help because he's 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.”

“We didn't know he was going to have so many problems, because he was just a little over one. So, we wrote off a lot in the beginning. That was our fault. Until he went into pre-school and started hurting kids on a daily basis, and it escalated which opened our eyes... I think [training] would have been more helpful if we chose to do it the right way [through the child welfare system] instead of the way that we did it.”

Provide services in the home

When families were asked about the various components of the AGES program, families reported that home visits were essential. They stated that home visits respect the families' privacy all while giving the workers a truer picture of how the family interacts, and helped them feel more relaxed:

"We were under so much stress that it helped tremendously that she came to the home and that we didn't have to drag him out because we were having difficulty getting him to places without having severe meltdowns...I also thought it helped for her to see how he's as cute as can be until he's raging. She got to see that happen because she was in the home."

"I think home visits are good because...it's more private...when you're talking about pretty personal stuff you don't necessarily want other people to hear."

"She came to the house and I think it was two hours that she was here...I enjoyed it...She made me feel relaxed. I was able to talk to her and I don't know I just liked talking to her...Having someone to bounce ideas off."

Increase available supports, services and trained practitioners

The majority of the adoptive parents and guardians interviewed reported being proactive in seeking services for their family. A number of the participants said they were "educated" and had "researched" the available services in their area. One participant noted, "I had already gone through all the years of finding things on my own." Another said she had worked for the county and was well aware of the local resources. However, the majority of the participants also felt:

1. the areas where they lived lacked relevant resources or services;
2. resources or services that were available were often inconvenient and/or unaffordable, and;
3. resources or services were needed earlier in the adoption and guardianship process to prevent problems that might occur later on.

Participants noted that the lack of resources and services in their county forced them to search for support outside their counties. However, participants said they were often reluctant to travel long distances to obtain needed services particularly during the winter months when driving conditions in Wisconsin could be hazardous. Services were also frequently held during daytime hours which was a barrier for working parents and guardians. In addition, the cost of services was prohibitive for some families. One participant expressed her frustration with medical providers who would not accept Medicaid.

Families reported that support was vital to their success as they needed someone to help them process and normalize situations. Examples include:

"It would be nice if there were similarly situated moms that maybe if there was a way...to set up some type of group that you could talk to them about issues and what's going on."

"We expected some tensions. I guess we were slightly prepared for that. I guess we weren't prepared for the extreme acting out. We felt as long as we were firm and we

said, 'This is the way things operate in this house,' that she would be doing the work to acclimate to our home and we found that we were doing a lot of work to acclimate to her history. So, to be better prepared, maybe had there been a support group for adopting teens...like a mentor to call on... that would be really helpful."

Limitations

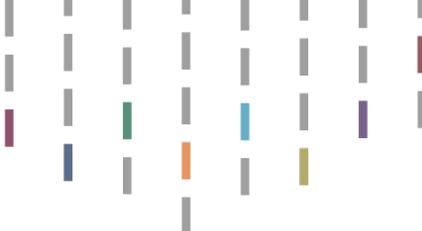
As with any research study, there were several limitations for the QIC-AG evaluation in Wisconsin. Unlike other QIC-AG sites that used existing, manualized interventions, the Wisconsin QIC-AG team developed and tested AGES during the project period. A strength of this phase of intervention development is that the team was able to take specific requests from stakeholders into consideration when developing the program. For instance, stakeholders expressed the need to focus on supporting adoptive and guardianship families, and support became an important part of the AGES design. However, a limitation of this phase is the time it takes to carefully design and test an intervention. For the AGES program, a small number of families completed the program prior to the study period ending. As such, the proximal and distal outcomes were not observed. Pilot studies are a fundamental phase of the research process, focusing on the feasibility of an approach, with the idea that it can be tested on a larger scale study in the future. AGES participants reported receiving and benefiting from the key ideas that were the foundation of the AGES program. Additional research is needed to assess the overall impact of AGES.

SUMMARY OF FINDINGS

In sum, the issues that the families identified aligned with those detailed in the AGES manual and those that the case record review found were delivered. In the development of AGES, one of the key considerations, from staff and stakeholders alike, was that families formed through adoption or guardianship needed *support*. This was born out in this evaluation. Much of what was provided to families, and what families reported as helpful, were the supports that AGES workers provided. Furthermore, many of the issues outlined in the AGES manual related to the needs of adoptive and guardianship families were the same issues that families identified as critical to their success, and the stability and continuity of their family life.

Families also reported that it was very helpful for them to have services in the home, where they could receive support in a relaxed and familiar setting that allowed workers to witness, first-hand, some of the issues and struggles they were facing.

Adoptive and guardianship families struggle like other families. But there is a uniqueness to their struggle that may require a different approach to reach families. Adoptive parents and guardians reported having struggled to access the supports and services that they needed. They reported that the advocacy provided by AGES workers was critically important to their families. Simply providing services may not be enough. The augmentation of AGES, specifically, the support, advocacy, and resources provided by the AGES workers, was what made the difference for these families in getting services that were targeted to the specific needs of their children and family.



Cost Evaluation

The Wisconsin QIC-AG project implemented and tested the effectiveness of AGES, a post permanency intervention designed to support families formed through adoption or guardianship. The Wisconsin team designed and tested the AGES intervention. The project served 32 families formed by adoption and guardianship.

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). The Wisconsin site was a descriptive study with no comparison group and no pre and posttest of participants. Thus, an effectiveness evaluation was not possible. In this portion of the evaluation, we were only able to calculate a cost per participant.

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. For this reason, it is important to record assumptions, constraints, and conditions relevant to Wisconsin 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 was long enough to achieve change in the outcome measures. We are assuming that the impact of AGES was achieved or not achieved within the timeframe of the project. However, it is likely that the AGES' true impact will not be seen until after the project period.

We also assumed multiple positive outcomes were likely impacted by the QIC-AG site programs. For AGES, the desired impact of the programs is to improve child wellbeing. However, other positive outcomes may not necessarily be captured within the intervention. A final assumption was that the resource allocation captured in costs paid to sites was accurate. It was 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 have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For Wisconsin, constraints included the development of an intervention, a time-consuming process. In addition, time allocated for training AGES staff, and staff turnover were constraints.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. For Wisconsin, conditions included a state system with a long history of conducting research studies, and interest on the part of the DCF leadership to engage in intervention research and evaluation.

Cost Estimation

The next step in this cost analysis was to estimate the costs Wisconsin incurred to implement the intervention. This cost estimation includes actual costs paid to Wisconsin 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 Cost 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 Wisconsin.

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. Prior to implementation, Wisconsin's intervention site, The Wisconsin Department of Children and Families, had substantial infrastructure as a state agency. Infrastructure costs specific to these non-profits were not estimated for this cost evaluation. 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 were 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 were determined from the perspective of the Wisconsin QIC-AG site. In other words, if funds were spent by the program, they were considered costs. Participant costs such as travel or childcare were 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 Wisconsin implemented this intervention for a two-year period, costs did not change dramatically. The major cost that would have been impacted in this short time frame was staff salary and this change was accounted for in the direct expenses that Wisconsin incurred each year.

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

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 Wisconsin were taken from monthly budget forms and summarized into Table 7.8.

Table 7.8. Costs for Wisconsin

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL COSTS				
SITE IMPLEMENTATION MGR. SALARY	\$9,106	\$23,702	\$30,585	\$63,392
SITE IMPLEMENTATION MGR. FRINGE	\$1,749	\$10,784	\$14,596	\$27,129
IN-KIND SALARIES	\$56,617	\$216,295	\$139,332	\$412,244
NON-PERSONNEL DIRECT COSTS				
COMPUTER/ IT	\$1,946	\$5,847	\$11,544	\$19,336
CONTRACTED SERVICES: 2 AGES WORKERS:LUTHERAN SOCIAL SERVICES	\$26,305	\$84,466	\$76,539	\$187,310
DISSEMINATION COSTS		\$345		\$345
GIFT CARD INCENTIVES	\$108			\$108
POSTAGE	\$6			\$6
PRINTING/DUPLICATION	\$13	\$649	\$91	\$753
PROGRAM SUPPLIES	\$250	\$2,226	\$86	\$2,562
PROGRAM SUPPLIES-QIC-AG FILMING DAY		\$104		\$104
TELEPHONE	\$327	\$1,029	\$1,492	\$2,849
TRAVEL	\$18	\$12,444	\$5,347	\$17,809
OTHER: MAGNETS			\$3,915	\$3,915
OTHER: MILEAGE REIMBURSEMENT FOR AGES		\$1,119	\$227	\$1,347
NON-PERSONNEL: INDIRECT COSTS				
OTHER: POSTAGE			\$5	\$5
OTHER: MATERIALS & SUPPLIES-RESOURCE BOOKS		\$4,237		\$4,237
GENERAL INDIRECT COSTS	\$2,392	\$6,818	\$11,001	
TOTAL	\$98,836	\$370,065	\$294,760	\$763,662

*FY2019 ended 3/31/19

**FY 2017 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 7.8.

Collect Data on Resource Allocation

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

Estimation of Direct Costs

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

Personnel

Personnel costs for the Site Implementation Manager totaled \$63,392 for staff time allocated to the project during the implementation phase. Personnel costs include \$412,244 for in-kind staff costs from the state child welfare department. This staff time represents over 11,000 hours of work.

Fringe

Overall fringe for the Site Implementation Manager totaled \$27,129. For in-kind salaries, fringe costs could not be distinguished from the overall total.

Contractual expenses

Wisconsin contracted for services from Lutheran Social Services for \$187,310. Lutheran Social Services provided two for AGES workers.

Gift cards

Gift cards were provided to stakeholders who participated in meetings. A total of \$107 was spent on gift cards.

Materials and supplies

Over the implementation period, \$2,666 was spent on program supplies that were specific to the operation of the intervention.

Travel

Over implementation and installation, \$17,809 was paid for travel. An additional \$1,348 was spent on mileage reimbursement for the AGES workers.

Facilities/Office space

No charges were made for the office and/or facility space.

Other direct charges

Other direct charges include all non-personnel direct costs that do not fit into the categories listed above such as postage (\$6), phones (\$2,849), printing and duplication (\$753), dissemination (\$345) and magnets (\$3,915).

Estimation of Indirect Costs

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

IT support

IT support includes all expenses related to IT including computers, contract with a person for IT work, data base design, and software. \$19,336 was spent on IT support.

Postage

\$5 was spent on postage not related to the intervention.

Materials and supplies

\$4,236 was spent on resource books that were not related to the intervention.

Other

\$20,211 were billed to the project as general overhead costs.

Indirect costs often include facility costs and infrastructure not captured in the above categories. Since this cost evaluation is designed to help other state child welfare policymakers understand the total costs associated with each site program, indirect costs are important to document. The Wisconsin state agency 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; and some administrative support for contracting and financial management.

Summary of Costs

Total implementation costs for Wisconsin were \$763,661.

Cost calculation

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 \$763,661 and 32 participants, the cost per participant for this intervention was \$23,864.

COST-EFFECTIVENESS ESTIMATION

Because there were no statistically significant findings, 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 were 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.
2. Gift cards were removed from the cost calculation. Gift cards were provided to thank people for their time in completing evaluation materials.
3. Program supplies for QIC-AG filming and resource books were removed. Program supplies were also removed because it was unclear if these were specific to the intervention.

4. All travel costs were excluded, including mileage. Travel was primarily to off-site locations for annual and quarterly meetings. Agencies wishing to implement the intervention would need to consider mileage as a cost for facilitators, but this cost will vary greatly by area.
5. Fees related to postage, printing, phones, dissemination and computer costs were removed.
6. The costs for magnets were removed.
7. General 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 7.9 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was \$618,890 which amounted to \$19,340 per participant. The only costs remaining in the analysis were related to staffing for the intervention.

Table 7.9. Sensitivity analysis: Adjusted costs for Wisconsin

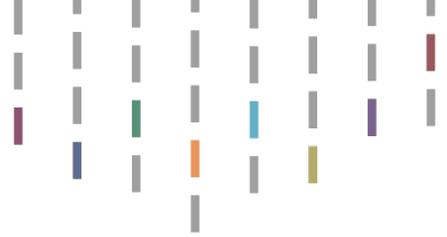
	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL COSTS				
IN-KIND SALARIES	\$56,617	\$216,295	\$139,332	\$412,244
NON-PERSONNEL DIRECT COSTS				
CONTRACTED SERVICES: 2 AGES WORKERS:LUTHERAN SOCIAL SERVICES	\$26,305	\$84,466	\$76,539	\$187,310
TOTAL	\$84,868	\$306,608	\$227,414	\$618,890

*FY2019 ended 3/31/19

**FY 2017 began 4/1/17

Cost Evaluation Summary

Based on the total costs of \$763,661 and 32 participants, the cost per participant for this intervention was \$23,864. However, the sensitivity analysis demonstrated that many costs could be reduced if the intervention were replicated. Thus, a more realistic cost of the project was \$618,890 which results in \$19,340 per participant.



Discussion

The QIC-AG project in Wisconsin developed the AGES intervention, following a deliberate and well-established set of steps as outlined by Fraser and colleagues (Fraser, Richman, Galinsky & Day, 2009). This is the first pilot test of the AGES intervention. The AGES program was developed to progress through five stages. Each stage had a list of specific activities associated with the stage. Time frames to accomplish key steps were set and reviewed as part of the process evaluation. In short, while most of the time frames worked, there were a few tasks that took longer than expected. When AGES is replicated, goals associated with the AGES phases may need to be slightly altered. The AGES manual will help guide future replications of the AGES program.

This evaluation found that the primary issues facing families served by the AGES program were related to complicated mental health and medical histories. Parents or guardians sought help to manage difficult behaviors, and problems their children and youth were facing at school.

AGES workers were flexible and often provided comprehensive case management, including individualized support and services to the entire family. Key ingredients for this support was the ability to match specific needs (either child or caregiver needs) to specific services and supports in the community. AGES workers needed to be flexible, meeting the families in their home, accompanying families to appointments in the community where they would serve as an advocate for the family. AGES workers also needed to be direct and candid with children and caregivers alike, sometimes pointing out difficult issues or conflicting messages that were being sent.

Caregivers reported feeling better equipped to address the needs of their children after participating in AGES. Parents and guardians felt that the issues they were facing at the beginning of AGES were addressed through the program. This did not mean that the issues disappeared, rather that they felt better equipped to help their children and youth manage the issues. Parents and guardians also reported, after participating in AGES, they now know where to go for services and supports.

Prior to AGES, many families had searched for appropriate services and supports, often for many years. They reported that, with the support of AGES, they accessed more appropriate and helpful services. Families also reported that the difference between reaching out for assistance alone (prior to AGES) and with AGES support, was that they felt more empowered with AGES. Prior to AGES, parents and guardians were often dismissed by service providers. The AGES worker would stand up for parents and guardians, which made them feel heard and seen.

However, for a few families the intervention came too late, beyond the point where the parent or guardian felt they could continue to parent their children. In these few situations, the AGES worker reported that the parent or guardian came to AGES after having tried everything they could think of, they were defeated, and ready to give up, and maintaining the child in the home was not possible. In these situations, the AGES workers connected families with services and supports, providing an important service to the children, youth and caregivers.

In closing, there were a number of recommendations that families suggested during the interviews that are summarized below.

Recommendations

INTERVENE EARLIER, PROVIDE HELP SOONER

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. One parent believed that had services been available earlier, she might not have gotten divorced. Other families felt that their children may not have been hospitalized or ended up back in the county system. Some parents and guardians could not understand why services and support ended once their children were adopted or in guardianship.

PROVIDE SERVICES IN THE HOME

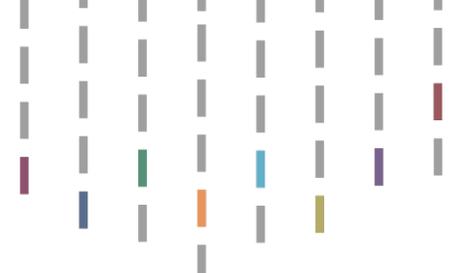
Families reported that home visits were essential to the success of the program. Home visits allowed the worker to get to know the family in a way that is different from if it occurred in an office. They stated that home visits respect the families' privacy and allowed support to be provided in a relaxed and familiar setting.

INCREASE AVAILABLE SUPPORTS, SERVICES AND TRAINED PRACTITIONERS

The majority of the adoptive parents and guardians interviewed reported being proactive in seeking services for their family. One participant noted, "I had already gone through all the years of finding things on my own." Participants noted that the lack of resources and services in their county forced them to search for support outside their counties, often requiring them to travel long distances to obtain services. In addition, the cost of services was prohibitive for some families.

In sum, the issues that the families identified aligned with those detailed in the AGES manual and those that the case record review found were delivered. In the development of AGES, one of the key considerations, from staff and stakeholders alike, was that families formed through adoption or guardianship needed **support**. This was born out in this evaluation. Much of what was provided to families, and what families reported as helpful, were the supports that AGES workers provided. Furthermore, many of the issues outlined in the AGES manual related to the needs of adoptive and guardianship families were the same issues that families identified as critical to their success, and the stability and continuity of their family life.

Adoptive and guardianship families struggle like other families. But there is a uniqueness to their struggle that may require a different approach to reach families. Adoptive parents and guardians reported having struggled to access the supports and services that they need. They reported that the advocacy provided by AGES workers was critically important to their families. Simply providing services may not be enough. The augmentation of AGES, specifically, the support, advocacy, and resources provided by the AGES workers was what made the difference for these families in getting services that were targeted to the specific needs of their children and family.



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Appendix

Definitions of Guardianship in Wisconsin

- **Family Court – Ch. 54 Guardianship:** Transfer of guardianship granted under Ch. 54 of a child who was not found to be in need of protections and services. The transfer of guardianship did not require involvement from child welfare.
- **Public Child Welfare – Ch. 54 Guardianship:** Transfer of guardianship granted under Ch. 54 of a child who was found to be in need of protection and service. In order to dissolve the guardianship, the birth parent is not required to meet conditions of return.
- **Guardianship under s. 48.977:** Transfer of guardianship granted under s. 48.977 of a child who was found to be in need of protection and services. In order to dissolve the guardianship, the birth parent must meet conditions of return. This type includes Subsidized Guardianships.
- **Out-of-State Guardianship:** Any type of transfer of guardianship that occurred outside of Wisconsin.

Table 7.10. Mean Responses to AGES Screening Questions

VARIABLE	SCALE RANGE	N	M	SD	MIN	MAX
ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN						
HOW OFTEN HAVE YOU OR YOUR SIGNIFICANT OTHER STRUGGLED TO APPROPRIATELY RESPOND TO YOUR CHILD IN THE LAST 30 DAYS?	1 to 5	42	4.02	0.87	2	5
HOW OFTEN HAVE YOU OR YOUR SIGNIFICANT OTHER EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS?	1 to 5	42	4.76	0.48	3	5
HOW OFTEN HAVE YOU OR YOUR SIGNIFICANT OTHER STRUGGLED TO EFFECTIVELY MANAGE YOUR CHILD'S BEHAVIOR IN THE LAST 30 DAYS?	1 to 5	42	3.98	0.98	1	5
HOW OFTEN HAVE YOU OR YOUR SIGNIFICANT OTHER FELT STRESS AS A RESULT OF YOUR CHILD'S EDUCATIONAL NEEDS IN THE LAST 30 DAYS?	1 to 5	42	3.21	1.44	1	5
HOW OFTEN HAVE YOU OR YOUR SIGNIFICANT OTHER FELT STRESS AS A RESULT OF YOUR CHILD'S DEVELOPMENTAL NEEDS IN THE LAST 30 DAYS?	1 to 5	42	3.02	1.57	1	5
HOW OFTEN DO YOU THINK ABOUT ENDING YOUR ADOPTION OR GUARDIANSHIP?	1 to 5	42	2.05	1.15	1	4
ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN						
WHICH PHRASE BEST DESCRIBES YOUR RELATIONSHIP WITH YOUR CHILD?	1 to 5	42	3.38	1.15	1	5

Table 7.11. Case Review: Issues AGES Participants Were Confronting

COMPLICATED MENTAL HEALTH OR MEDICAL HISTORIES
<p>One of the most frequently cited problem in the records was complicated mental health/medical histories. Over 20 different Diagnostic and Statistical Manual of Mental Disorders (DSM-5) mental health diagnoses were noted. Recurrent diagnoses included Attention-Deficit/Hyperactivity Disorder (ADHD), Anxiety, Autism, Depression, Post Traumatic Stress Disorder (PTSD), Reactive Attachment Disorder (RAD), Alcohol and Other Drug Abuse (AODA), Attachment Disorder, and Fetal Alcohol Spectrum Disorder. Psychotropic medications and past hospitalizations were also documented. Medical problems included conditions such as eczema, asthma, allergies, cardiac problems, kidney disease, immunosuppression, dental problems, arthritis, diabetes, and a genetic disorder.</p>
DIFFICULTY IN MANAGING BEHAVIORS
<p>Tied with complicated mental health and medical histories were behaviors that were difficult for caregivers to manage. These behaviors were frequently related to the previous category, but not necessarily. Challenging behaviors ranged from children and youth being disrespectful and questioning rules to more problematic behaviors such as poor impulse control, headbanging, hoarding food, and inappropriate sexual behaviors. Problematic behaviors were also documented when children and youth were informed they were adopted or told they had a chronic medical condition.</p>
PROBLEMS AT SCHOOL
<p>The next most frequently cited concern was problems at school. A number of the children and youth had 504 Plans with their school districts. While some Individualized Education Programs (IEPs) were working well for children, others required interventions with teachers and/or the school district to ensure the children were receiving appropriate accommodations. Other children need to be tested for special education and have 504 Plans developed. Concerns from caregivers included their children being behind in school, expelled due to uncontrolled behaviors, transiting to new schools, and bullied from classmates. Not wanting to go to school or struggling with classes academically was also cited in the records.</p>
CAREGIVER FATIGUE OR BURNOUT
<p>Caregiver fatigue or burnout was frequently documented in the case notes. Caregiver stress was usually related to the amount and/or degree of severity of the problems. Behaviors that were the most difficult to manage often required a significant amount of the caregivers' attention. This left less room for the needs of other family members (including the caregivers themselves) and caused rifts in relationships between and among family members. Records indicate caregivers were often overwhelmed with the responsibilities of parenting and struggled to find time for their own self-care. Other factors that contributed to caregiver fatigue or burnout included stress at work, conflicts with relatives, grieving from a recent loss, physical disabilities, financial problems, and marital strain.</p>
DEVELOPMENTAL ISSUES
<p>Developmental issues in case records presented in different ways. For some children, their age did not match with their physical, mental, emotional and/or cognitive development. Other children had sensory-motor processing difficulties causing developmental delay. Developmental issues varied depending on the child or youth's experiences. For example, one child expressed adultified behaviors because she had been primarily responsible for her younger siblings prior to being placed with her adoptive or guardianship family. Developmental issues also occurred when youth questioned their gender and sexual orientation.</p>
OTHER ISSUES
<p>There were a host of other issues that the reviewers placed in this category. Problems or issues included (but were not limited to): children or youth of a different race or ethnicity integrating in communities; financial difficulties in families; caregivers' own mental health and medical issues; bonding difficulties between caregivers and their children; unresolved caregiver feelings about adoption or guardianship, and; the caregiver's parenting style.</p>

Table 7.11. Case Review: Issues AGES Participants Were Confronting
Continued

CONFLICT WITH SIBLINGS
Conflicts between birth and adopted or guardianship siblings were cited in a number of different circumstances. Clashes between siblings occurred when they felt one of the children was receiving more attention from a caregiver, and they (the sibling) did not have a “voice.” The case notes revealed that siblings had their own issues that they were struggling with that increased the charged dynamics in the family including medical and mental health problems (suicide ideation, self-harm behaviors, AODA), problems at school (failing grades, conflict with peers), abuse (physical or sexual) from a sibling, etc. Conflicts with siblings appeared to be a significant source of tension in the family.
OTHER FAMILY INVOLVEMENT (BIRTH FAMILY)
Another concern cited in the case notes was with other family involvement (specifically, birth family involvement). This included problems with setting boundaries with the birth family and other relatives, children not wanting to visit their birth family, or having behaviors that were difficult to manage after birth parent visitations. This included the child having meltdowns or being despondent or the children expressing they preferred living with their birth parents rather than the adopted parent or guardian.
SOCIAL ISOLATION
Social isolation was defined as “caregiver’s, child, or youth’s need for socialization.” This issue was not often documented in the records and may have been defined too broadly in this review. One child stayed in her room because she struggled socially. Some children with Autism or Asperger Syndrome had difficulty with social cues and trouble making friends and therefore felt safer at home with adults. Caregivers who lost contact with friends when they became guardians to younger children also described feeling isolated.
LACK OF CAREGIVER SUPPORT
Lack of Caregiver Support was cited twice when “lack of support” was specifically written in the record. This category may have also been defined too broadly or possibly implicitly referred to in other categories such as Caregiver Fatigue or Burnout.

Chapter 10

CROSS-SITE EVALUATION

Table of Contents

OVERVIEW	5
CROSS-SITE RESULTS	6
Engagement with Adoptive and Guardianships Families.....	6
Survey Response Rates.....	8
Service Needs and Use.....	10
Outcomes.....	14
Limitations.....	15
EXAMINING POST PERMANENCY DISCONTINUITY	16
Post permanency Discontinuity	17
Analysis Along the Prevention Continuum.....	18
Impact of Caregiver Commitment on Key Measures	23
DISCUSSION	31
REFERENCES	37
APPENDICES	39
Appendix A. Engagement with Adoptive Families Finalized through Private Domestic and Intercountry Adoptive Processes	39
Appendix B. Data Tables.....	41

Tables and Figures

Table 10.1. QIC-AG Target Group 2 Sites and Interventions	5
Table 10.2. Vermont Service Use in Past 6 Months	11
Table 10.3. Catawba County (NC) Service Needs and Use after Adoption Finalization.....	11
Figure 10.1. Characteristics of Children Most Likely to Reenter Foster Care.....	17
Table 10.4. Number of Survey Respondents by Site, by Measure.....	18
Figure 10.2. Overall Behavioral Problem Index (BPI) Scores by Site.....	20
Figure 10.3. Mean Caregiver Strain Scores by Site	21
Figure 10.4. Overall Belonging and Emotional Security Tool (BEST-AG) Scores by Site.....	22
Figure 10.5. Percent of Caregivers who Expressed Hesitancy	25
Figure 10.6. Behavior Problem Index (BPI) by Inclination to Adopt/Assume Guardianship Again	27
Figure 10.7. Caregiver Strain by Inclination to Adopt or Assume Guardianship Again.....	28
Figure 10.8. BEST-AG by Inclination to Adopt or Assume Guardianship Again	29
Table 10.5. Key Measures by Inclination to Adopt or Assume Guardianship Again	41
Table 10.6. Survival Analysis Predicting Foster Care Reentry after Adoption or Guardianship....	42

Overview

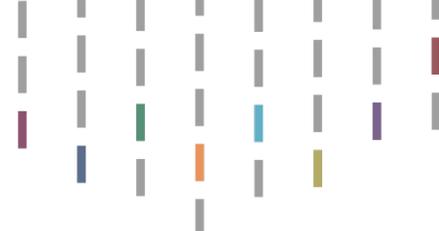
The cross-site evaluation summarizes the overarching themes and analyses found across six QIC-AG sites: Vermont, Illinois, New Jersey, Catawba County (North Carolina), Wisconsin, and Tennessee. These sites tested six different interventions (see Table 10.1) that served families after adoption or guardianship 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.

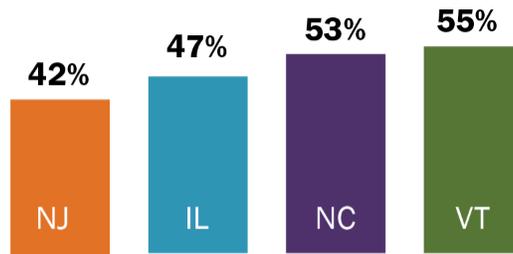
¹ The survey responses from Illinois and New Jersey discussed in this section are from the primary outcome surveys only.

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.

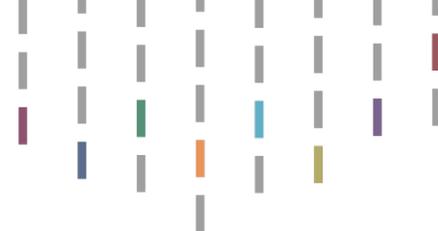
- In Catawba County (NC), families who needed post adoption services and supports were largely already engaged in services through the existing outreach methods and service delivery systems. Few additional families requested Success Coach services as a result of Reach for Success. However, through the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

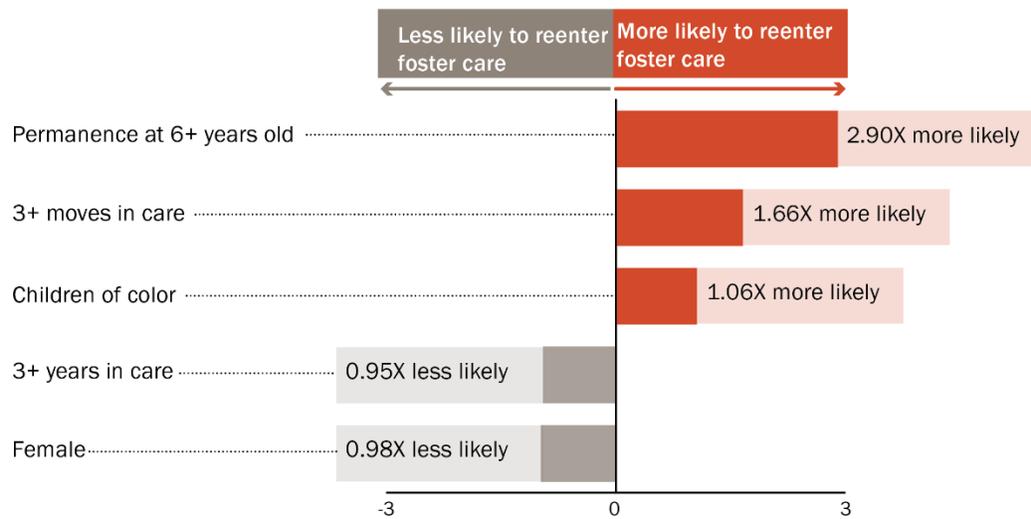
In sites that used BPI and caregiver commitment measures, families were compared across the continuum to see if there were differences in the families targeted for outreach. Specifically, it was hypothesized that families targeted for outreach at the Universal level would, on average, have low-risk scores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

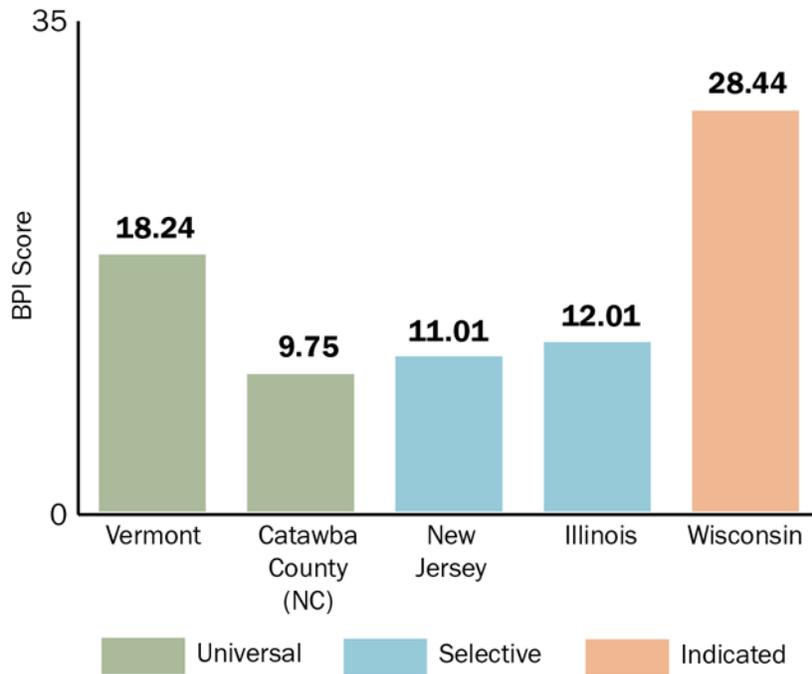


Figure 10.2 note: It should be noted that we expect to see higher levels of behavior problems in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are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

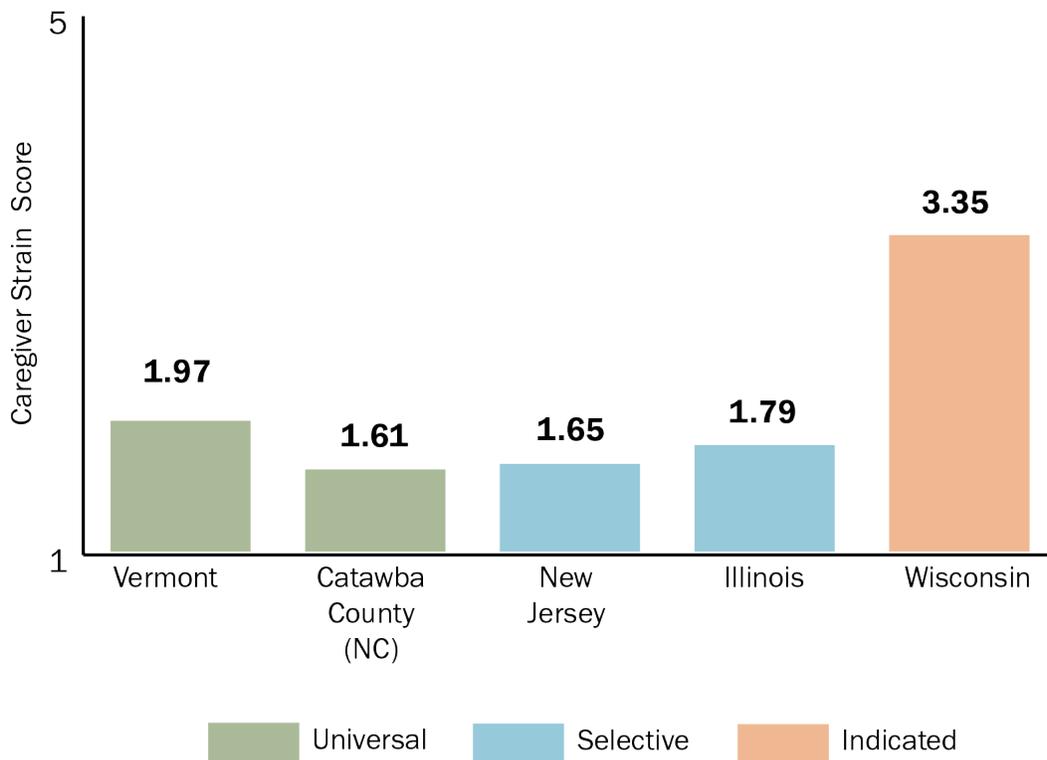


Figure 10.3 note: It should be noted that we expect to see higher levels of caregiver strain in the site that is serving families who reach out to request assistance (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin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

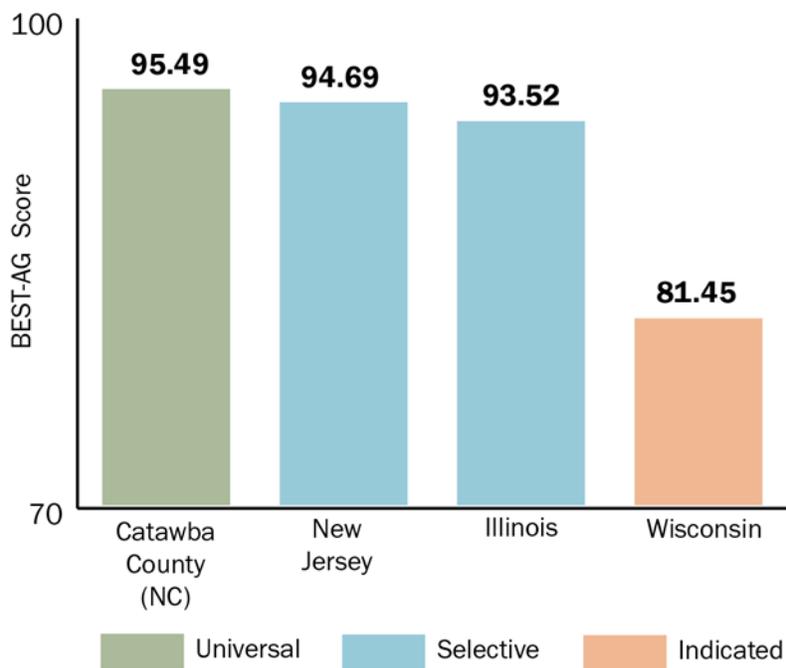


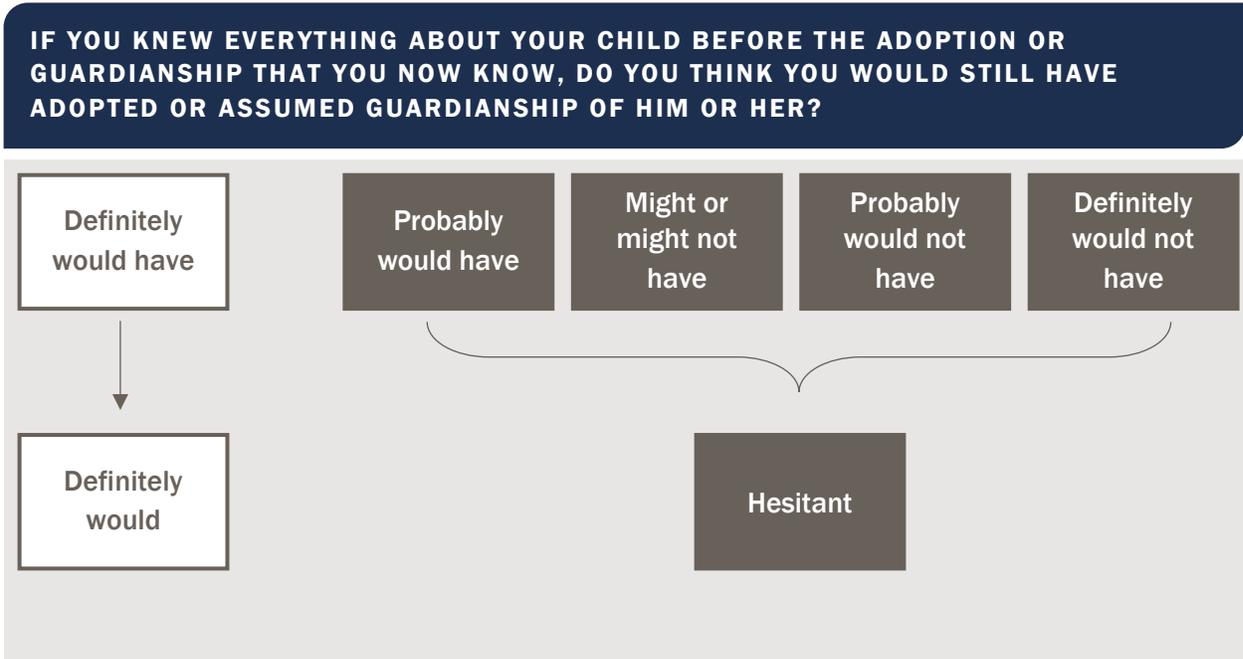
Figure 10.4 note: It should be noted that we expect to see lower levels of belonging and emotional security in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families 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.

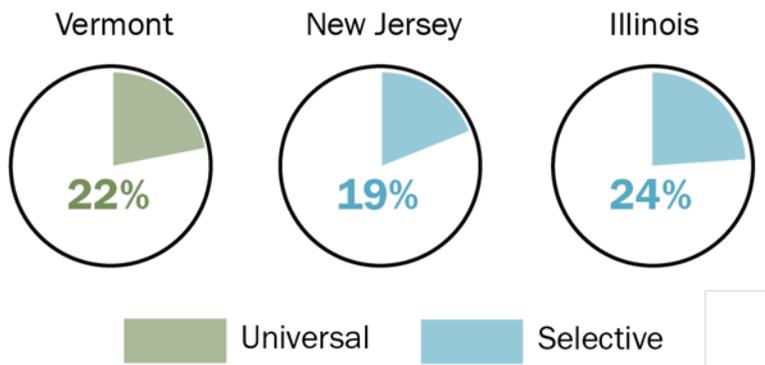
Keeping in mind the significant role caregiver commitment has played in understanding post permanency discontinuity and other challenges in prior studies (Liao & Testa, 2016; Testa et al., 2015; White et al., 2018), a series of commitment questions were asked of parents and guardians involved with this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

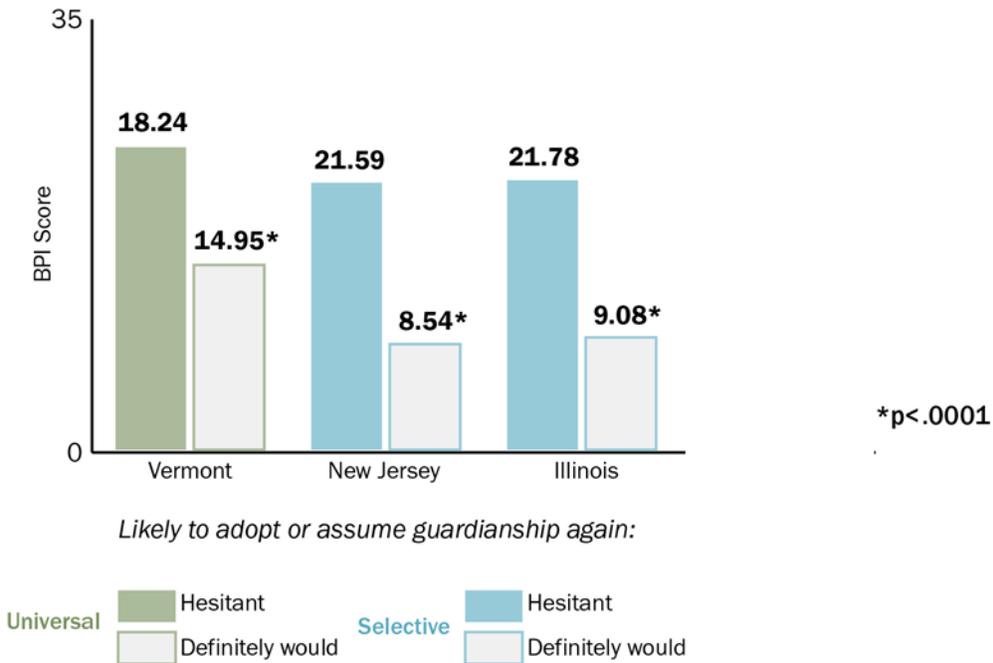
2. In Figure 10.6, the bars and the numbers above the bars are the mean BPI scores for each group.

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)

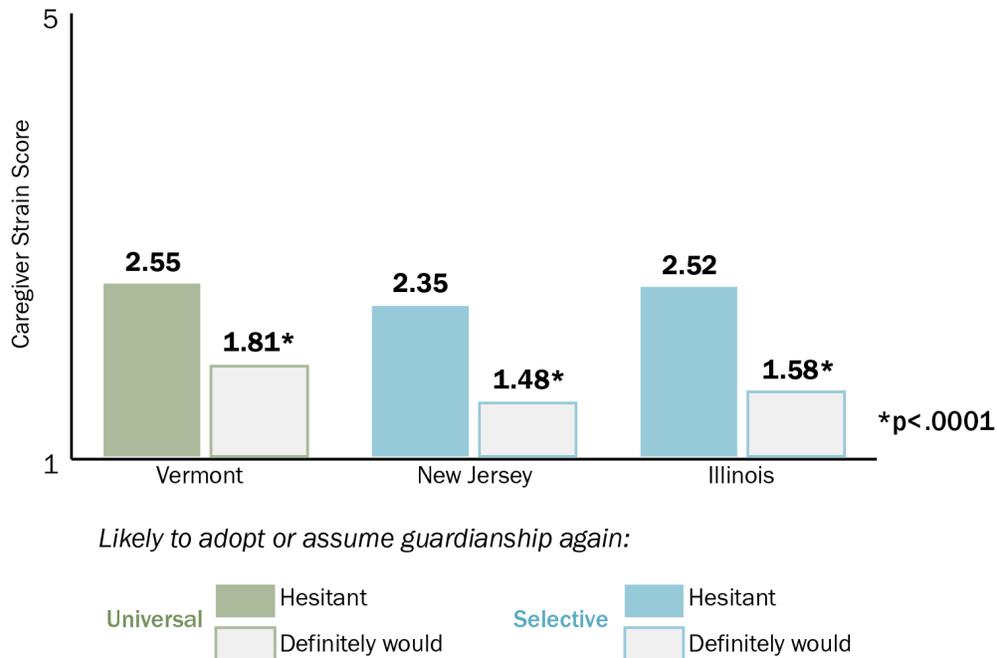
Figure 10.6. Behavior Problem Index (BPI) by Inclination to Adopt or Assume Guardianship Again



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

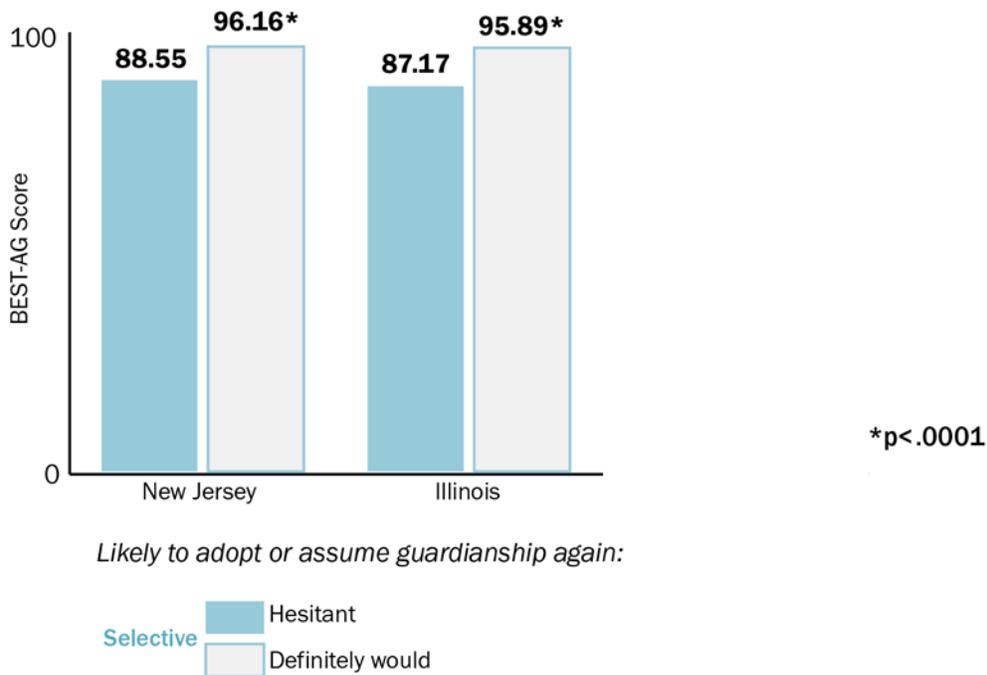


The Caregiver Strain Questionnaire-Adoption/Guardianship (CGSQ-AG) used in this project is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger, & Brickman, 1997), a measure to assess the extent to which caregivers experience additional demands, responsibilities, and difficulties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

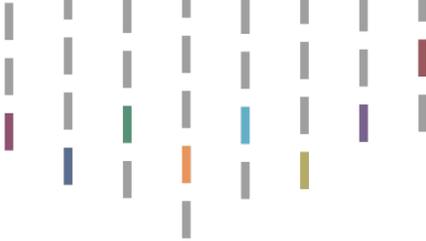


The BEST-AG, developed by Casey Family Services (Frey, Cushing, Freundlich, & Brenner, 2008), was originally designed to help social workers frame conversations about emotional and legal commitment with foster parent and youth who are unable to reunify with their family of origin. For this study, the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

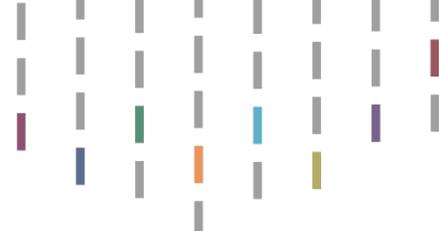
“Attachment disorder has severely impacted my daughter...She has struggled with attachment and reciprocity. I, too, have struggled with attachment to her, given her lack of reciprocity. Having worked with a therapist years ago who purportedly understood attachment disorder, my daughter and I received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

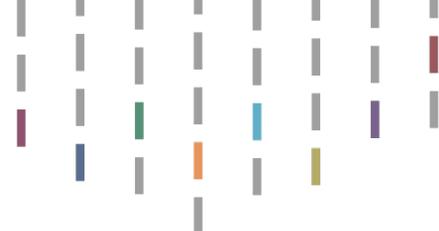
Furthermore, adoptive parents and guardians have found various ways to tell the QIC-AG project that they welcome outreach from the child welfare system after finalization. Some reported this in interviews, others in responses written in surveys, and others when they called a member of the research team 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.

