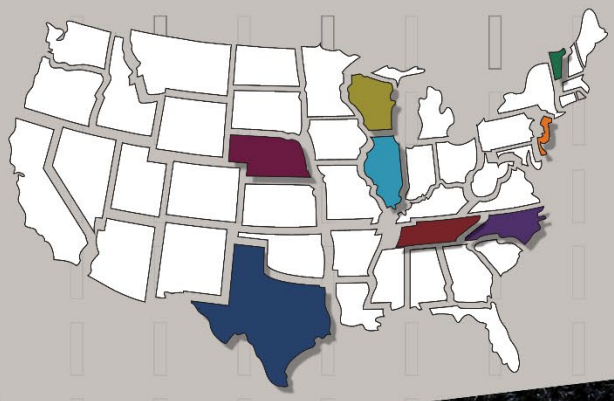
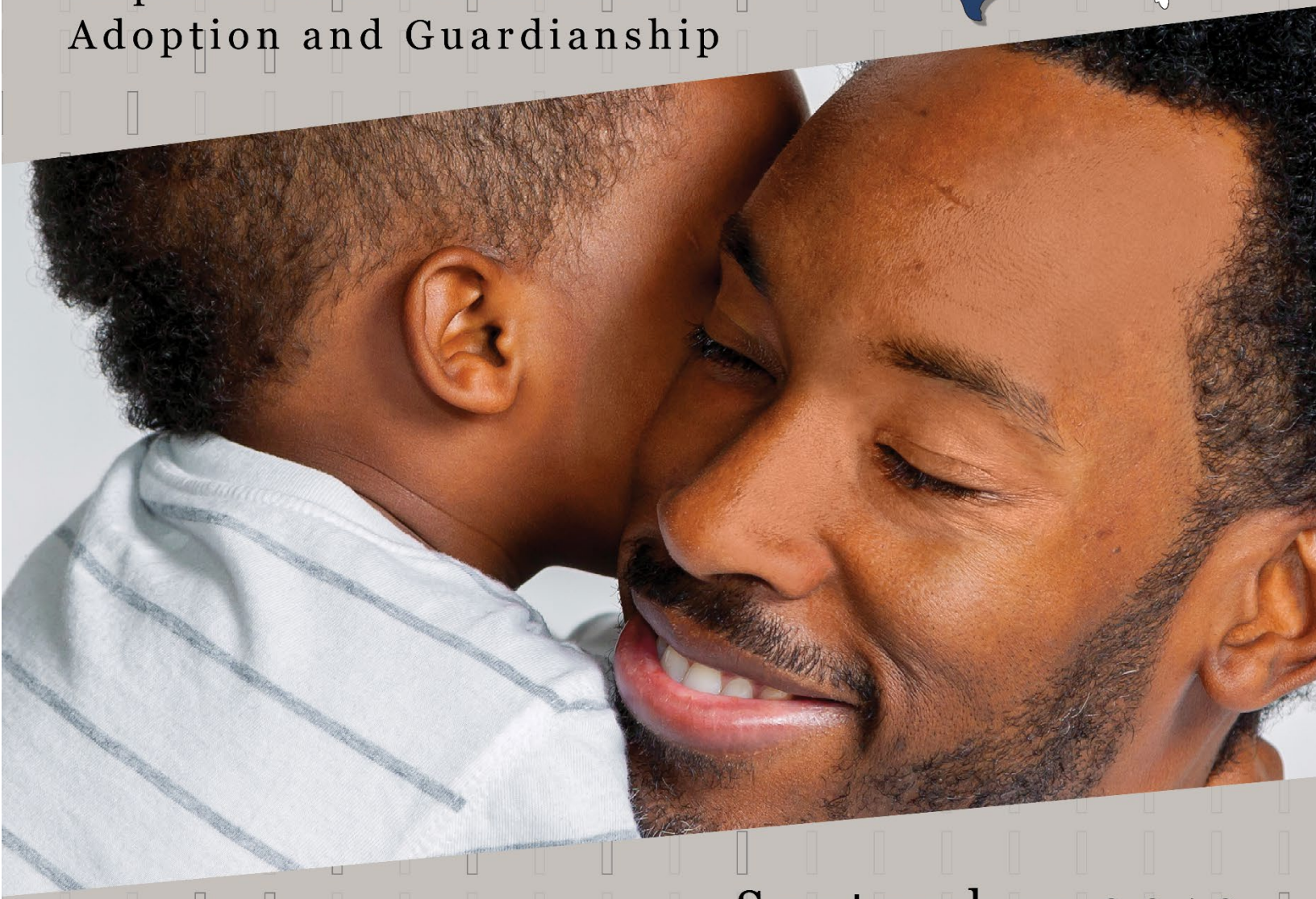
QIC-AG

Final Evaluation Report

Supporting Adoption and Guardianship: Evaluation of the National Quality Improvement Center for Adoption and Guardianship





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QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Authors

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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

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QIC-AG Final Evaluation Report Chapters

Chapter 1

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QIC-AG Overview

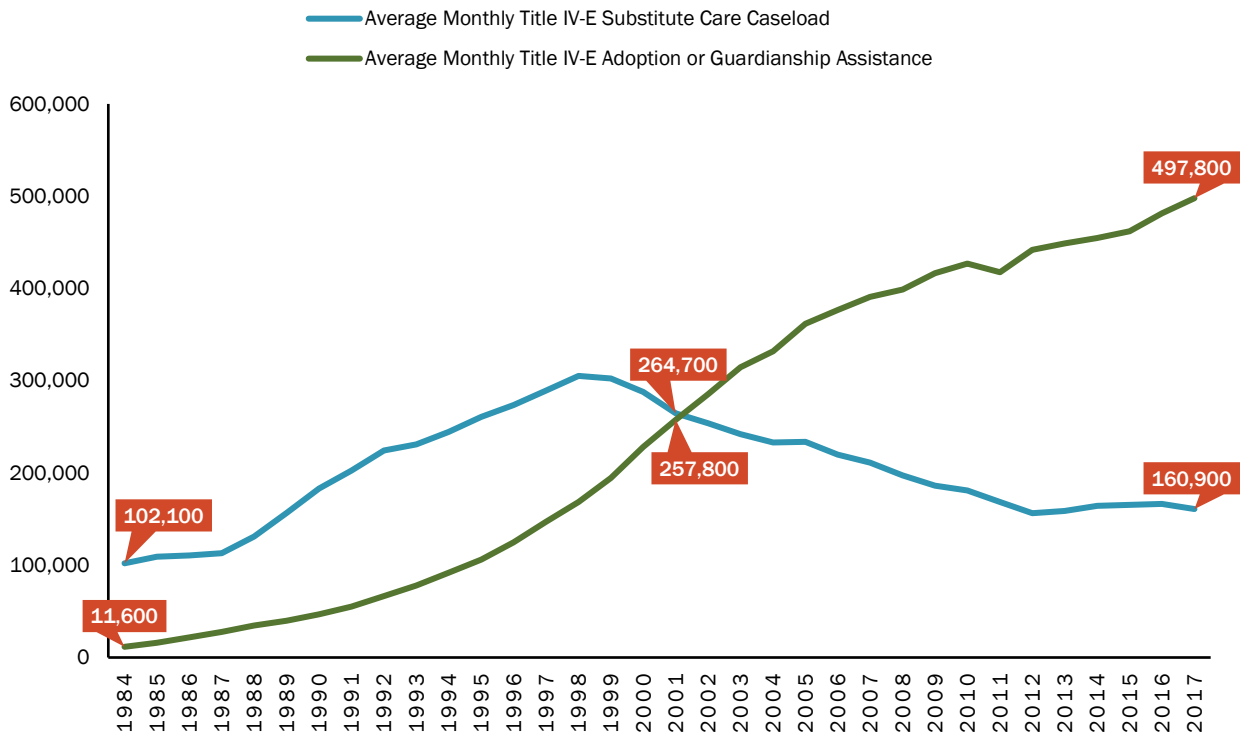
The Children's Bureau, Administration for Children and Families, and Department of Health and Human Service established the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG). In October 2014, the QIC-AG was awarded to Spaulding for Children in partnership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

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

Background

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

Figure 1.1. National Average Monthly IV-E Funded Caseloads



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

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

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

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

QIC-AG Target Populations

Target Group 1

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

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

PICO RESEARCH QUESTION

The PICO question for Target Group 1 was:

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

THEORY OF CHANGE

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

Target Group 2

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

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

RESEARCH QUESTION

The PICO question for Target Group 2 was:

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

THEORY OF CHANGE

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

Private Domestic and Intercountry Adoptive Families

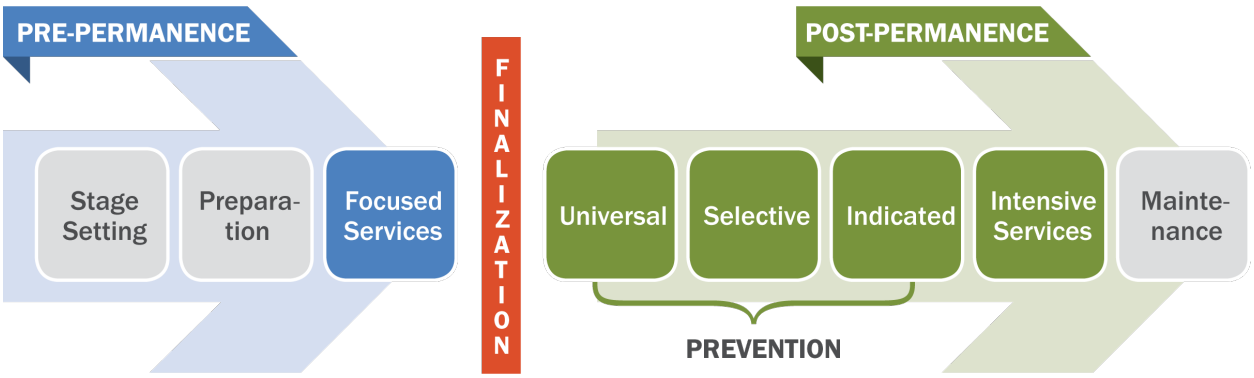
The challenges associated with providing a stable, long-term and permanent home are not consigned to adoptions and guardianships that occur through the child welfare system. Private domestic and intercountry adoptive families can also encounter post permanency disruptions and discontinuity. Children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

QIC-AG Continuum of Services

Pre Permanence

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

Figure 1.2. QIC-AG Permanency Continuum



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

Stage Setting

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

Preparation

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

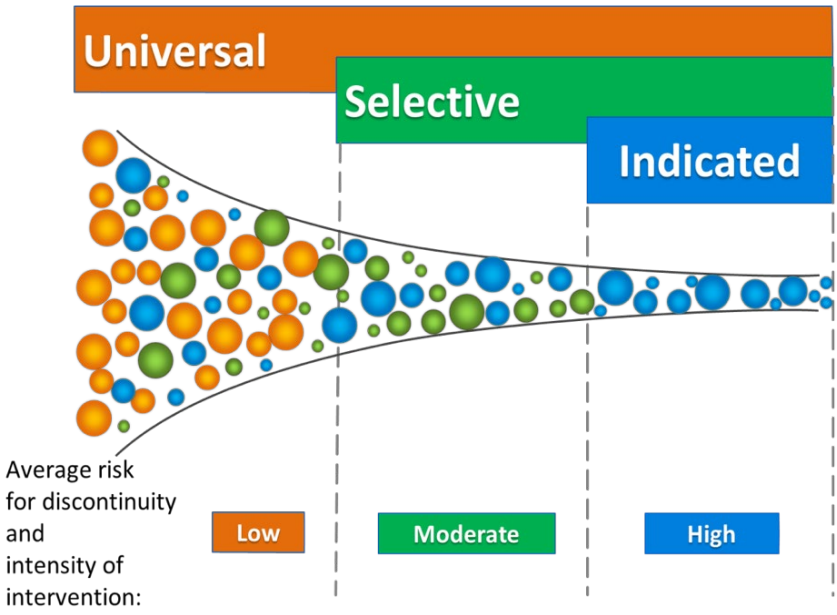
Focused Services

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

Post Permanence

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

Figure 1.3. Prevention Framework



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

Universal

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

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

Selective

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

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

Indicated Services

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

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

Intensive

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

Maintenance

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

Site Selection

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

Pre Assessment

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

Initial Assessment

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

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

Full Assessment

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

Tribal Selection Process

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

Implementation & Evaluation

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

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

Evaluation

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

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

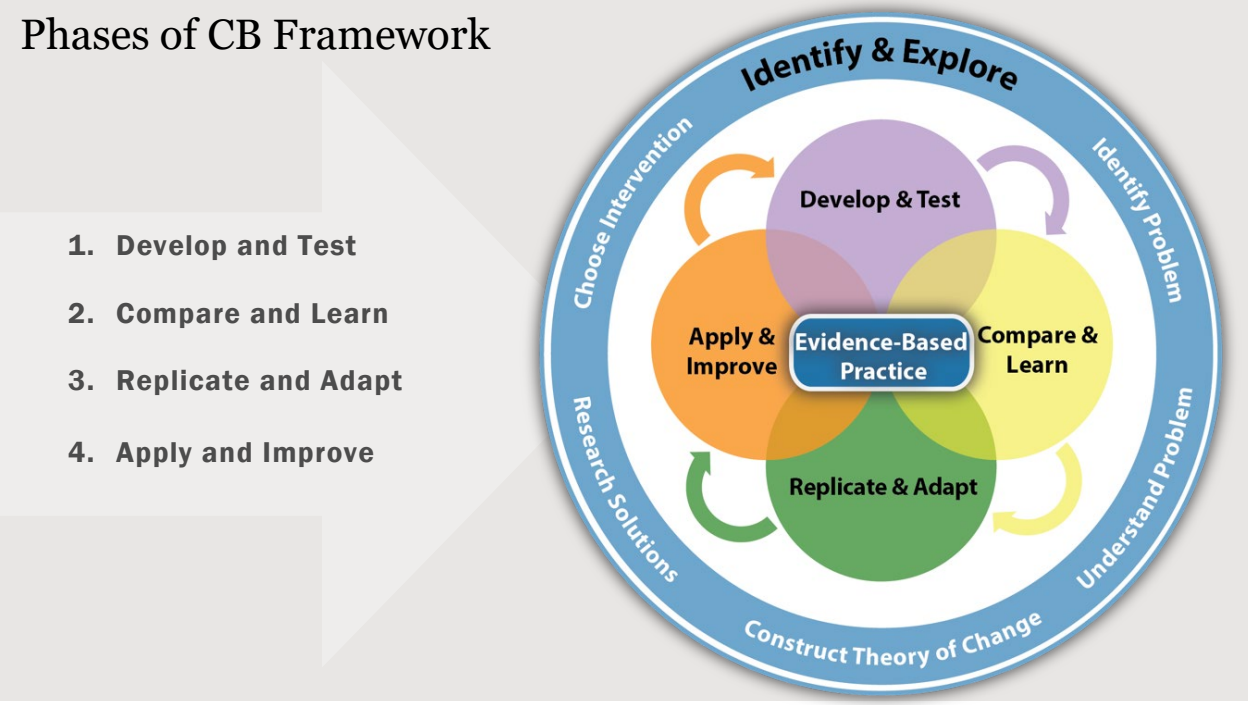
Guiding Frameworks

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

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

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

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



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

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

- Needs of the target population
- Fit with current initiatives
- Availability of resources and supports for training, technology, etc.
- Level of research evidence, and similarities between existing outcomes and project-defined outcomes
- Readiness for replication of the intervention
- Capacity of the site to implement the intervention as intended by the purveyor over time (Blase, Kiser & Van Dyke, 2013).

Figure 1.5. National Implementation Research Network's (NIRN) Hexagon Tool

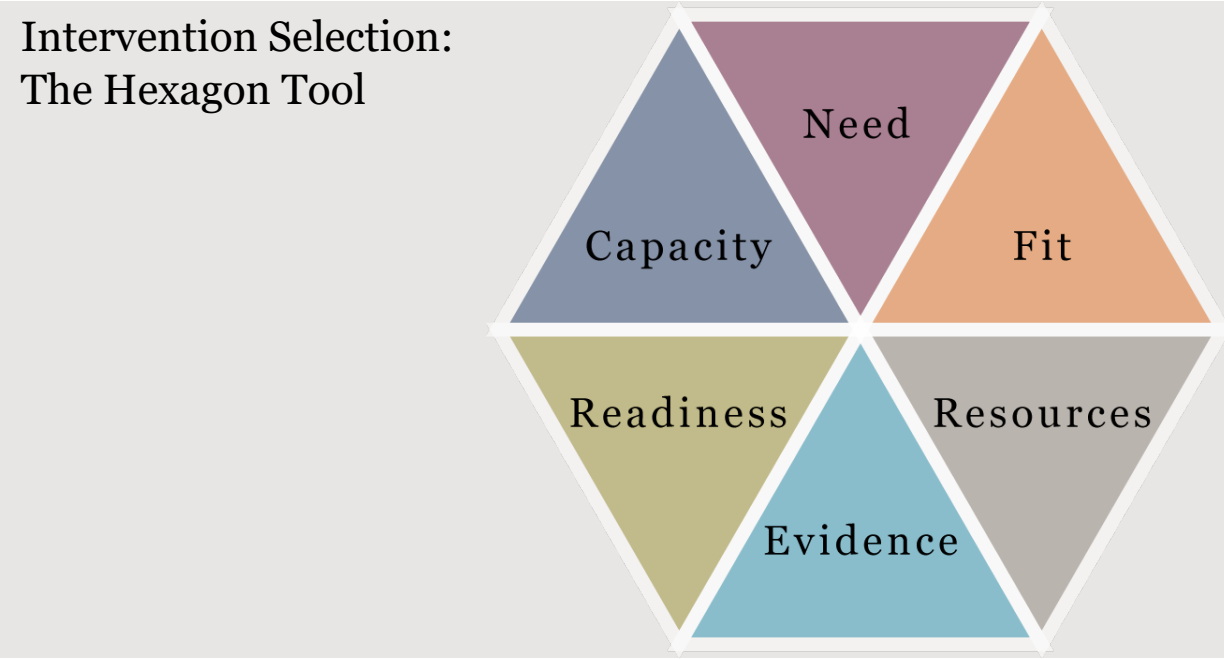


Table 1.1. Site, Target Population, Intervention and Study Design

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

Process Evaluations included the following types of information:

- Recruitment procedures
- Intervention participation
- Participant profiles for public adoptive and guardianship families and, when applicable, private domestic and intercountry adoptive families.
- Program outputs
- Results of usability testing
- Fidelity

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

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

Summary

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

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

References

Barth, R. P., Crea, T. M., John, K., Thoburn, J., & Quinton, D. (2005). Beyond attachment theory and therapy. Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child and Family Social Work, 10,* 257-268. doi: 10.1111/j.1365-2206.2005.00380.x

Blase, K., Kiser, L. & Van Dyke, M. (2013). The Hexagon Tool: Exploring Context. Chapel Hill, NC: National Implementation Research Network, FPG Child Development Institute, University of North Carolina at Chapel Hill.

Casey Family Programs (2012). *USA: Stepping up for kids: What government and communities should do to support kinship families.* Annie E. Casey Foundation. Retrieved from http://www.aecf.org/resources/stepping-up-for-kids/

Committee on Ways and Means (CWM) of the U.S. House of Representatives. (2018). 2018 Green book: Background material and data on the programs within the jurisdiction of the Committee on Ways and Means. http://greenbook.waysandmeans.house.gov.

Crumbley, J. & Little, R.L. (1997). *Relatives raising children: An overview of kinship care.* Washington, DC: CWLA Press.

Crumbley, J. (2017). Engaging kinship caregivers with Joseph Crumbley. Retrieved from http://www.aecf.org/blog/engaging-kinship-caregivers-with-joseph-crumbley/

Egbert, S. C. (2015). Supporting and strengthening foster adoptive families: Utah's story of post-adoption service development, delivery, and ongoing evaluation. *Journal of Public Child Welfare, 9*(1), 88-113. http://dx.doi.org/10.1080/15548732.2014.1001936

Framework Workgroup. *A Framework To Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Fong, R., McRoy, R. G., & McGinnis, H. (2016). Overview of intercountry adoptions. In R. Fong & R. G. McRoy (Eds.), *Transracial and intercountry adoptions: Culturally sensitive guidance for professionals* (pp. 19-37). New York, NY: Columbia University Press.

Lloyd, E. C., & Barth, R. P. (2011). Developmental outcomes after five years for foster children returned home, remaining in care, or adopted. *Children and Youth Services Review, 33*(8), 1383-1391. http://dx.doi.org/10.1016/j.childyouth.2011.04.008

Niemann, S., & Weiss, S. (2011). Attachment behavior of children adopted internationally at six months post adoption. *Adoption Quarterly, 14*(4), 246-267. doi:10.1080/10926755.2011.628262

Orsi, R. (2014). Predicting re-involvement for children adopted out of a public child welfare system. *Child Abuse & Neglect, 39*, 175-184. doi:10.1016/j.chiabu.2014.10.005

Reilly, T., & Platz, L. (2004). Post-adoption service needs of families with special needs children. *Journal of Social Service Research, 30*(4), 51-67. http://dx.doi.org/10.1300/J079v30n04_03

Rolock, N. (2015). Post-permanency continuity: What happens after adoption and guardianship from foster care? *Journal of Public Child Welfare*, 9:2, 153-173, doi:10.1080/15548732.2015.1021986

Rolock, N. & White, K. R. (2016). Post-permanency discontinuity: A longitudinal examination of outcomes for foster youth after adoption or guardianship. *Children and Youth Services Review*, *70*, 419-427. doi:10.1097/01.chi.0000220850.86768.e8

Rolock, N., Pérez, A. G., White, K. R., & Fong, R. (2018). From foster care to adoption and guardianship: A 21st century challenge. *Child & Adolescent Social Work Journal*, 1-10. http://dx.doi.org/10.1007/s10560-017-0499-z

Simmel, C., Barth, R. P., & Brooks, D. (2007). Adopted foster youths? Psychosocial functioning: a longitudinal perspective. *Child & Family Social Work, 12*(4), 336-348. http://dx.doi.org/10.1111/j.1365-2206.2006.00481.x

Springer, F. & Phillips, J. L. (2006). The IOM model: A tool for prevention planning and implementation. Folsom, CA: Community Prevention Institute *Prevention Tactics* 8:13.

Tan, T. X., & Marn, T. (2013). Mental health service utilization in children adopted from US foster care, US private agencies and foreign countries: Data from the 2007 National Survey of Adoption Parents (NSAP). *Children and Youth Services Review, 35*(7), 1050-1054. http://dx.doi.org/10.1016/j.childyouth.2013.04.020

Testa, M. F., Bruhn, C., & Helton, J. (2010). Comparative safety, stability, and continuity of children's placements in formal and informal substitute care. In M. B. Webb, K. Dowd, B. Jones Harden, J. Landsverk, & M. F. Testa (Eds.), *Child welfare and child well-being: New perspectives from the National Survey of Child and Adolescent Well-Being* (pp. 159 – 191). New York: Oxford.

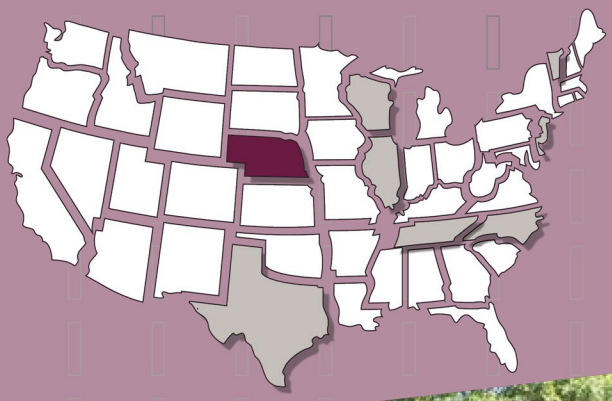
Testa, M. F., Snyder, S. M., Wu, Q., Rolock, N., & Liao, M. (2015). Adoption and guardianship: A moderated mediation analysis of predictors of post-permanency continuity. *American Journal of Orthopsychiatry, 85*(2), 107-118.

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/ Data current as Oct. 2017.

White, K. R. (2016). Placement discontinuity for older children and adolescents who exit foster care through adoption or guardianship: A systematic review. *Child and Adolescent Social Work Journal, 33*(4), 377-394. http://dx.doi.org/10.1007/s10560-015-0425-1

Evaluation Results from

Winnebago Tribe of Nebraska



Final Evaluation Report

September 2019

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

This report was designed by staff at the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work. We thank them for their partnership and dedication to the work of translational research.

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

Report Authors

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

Alian Kasabian, PhD | Research Assistant Professor
Operations Director of the Methodology and Evaluation Research Core Facility,
University of Nebraska at Lincoln

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

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

Chun Liu, MSSA | Doctoral Student
The University of Texas at Austin, Steve Hicks School of Social Work

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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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.

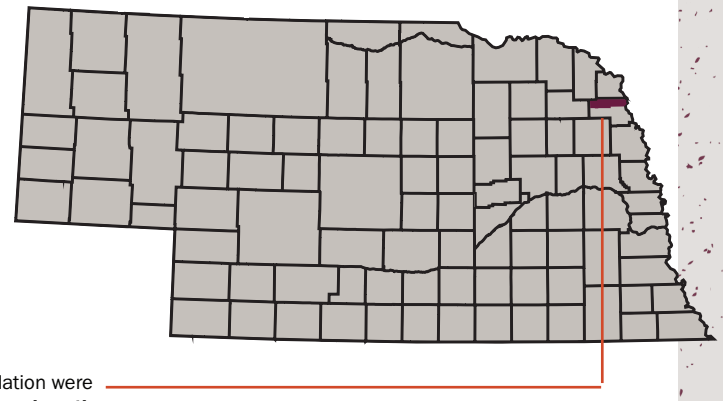
We also thank the many stakeholders on the QIC-AG site specific Project Management Team (PMT), Stakeholder Advisory Team (SAT) and Implementation Team (IT) who were invaluable in providing the support and direction needed to implement the study. The participants on these three teams included community 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 Winnebago Children and Family Services, Tribal Elders, Tribal Council members and other Winnebago community leaders, site team leaders, and the Site Implementation Manager (SIM), who guided this work, in addition to their other roles within the agencies they work. Your partnership made this project a success.

The QIC-AG site consultants worked closely with the evaluation team to ensure the project work was implemented with integrity. Thank you for the collegial team work.

A special appreciation goes to the intervention purveyor, Kempe Center who supported the Winnebago site in adapting its model for this study.

Evaluation Results from Winnebago Tribe of Nebraska



PROJECT PARTNERS

QIC-AG partnered with **Winnebago Child and Family Services.**

CONTINUUM PHASE

Focused Services

INTERVENTION

The Winnebago adapted **Family Group Decision Making (FGDM): Važokį Wošgą Gicą Wo'ųpį**. This model ensures culturally viable decisions by involving the entire available family in a Family Group Conference or Stokį; which is when the family comes together to develop a family plan regarding the child's permanency goal.

STUDY DESIGN

Descriptive

Target population were **Winnebago children and youth in foster care** who: 1) could not reunify with their biological parents and had a non-permanency reunification plan, and 2) did not have a permanency placement identified OR did have an identified placement.

RESEARCH QUESTION

Will Winnebago tribal children and youth, ages 5-18 years, who cannot reunify with their biological parents, have a non-permanency reunification plan, and have yet to identify a permanency placement or a permanency placement has been identified, experience increased placement stability, improved child and family wellbeing, improved behavioral and health, decreased time to finalization/time in care, and increased permanency outcomes if they are provided Family Group Decision Making?

Findings

RECRUITMENT

- **28** cases were referred
  - **12** cases were determined to be ineligible
  - **5** cases consent was not obtained
  - **4** cases withdrew or were outside service area
- **7** cases were included in the study
  - **3** cases successfully scheduled a family conference
    - **1** case successfully scheduled a follow-up conference

PARTICIPANT SATISFACTION

After attending a Family Conference:

PARTICIPANTS AGREED OR STRONGLY AGREED WITH:

98%

- Family traditions were respected in the family plan
- The child and family needs were clearly identified

PARTICIPANTS AGREED LESS WITH THE FOLLOWING:

58%

- The right people were at the meeting
- Family cultural needs were identified during meeting

OUTCOMES

Given that the sample size includes only seven families, a quantitative analysis was not possible. But here is what the core staff had to say about working with the families who did participate:

INCREASED KNOWLEDGE OF PERMANENCY OPTIONS

I feel our families understand more and better comprehend what the courts are asking for or what the options are.

INCREASED PROTECTIVE FACTORS

The project increased protective factors by involving the larger extended family and support network in the child welfare case.

INCREASED KNOWLEDGE OF WINNEBAGO SPECIFIC PATHWAYS

I think this project shed a light on our community's trauma and conflicted relationships with 'systems.' We have a long way to go to really engage and empower our families. It is going to take time and patience to get there.

INCREASED CONNECTEDNESS

The children who have had conferences have felt cared about and included. For some of them, it was the first time they felt listened to.

LESSONS LEARNED

A significant accomplishment stemming from this project was the changes to strengthen and clarify the Tribal Code. This change in Tribal Code strengthened customary adoption and guardianship as permanency plan options for Winnebago families in Nebraska. Engaging in a "By the Tribe, for the Tribe" process by actively including Tribe Elders and community members in the project is highly recommended.

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

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Jack, Joseph and Morton Mandel School of Applied Social Sciences Case Western Reserve University

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

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

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

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

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Executive Summary

Overview

The National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) site, working with the Winnebago Tribe, adapted the Family Group Decision Making model for use within their community.

The Winnebago site used both linear and circular Logic Models. The linear Logic Model reflects a European-centric approach to programs and change. Circular Logic Models take a more relational perspective and illustrate the inter-connectedness of the programming, including how the change impacts the community. The Winnebago site developed a circular Logic Model that is more reflective of the Tribe's practices and beliefs. Both logic models lead to the primary research question which guided the program evaluation.

The Theory of Change for the project was the Winnebago Tribe does not have a practice intervention supporting culturally competent family engagement to promote decision making regarding sustainable permanence. To address this gap, a culturally relevant child welfare practice intervention for the Winnebago Tribe based on indigenous practices is needed. This practices should ensure culturally viable decisions are made and that these decisions promote the timely achievement of permanence through customary adoption or guardianship. Finally, if a practice intervention is adapted to meet the needs of the Winnebago Tribe then the Winnebago people will be able to implement a culturally relevant child welfare practice, which will increase legal permanence for Winnebago children.

Intervention

Three teams of the QIC-AG project, the Project Management Team (PMT) and Stakeholder Advisory Team (SAT) and Implementation team, in conjunction with the Tribal Elders and Winnebago community members, designed the Winnebago adapted intervention of Family Group Decision Making (FGDM): Ważokį Wošgą Gicą Wo'ųpį (pronounced *Wha-zho-kee Wo-shga Gi-cha Wo-oo-pi*). The Tribe chose this intervention because there are tribal children and youth who need permanent family units, but the process of finding and engaging tribal families requires culturally competent social work practices that engage families to make decisions about their children.

The Winnebago Tribe program team adapted FGDM to reflect Ho-Chunk cultural values and practices, which are core to the Winnebago Tribe of Nebraska. Interviews were set up with Elders from the Winnebago Tribe as recognized experts of cultural practices, values, and language. The six themes that emerged from those interviews guided the cultural adaptation of the FGDM intervention: family support, family functioning, informal supports, formal social support, important cultural values and children without caregivers. FGDM was in the **Replicate and Adapt** phase of the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*.

Primary Research Question

The research question was:

Will Winnebago tribal children and youth, ages 5-18 years, who cannot reunify with their biological parents, have a non-permanency reunification plan, and have yet to identify a permanency placement or a permanency placement has been identified, experience increased placement stability, improved child and family wellbeing, improved behavioral and health, decreased time to finalization/time in care, and increased permanency outcomes if they are provided FGDM?

The target population were Winnebago children and youth in foster care who: 1) could not reunify with their biological parents and had a non-permanency reunification plan, and 2) did not have a permanency placement identified OR did have an identified placement whose prospective caregivers would benefit from FGDM to prepare for finalization. Children ages 5-18 years could participate in the FGDM conference; however, youth 12 years and older were considered as the subjects of the intervention evaluation.

The original evaluation of the adapted FGDM model included a mixed-method outcome evaluation using a non-experimental pre-posttest design. However, based on the low sample size, the research study design shifted to a descriptive study with a greater focus on process evaluation. There was limited data collected from caregiver pre surveys, caregiver and child interviews, and core site staff surveys. Also, due to the concern about confidentiality issues in the Winnebago tribal community, composite case scenarios were created from characteristics of the individual cases rather than use a traditional qualitative case study approach.

Key Findings and Recommendations

The Winnebago site served seven youth. Qualitative information gathered through interviews with participants and staff, activities that occurred during implementation and insights from the case studies. Respondents reported that the intervention had a positive impact on families, as summarized in these examples:

FGDM Coordinators reported on their core site staff survey that their impression is that the families going through the FGDM process were gaining a better understanding and that this helped them work with the courts. One core site staff member said,

> **"I feel our families understand more and better comprehend what the courts are asking for or what the options are."**

Winnebago core site staff noted that involving family in the child's life helped create a sense of community. For example, the staff noted that the Stokį was hard for family members who had been disconnected with the youth. Once that family member re-engaged with the youth, there was more connection where adults assumed responsibility for being involved in the child's life. One core site staff member noted,

> **"The project increased protective factors by involving the larger extended family and support network in the child welfare case."**

Core site staff described the ongoing growth of their own knowledge, and how awareness of the program is growing in the community. Overall, the core site staff noted that this project highlighted historical issues the Tribe has had with the child welfare system. One core site staff member said,

> **"I think this project shed a light on our community's trauma and conflicted relationships with 'systems.' We have a long way to go to really engage and empower our families. It is going to take time and patience to get there."**

The process of outreach and preparation, combined with broadening support networks, is helping to build greater trust in professionals and community partnerships. While the FGDM Coordinator faced distrust from some families in the process of doing their jobs, there was an increase in communication and trust as the program continued. One core site staff member noted,

> **"The children who have had conferences have felt cared about and included. For some of them, it was the first time they felt listened to."**

The Winnebago site has several lessons learned that can be applied to other programs working with Tribes. Central to these lessons is that work with Tribes needs to be grounded within and driven by the cultural values of the Tribe rather than the funding entities.

- While this program evaluation cannot provide evidence to support FGDM as a model to be adapted and used with Tribes, the response from participants and staff are positive in terms of the impact on families.
- A significant accomplishment stemming from this project was the changes to strengthen and clarify the Tribal Code that was supported by the site team as part of capacity building. This change in Tribal Code strengthened customary adoption and guardianship as permanency plan options for Winnebago families in Nebraska. In working with a tribe, it is important to ensure that the laws, codes, policies, and procedures support the planned intervention. One of the first challenges this site experienced was a cultural difference between tribal practice and the larger child welfare practices. It is common for parental rights to be terminated under standard (European) child welfare practices, but this goes against tribal beliefs. Customary adoption recognizes the extension of parental rights and adoption is more about placement stability. Native children permanently belong to the Tribe, as explained by the Elders.
- Engaging in a "By the Tribe, for the Tribe" process not only enhances and strengthens tribal sovereignty and existing relationships, but also supports new relationships built upon a common understanding of the project, resulting in establishing trust, respect, and buy-in. When adapting an intervention for a specific culture, it is important to build partnerships that are inclusive and transparent by fostering and developing an ongoing dialogue with stakeholders. The Winnebago Team engaged in ongoing communication with the Winnebago Tribal Elders, the community, service providers, Ho-Chunk Renaissance (language support and cultural etiquette service provider), legal counsel, the Winnebago Tribal Court, and the intervention purveyor.

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 2

WINNEBAGO FAMILY GROUP DECISION MAKING

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List of Figures and Tables

Site Background

The Winnebago Indian Reservation covers approximately 120,000 acres in northeastern Nebraska. The Village of Winnebago is the largest community on the reservation and home to 30% of the reservation's resident population. There are over 5,000 enrolled members of the Winnebago Tribe of Nebraska (WTN), but fewer than eight hundred live on the reservation in North Thurston County. The population of the Winnebago Indian Reservation is growing. From 1990 to 2040, the Reservation is expected to more than double its population due in part to high birthrates and youthful composition of the Native American inhabitants (Winnebago Tribe of Nebraska, 2015).

A Winnebago belief is:

> **"We don't live for today - Do what we do for today - We live for years to come, days not yet seen - With the Hope & Prayers that our children & their children, their children's children - and so on & so on. We do what we can for them - not for us because we made it here today - not by chance - but by the Hopes & Prayers of our ancestors. Someone who loved us that much prayed for this day for us - for our people."**

The population increase coupled with a housing shortage resulted in an increase in multi-generational homes that often do not meet the licensing standards for foster care placements required by the state. As a result, few positive Native placements are available for tribal youth and adolescents. With limited licensed homes available within the Winnebago Tribe, tribal children are placed in non-tribal licensed homes that may not affirm or respect the Winnebago culture, which ultimately negatively impacts Winnebago children and families.

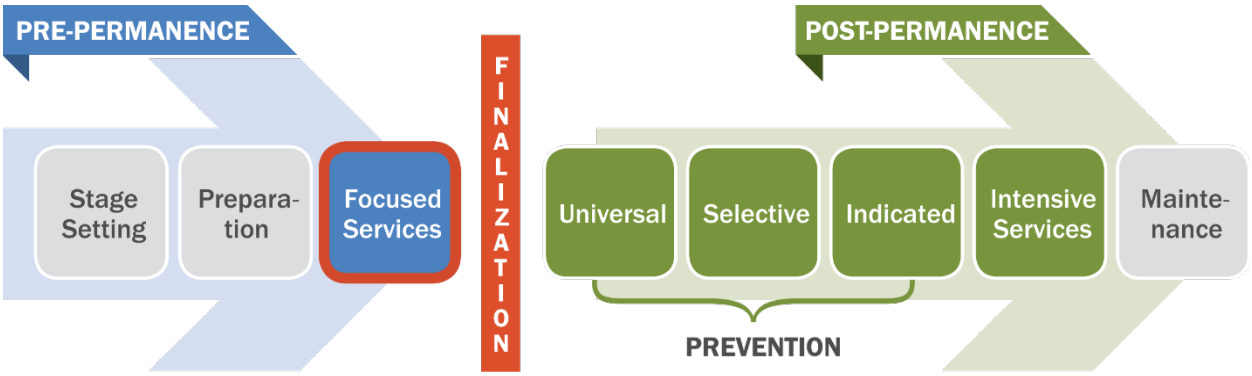
This is made more difficult because state service providers are limited in their knowledge of tribal sovereignty, tribal courts, and tribal practices. For example, current child welfare assessments and placements do not identify issues with multi-generational trauma nor do they recognize the strengths of intergenerational parenting practices of the Traditional Ho-Chunk Kinship System. Intergenerational parenting practices, where grandparents and extended family are recognized as primary caregivers, are not acknowledged. Moreover, definitions of what it means to be a relative and kin differ between the state and Tribe. Finally, the Winnebago Tribe does not recognize the termination of parental rights as a valid practice for most child welfare cases. However, customary adoption is culturally and legally recognized by the Tribe.

There are tribal children and youth who need permanent families but the process of finding and engaging tribal families requires culturally competent social work practices that reflect engagedfamilies to make decisions about their children. The QIC-AG project in the Winnebago Tribe chose the FGDM model to adapt and evaluate with their community. Three teams established as part of the QIC-AG (the Project Management Team [PMT] and Stakeholder Advisory Team [SAT], and Implementation team), in conjunction with Tribal Elders from Ho-Chunk Renaissance and Winnebago community members, worked with the purveyor of FGDM to incorporate Winnebago specific tools into the FGDM practice and create the intervention of FGDM: Ważokį Wošgą Gicą Wo'ųpį (pronounced *Wha-zho-kee Wo-shga Gi-cha Wo-oo-pi*).

QIC-AG Permanency Continuum Interval

The Winnebago intervention fits within the **Focused Services** of the QIC-AG Permanency Continuum.

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 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.



Primary Research Question

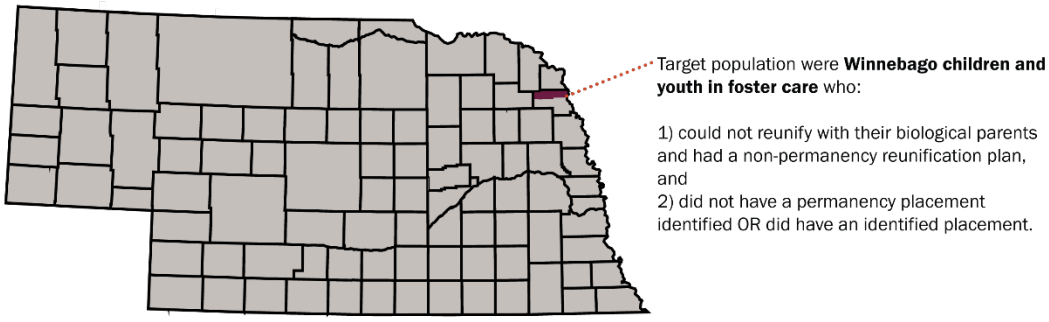
The Winnebago Tribe adapted, implemented, and evaluated the FGDM model. The evaluation of the model was focused on answering the research question using the Population, Intervention, Comparison Group, Outcome (PICO) framework (Richardson, Wilson, Nishikawa, & Hayward, 1995; Testa & Poertner, 2010). For Winnebago, the evaluation design does not include a comparison group, as this is a descriptive analysis only of an adapted intervention.

The research question was:

Will Winnebago tribal children and youth, ages 5-18 years, who cannot reunify with their biological parents, have a non-permanency reunification plan, and have yet to identify a permanency placement or a permanency placement has been identified (P) experience increased placement stability, improved child and family wellbeing, improved behavioral and health, decreased time to finalization/time in care, and increased permanency outcomes (O) if they are provided FGDM?

Target Population

The target population were Winnebago children and youth in foster care who: 1) could not reunify with their biological parents and had a non-permanency reunification plan, and 2) did not have a permanency placement identified OR did have an identified placement whose prospective caregivers would benefit from FGDM to prepare for finalization. Children ages 5-18 years could participate in the FGDM Conference (Family Group Conference); however, youth 12 years and older were considered as the subjects of the intervention evaluation.



Intervention

Because the Winnebago Tribe of Nebraska (WTN) did not have a child welfare practice intervention that was culturally relevant and respectful of tribal values, the FGDM model was chosen. This model, based on indigenous practices of the Maori people in New Zealand, ensures culturally viable decisions are made and that these decisions (enriched with culturally relevant tools) promote the timely achievement of legal permanence for Winnebago children through permanency options (such as customary adoption).

PROCESS OF SELECTING AND ADAPTING AN INTERVENTION

As part of the intervention selection, a project management team (PMT) and stakeholder advisory team (SAT) were convened from community stakeholders and local child welfare experts. Meetings were held to decide on the evidence-supported intervention to address the needs of two populations: children in foster care and families with finalized adoption/guardianship. While in the process of selecting an intervention, the State of Nebraska mandated the use of Family Team Meetings but did not specify a meeting model. FGDM was identified as an indigenous practice, introduced by the Maori people of New Zealand and found successful for supporting families in making decisions in the best interest of their children. The practice was later adopted by the people of Hawaii, and the Cheyenne River Lakota to meet their individual cultural needs. Therefore, the WTN selected FGDM as their "Focused" intervention.

FGDM had not been previously tested, and components of it had not been previously developed. The QIC-AG team worked with the developer of FGDM to develop portions of FGDM, and to adapt it to reflect Ho-Chunk values. As such, according to *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*, FGDM was in the **Replicate and Adapt** phase of intervention development. The goal of this phase is "widespread, consistent, and appropriate implementation of the adopted intervention with other populations and in other contexts that continue to achieve the desired outcomes" (Framework Workgroup, p. 4).

To adapt FGDM to reflect Ho-Chunk cultural values and practices, core to the Winnebago Tribe of Nebraska, interviews were set up with Elders from the Winnebago Tribe. Elders, as recognized experts of cultural practices, values, and language, were recruited through contacts within the tribe, including the partnership with Ho-Chunk Renaissance – the language program in Winnebago, Nebraska. Nine structured interviews were conducted by researchers from the University of Texas at Austin and the University of Nebraska-Lincoln. The six themes that emerged from those interviews guided the cultural adaptation of the FGDM intervention were: family support, family functioning, informal supports, formal social support, important cultural values and children without caregivers. Each theme is described in detail in the following paragraphs.

Family Support

Although it is expected that children will be cared for by their parents, family support extends beyond any single-family unit. Grandparents are a particularly strong source of support in raising children. Other extended family members help raise children. Unity among the family is demonstrated through sharing meals, playing games, and praying together. There is great importance in valuing and loving everyone in the Tribe as part of an extended family. Tribe members may leave the community during childhood or as adults to work, but they generally return to the community.

Family Functioning

Decisions about children are made by family members and those decisions may include anyone involved in raising a child. Mothers and grandmothers are viewed as caretakers and teachers, especially for girls. Fathers are viewed as authoritative and teach boys how to fulfill their roles in the tribe. If mothers and fathers are not available to assume these roles, extended family steps in.

Informal Support

If an individual loses someone or he/she comes from a family that is not functioning well, they are never actually alone. These individuals will always have a family because of the extended family and the tribe. Because there are no formal social services, extended family fills the role of providing social support.

Formal Social Support

In the past, there were no social services to rely on in hard times. Elders generally reported that individuals rely on family for support, but that younger generations have more access to support. Providing care and support for others is a means of valuing and loving everyone in the tribe.

Positive Cultural Values

Positive cultural values of the Tribe include respect, responsibility, hard work, remembering the people and the culture, the language, families, children, Elders, tradition, spirituality, honor, integrity, kindness, generosity/ giving, and gratitude. In terms of values specifically related to families, respect, particularly respect for Elders, was specifically important. Children are expected to learn the history and traditions to keep it going. However, there is a feeling that the younger generation is losing the culture and history that these are "different times."

Children Without Caregivers

If a child's parents cannot care for the child, the maternal side of the family would be asked to take the child first. After the maternal side is consulted, the paternal side of the family would be asked to care for the child. If no family member is able to care for the child, someone in the tribe who was willing and able would step in. Elders in the Tribe believe that the government should not step in and care for a child outside of the tribe. Having a child grow up with the values and traditions of the Tribe is crucial. Younger generations may vary in their beliefs about government assistance. Because there is always a place in the Tribe for children, "orphans" do not exist in the traditional sense. The western idea of adoption is not part of Ho-Chunk culture. Because children are cared for by family or the Tribe, adoption is not a known concept or practice. Being adopted outside of the Tribe would not be acceptable. In general, having a child cared for outside of the family is a private issue and should not be publicized or celebrated. If a child moves to a different family, a welcoming meal might be appropriate. Within the Tribe, a Naming Ceremony may be important after adoption to officially demonstrate the child was a part of the family that took the child in.

These six themes described above were integrated into the adaptions made to the FGDM intervention**.** First, the team chose a name that reflected the project, after consulting with Ho-Chunk Renaissance and Elders about word choice. The team decided on the Ho-Chunk translation: Wažokį Wošgą Gicą Wo'ųpį. The Site Implementation Managers (SIMs) who were also the independent FGDM Coordinators put together several documents to support the cultural adaptation. These documents included Ho-Chunk language translations, Ho-Chunk kinship charts, clan identification charts, and a Wažokį ecomap.

In addition to adaptations to the intervention, the team also worked to strengthen and clarify Tribal Code and build capacity, so that FGDM participants had clarity on permanency options. The team worked with the Tribal Court to clarify customary adoption in the Tribal Code (Title 4, article 7), and stabilize protections concerning guardianship. Prior to these edits, the code allowed all guardianships to expire after two years and allowed petitioners to dissolve guardianships without evidence. Besides removing the guardianship expiration date and putting the burden of evidence on the petitioner for guardianship dissolution, the team also created standby guardianship (i.e. a contingency plan in case of emergency), stronger ties to other parts of the Code (like the Grandparent's Code), and a requirement whereby CFS would be notified if one of their prior cases that had

established guardianship permanency was referred to the Tribal Court again. Information in the Tribal Code falls under the sovereignty of the Winnebago people, and the state courts must follow Tribal Code for cases that are covered by the Indian Child Welfare Act (ICWA). This also provides another permanency option for families who are going through family conferences. From the Tribal Code:

> **"These provisions governing customary adoptions shall be interpreted liberally to provide what is in the best interest of the child and the Tribe and to provide a sense of permanency and belonging to children throughout their lives and at the same time provide them with knowledge about their unique cultural heritage including their tribal customs, history, language, religion and values" (p.4-723).**

By this definition, the Tribal Court would also accept relational permanence as an acceptable permanency plan. This means that youth can stay with non-relatives they are most comfortable with ("*provide a sense of permanency and belonging*"), as long as the non-relatives fulfill the minimum requirements for safety as required by the court. Further, the addition of customary adoption to the code included the following text: "*A decree certifying a customary adoption as the same effect as a decree or final order of statutory adoption issued by this Court*." This provides the same supports as any other adoption completed in the Tribal Court.

FAMILY GROUP DECISION-MAKING CORE COMPONENTS

While the Winnebago team thoroughly explored the intervention within the context of the Tribe's cultural values, there are six core components of FGDM that must be practiced in order to conduct the intervention with fidelity (Kempe Center, 2016). These six core components include:

1. An independent (i.e., non-case carrying) coordinator is responsible for convening the family group meeting with agency personnel. When a critical decision about a child is required, dialogue occurs between the family group and the responsible child protection agency. Providing an independent coordinator who is charged with creating an environment in which transparent, honest, and respectful dialogue occurs between agency personnel and family groups signifies an agency's commitment to empowering and non-oppressive practice.

2. The agency personnel recognizes the family group as their key decision-making partner, and time and resources are available to convene this group. Providing the time and resources to seek out family group members and prepare them for their role in the decision-making process signifies an agency's acceptance of the importance of family groups in formulating safety and care plans.

3. Family groups have the opportunity to meet on their own, without the statutory authorities or other non-family members present, to work through the information they have been given and formulate their responses and plans. Providing family groups with time to meet on their own enables them to apply their knowledge and expertise in a familiar setting and in ways that are consistent with their ethnic and cultural decision-making practices. Acknowledging the importance of this time and taking active steps to encourage family groups to plan in this way signifies an agency's acceptance of its own limitations, as well as its commitment to ensuring that the best possible decision and plans are made.

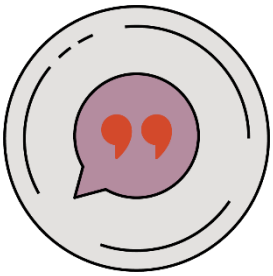
4. When agency concerns are adequately addressed, preference is given to the family group's plan over any other possible plan. In accepting the family group's lead, an agency signifies its confidence in and commitment to working with and supporting family groups in caring for and protecting their children and building their capacity to do so.

5. Follow up processes after the FGDM meeting occur until the intended outcomes are achieved to ensure that the plan continues to be relevant, current, and achievable because FGDM is not a one-time event but an ongoing, active process. Follow-up efforts include but are not limited to ongoing family group-driven follow-up FGDM meetings that are scheduled to accommodate the family group's needs and availability and which are focused on progress, achievements, unresolved issues/ concerns, new information, and additional resources. The result is that the plan is updated and revised as needed, and frequent proactive communication between system and family group representatives supports the successful implementation of the plan.

6. Referring agencies support family groups by providing the services and resources necessary to implement the agreed-on plans. In assisting family groups in implementing their plans, agencies uphold the family groups' responsibility for the care and protection of their children and contribute by aligning agency and community resources to support the family groups' efforts.

The FGDM adapted intervention was implemented by the FGDM Coordinators, who are both the SIMs and the Family Support Workers in the project.

FAMILY GROUP DECISION MAKING PROCESS



The FGDM process consisted of four steps: 1) referral and intake/outreach 2) preparation 3) Family Group Conference and 4) plan intervention and follow up. In the first phase of **referral and intake/outreach**, Child and Family Services (CFS) caseworkers reviewed cases and referred eligible children (those with a non-reunification permanency goal under the jurisdiction of the Winnebago Tribal Court with a CFS caseworker) for FGDM. The Winnebago team assigned an FGDM Coordinator to manage staffing and intake.

The FGDM Coordinator then spent a significant amount of **preparation** time with the family. In this step of the process, the FGDM Coordinator gathered all information available to prepare all family for a meeting. This included making sure attendees had all relevant information prior to the meeting about CFS concerns, the youth's needs, and any additional pertinent details that may inform the decisions to be made by the family group.

Part of the preparation focused on widening the family net by exploring with a family who should come to the meeting. Participants in a meeting might include foster parents, relative caregivers, birth parents, kin, CFS caseworkers, and other service providers.

After preparation, the family would come together for a **Family Group Conference** (FGC). The Winnebago Ho-Chunk word for Family Group Conference is Stokį. Stokį is where and when the family comes together to develop a family plan regarding the child's permanency goal. There were five stages within the Stokį: Introduction, Sharing information, Private family time, Family plan finalization, and Meeting closure. Figure 2.1 details these stages.

After the Stokį, the family may have developed a permanency plan. If they did not, the Stokį is not complete and will need to be resumed to complete a plan. The family may choose to have another Stokį to review and enhance their plan, along with providing space for the family group to make any new decisions/plans that may be needed.

The final step of FGDMwas the **follow-up**. Follow-up consisted of the FGDM Coordinator engaging the family in discussion regarding the enactment of the permanency plan.

Figure 2.1. Stokį Process

Introduction

- Tribal prayer/blessing
- FGDM Coordinator inquires about additional cultural practices
- FGDM Coordinator describes purpose of meeting and logistics
- FGDM Coordinator clarifies roles & their obligations as a mandatory reporter
- Introductions and descriptions of how each participant is related to child
- FGDM Coordinator asks all unresolved family tensions to be set aside
- Family identifies its own guidelines, group norms for the meeting, if needed

Sharing information

- Sharing based on principles of honesty & transparency, compassion, non-judgment, balance of relevant & factual information
- Reports by service providers
- Sharing of available reources
- Non-negotiables of potential plan shared
- Available permanency options shared
- Families seeks clarification until they have all information needed to make well-informed decisions

Private family time

- FGDM Coordinator prepares family for their private time
- FGDM Coordinator and service providers leave room, but remains physically accessible to family
- Meal

Family plan finalization

- Family presents plan to FGDM Coordinator
- FGDM Coordinator addresses non-negotiables and accepts plan
- Family has as much private time as needed

Meeting closure

- FGDM Coordinator reviews next steps
- Family may have additional meetings if needed

Outcomes

SHORT-TERM OUTCOMES

The short term outcomes for the Važokį Wošgą Gicą Wo'ųpį intervention were:

- Increased knowledge permanency options;
- Increased protective factors; and
- Increased knowledge of Winnebago specific pathway.

LONG-TERM OUTCOMES

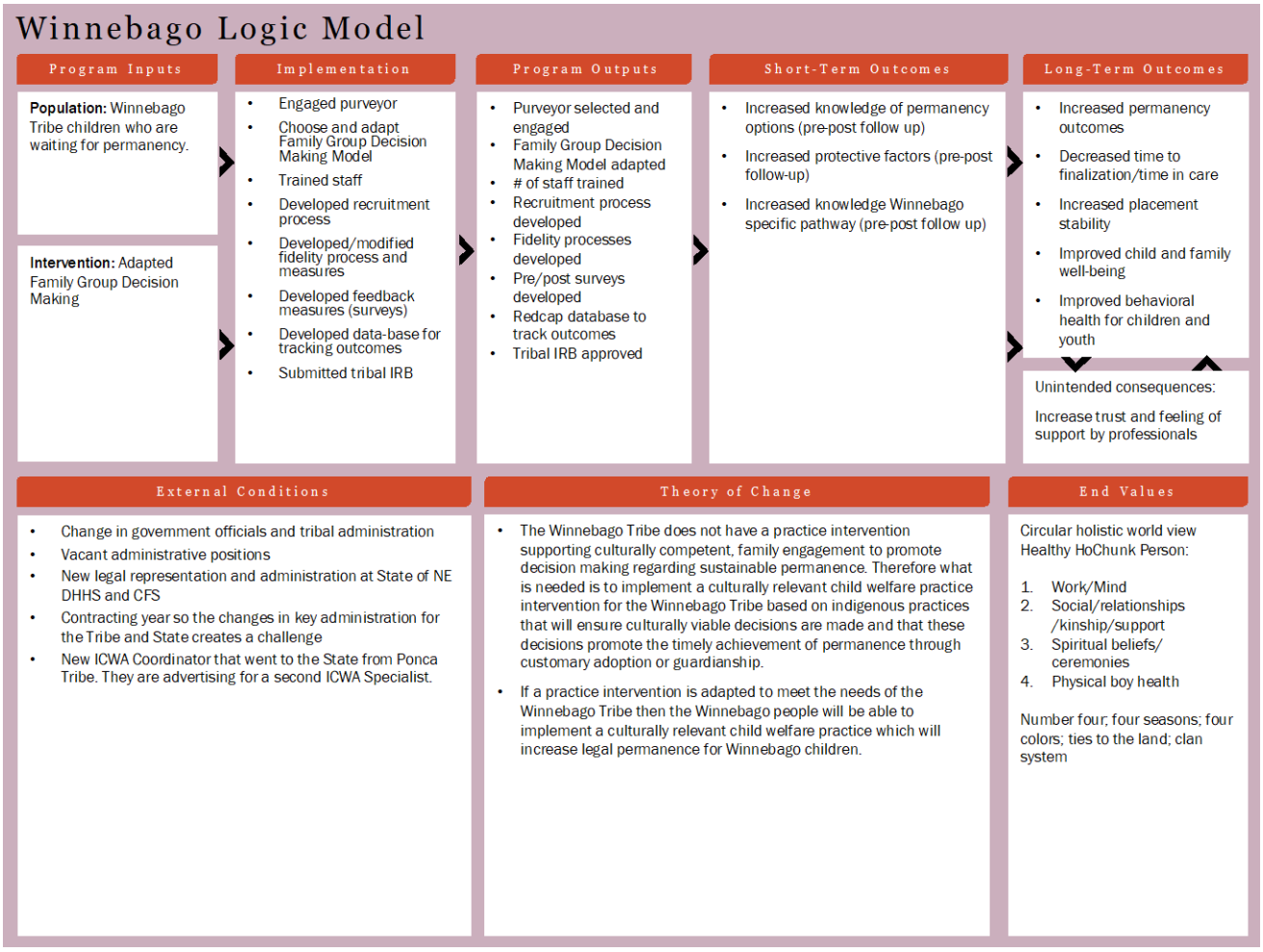
The long term outcomes for the Važokį Wošgą Gicą Wo'ųpį intervention were:

- Increased permanency outcomes;
- Decrease time to finalization/time in care;
- Increased placement stability;
- Improved child and family wellbeing; and
- Improved behavioral health for children and youth.

Logic Model

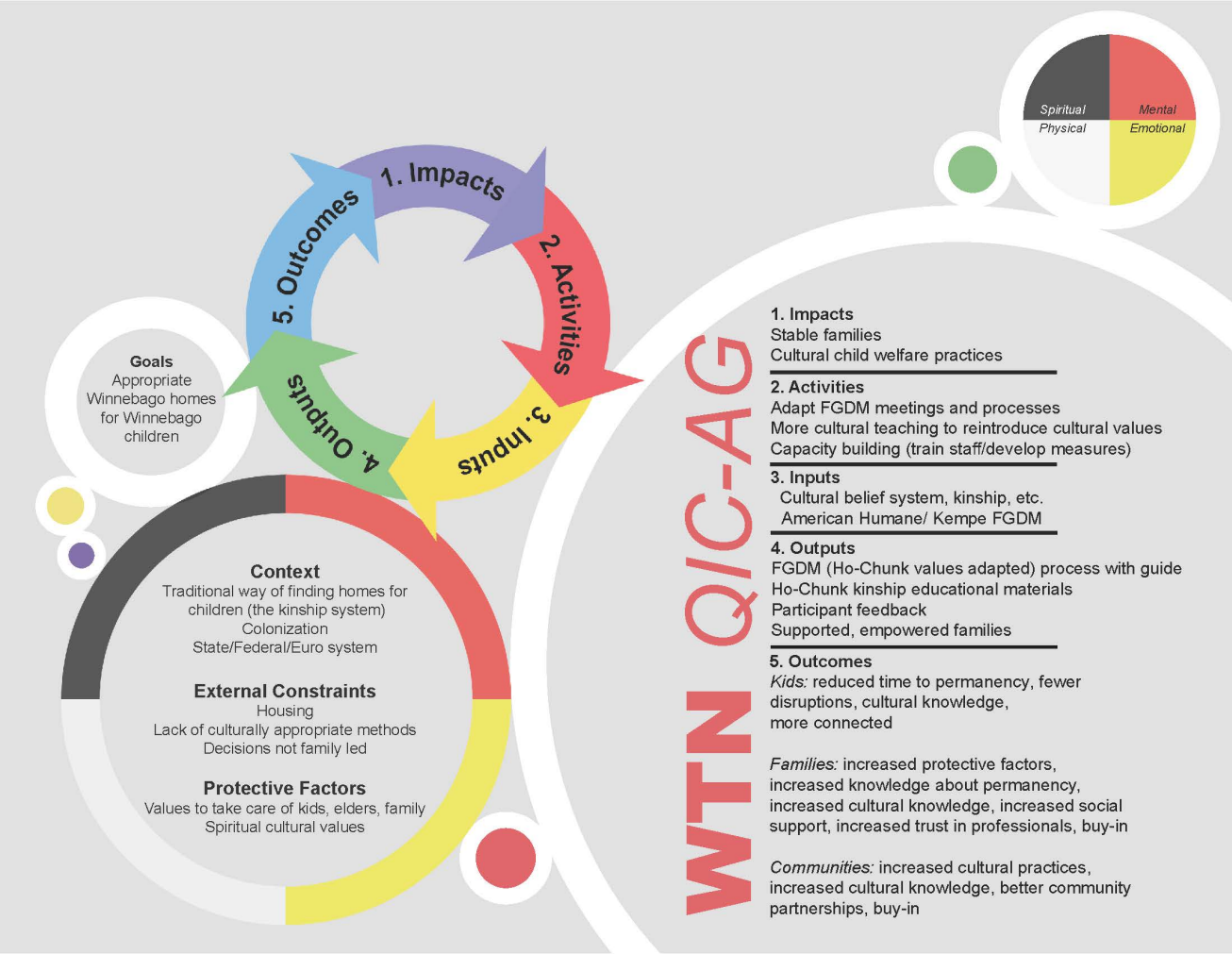
The Logic Model (Figure 2.2) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and core developmentally informed interventions to the intended proximal and distal outcomes. The model identifies the core programs, services, activities, policies, and procedures that were studied as part of the process evaluation, as well as contextual variables that may affect their implementation.

Figure 2.2. Winnebago Logic Model



The Winnebago QIC-AG site used both linear and circular Logic Models. The linear Logic Model reflects a European-centric approach to programs and change. Circular Logic Models take a more relational perspective and illustrates the inter-connectedness of the programming and how the change impacts the community. The Winnebago site developed a circular Logic Model (Figure 2.3) that is more reflective of the Tribe's practices and beliefs.

Figure 2.3. Winnebago Circular Logic Model



Evaluation Design & Methods

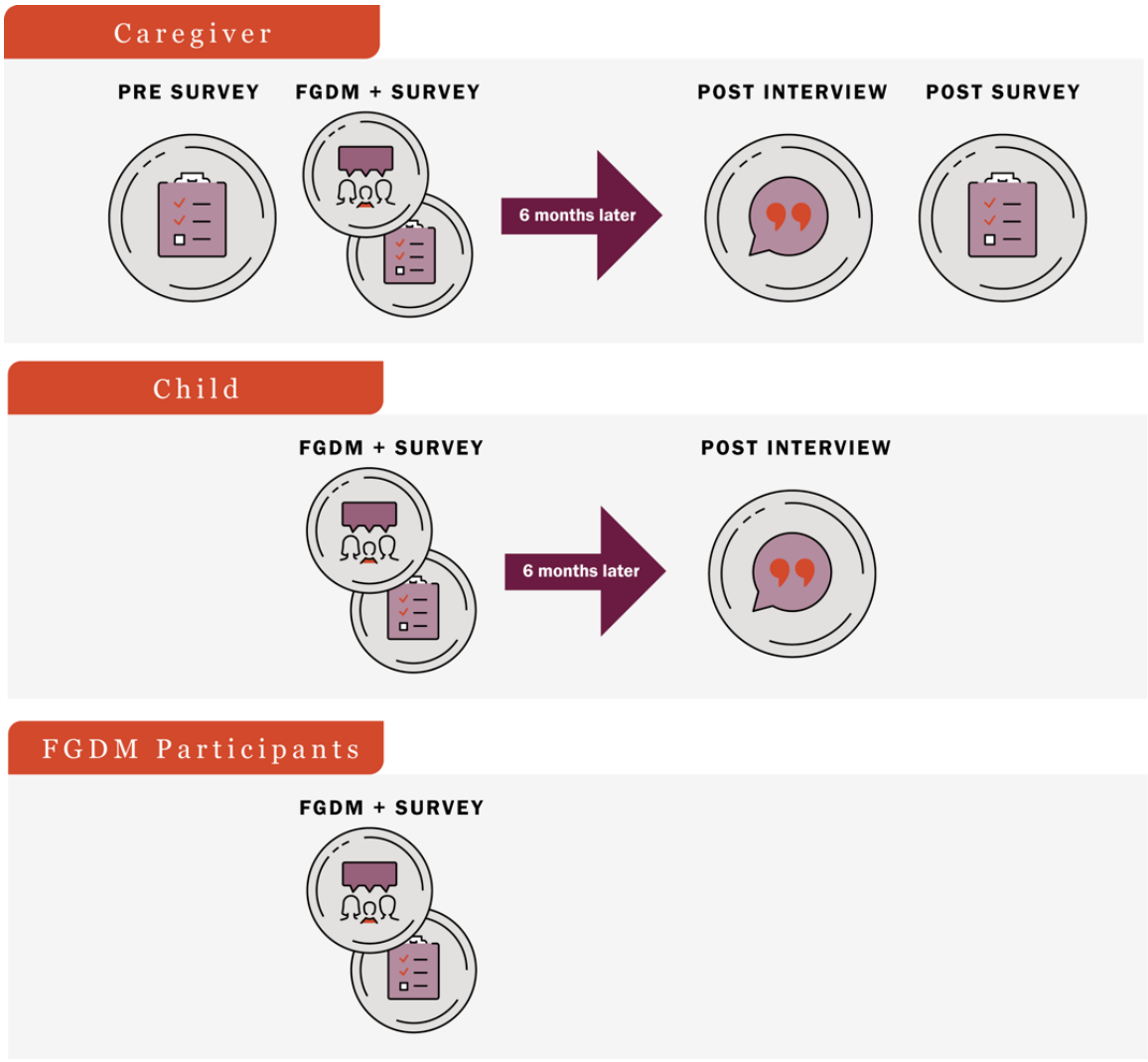
The original evaluation of Ważokį Wošgą Gicą Wo'ųpį included a mixed-method outcome evaluation using a non-experimental pre-posttest design. However, based on the low sample size, the research study design shifted to a descriptive study with a greater focus on process evaluation. There was limited data collected from caregiver pre surveys, caregiver and child interviews, and core site staff surveys. Also, due to the concern about confidentiality issues in the Winnebago tribal community, composite case scenarios were created from the individual cases rather than use a traditional qualitative case study approach.

The evaluation research design and human subject protocols were reviewed and approved by two Institutional Review Boards: the Winnebago Tribal IRB at Little Priest Tribal College and the University of Texas at Austin.

Procedures

In order to recruit families, the Site Implementation Manager (SIM) worked with the Winnebago Child and Family Service (CFS) agency to determine eligible children and youth. Outreach was made to them to see if they were interested in participating in the research study. Figure 2.4. provides a summary of outcome evaluation procedures.

Figure 2.4. Overview of Outcome Evaluation Procedures



Written informed consent to participate in the evaluation of the FGDM meeting (Family Group Conference or Stokį) for the primary caregiver and child was obtained from the caregiver by the FGDM Coordinator. A child had to be 12 years old or older to participate in the evaluation. If the primary caregiver consented for an eligible child to participate, the FGDM Coordinator met with the child to discuss the FGDM process and evaluation. If the child was interested in participating in the FGDM evaluation, the FGDM Coordinator obtained written assent for participation from the child. If the child was younger than 12 years old, or the child was 12 years old or older and did not wish to participate in the FGDM evaluation, they could still be included in the Stokį.

If the primary caregiver decided to participate in the Stokį, the FGDM Coordinator helped the primary caregiver identify additional family or community members in the child's life who could possibly participate in the Stokį with the child and caregiver. This process was family-driven and facilitated by the FGDM Coordinator; however, it was ultimately up to the family to decide who to invite to the meeting. This decision was a programmatic decision, and it was the responsibility of the FGDM Coordinator and Winnebago CFS to follow agency protocols and ensure the safety of the child and family throughout this process.

Once possible attendees were agreed upon, the primary caregiver contacted each relevant individual to see if he/she was willing to attend the Stokį. The FGDM Coordinator was available to explain the study and/or answer questions to any of the individuals identified by the caregiver. To avoid influencing participation, the FGDM Coordinator did not contact relevant individuals directly about participating in the intervention, only to prepare them once they had agreed to participate.

The FGDM Coordinator implemented the Stokį with children who served as the subject of the meeting, primary caregivers, family members, and relevant adults and children. All participants in the Stokį received a meal provided during the meeting.

After the Stokį, all present adults and youth (12 and older) participating in the evaluation were asked to complete the FGDM Participant Satisfaction Survey. This survey took approximately 10 minutes to complete. Additionally, the FGDM Coordinator completed the FGDM Coordinator Summary Survey that contained questions about the outcome of the meeting, attendee information, and model fidelity issues.

After a Stokį, additional meetings were warranted if no plan was decided. In that event, the FGDM Coordinator coordinated with the primary caregiver and child per the FGDM protocols to plan and hold additional meetings. Participants were surveyed and compensated for their first Stokį, and in subsequent Stokį they were asked to answer a brief program (not evaluation) survey. FGDM Coordinators were asked to complete an additional FGDM Coordinator Summary Surveys and follow the same protocol above for storing and sending materials to the research team.

Six months after the first Stokį, the FGDM Coordinator contacted the consenting primary caregiver to schedule the Caregiver Post Survey and the Caregiver Post Interview with a researcher. The Tribe requested for these interviews and surveys to be completed face to face. The FGDM Coordinator then coordinated a time to have a researcher conduct the 30 minute Youth Process Interview in person with the youth.

If the primary caregiver of the child had changed over the course of the intervention, the FGDM Coordinator also contacted the current primary caregiver to ask if that individual was interested in completing the Caregiver Post Survey and Interview.

MODIFIED PROCEDURES

Due to the low sample size in the timeframe of the implementation, the research team added an additional process evaluation component in order to best provide information about the FGDM. Case studies were created with the data gleaned from the 7 families that had caregiver consent and youth assent to participate in the study. These case studies were utilized to examine the breadth of experiences among this population during the process of FGDM. Although all cases fit within the parameters outlined for selection, were referred the same way, and participated in the same basic process for FGDM, their individual circumstances varied greatly. From the 7 case studies whose consent forms were obtained, these kinds of family situations were determined.

USABILITY TESTING

Due to turnover in staff and change in leadership, the usability testing had a very late start and did not begin until Year 4 of the project when the first family was referred and consented to participate. Two of the seven families were a part of the usability testing.

The Winnebago site made four changes as a result of usability testing. First, the team recognized that the nearly complete turnover in casework staff made a re-orientation to the evaluation project and FGDM practice necessary. As stated there were 5 SIMs involved in this site so onboarding a new SIM took time and delayed outreach efforts to families.

Second, the CFS leadership changed the case-flow process from requiring the CFS caseworkers to refer families to FGDM to having FGDM Coordinators "in-reach" to CFS caseworkers and then filter out families that were ineligible. The FGDM Coordinators had to make the extra time to contact the CFS caseworkers and set up meet times to go through case referrals and determine those families with youth eligible to participate in the research study.

Third, the Team modified the tracking documents to distinguish each of the four phases of the FGDM model. Tracking was broken down into Outreach, Preparation, Stokį, and Follow up. Fourth, the Team set specific days and timelines for completing the tracking tool and for sending data to the evaluator.

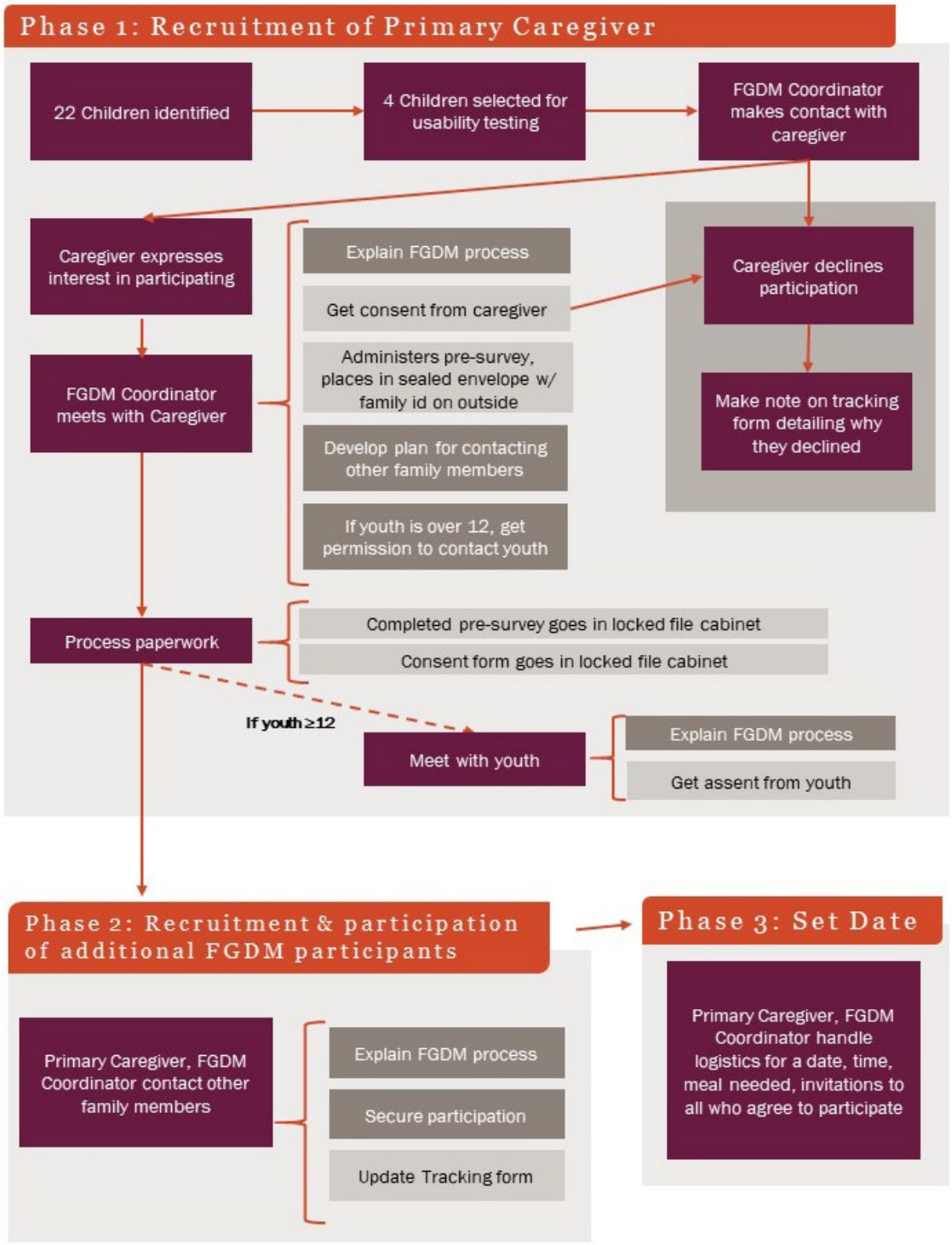
RECRUITMENT

Recruitment protocols for the evaluation followed the procedures outlined in Figure 2.5. The Tribe identified 22 eligible children between the ages of 2-19. The FGDM Coordinator made contact with the caregiver for each family. If a caregiver declined to participate, the FGDM Coordinator should have noted that on the tracking form, including why they declined. If the caregiver expressed interest in participating, the FGDM Coordinator met with the caregiver to: explain the FGDM process; get consent from the caregiver; administer the pre survey; develop a plan for contacting other family members and get permission to contact youth over the age of 12. After the meeting, the FGDM Coordinator processed all the paperwork including putting documents in locked file cabinets. If a youth was age 12 or older and the FGDM Coordinator had permission, they would meet with the youth to explain the FGDM process and get assent from the youth.

The next step in recruitment was to find additional family members, providers, and individuals from the youth's support system to participate in the Stokį. The primary caregiver or the FGDM Coordinator would contact other family members to explain the FGDM process and secure participation. The FGDM Coordinator would update the tracking form.

The final phase of recruitment involved setting a date for a Stokį, ensuring that all recruited participants were invited, and handling the logistics of scheduling, location, and ordering food.

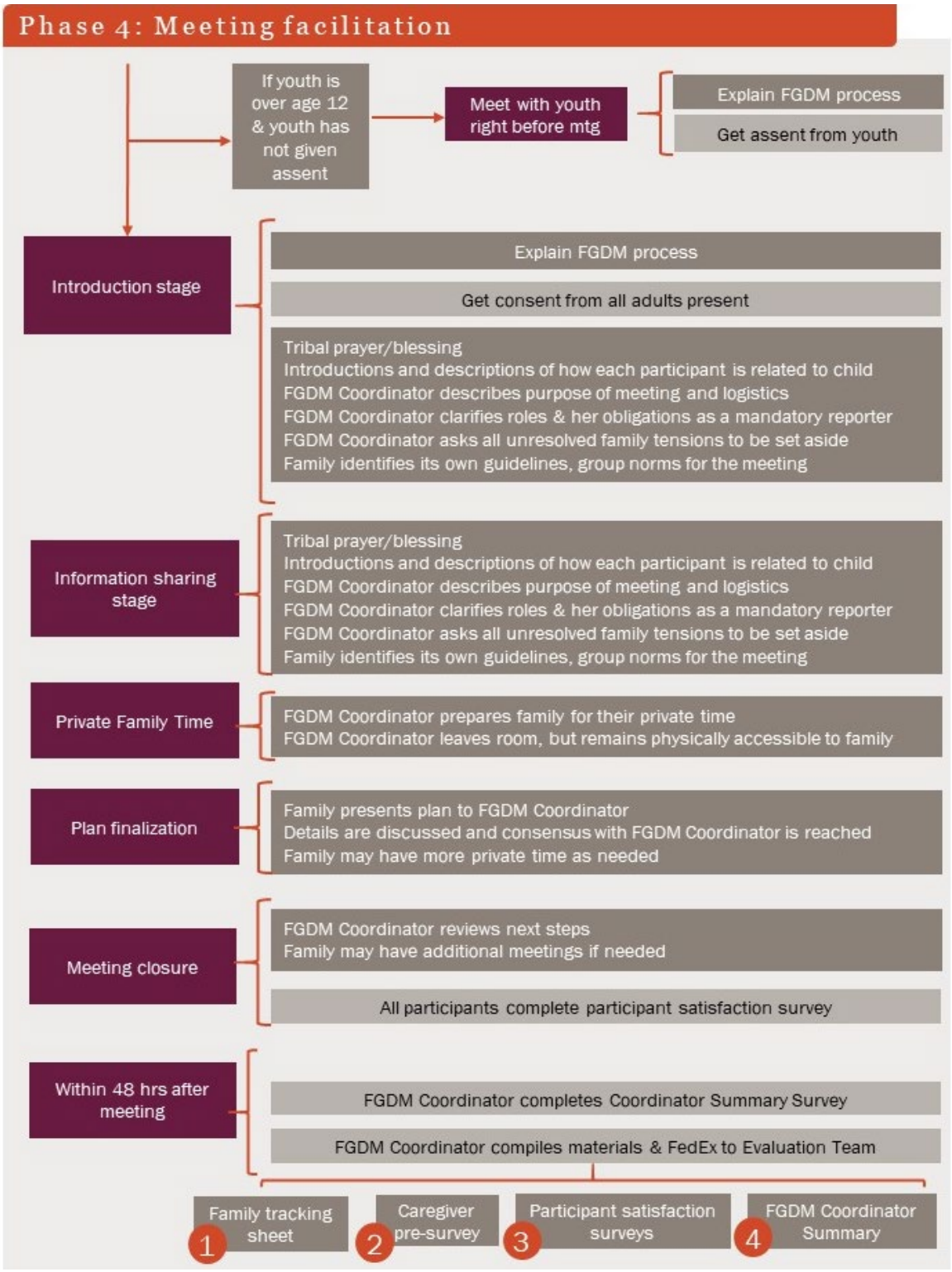
Figure 2.5. Evaluation of Recruitment Protocols



ADHERENCE

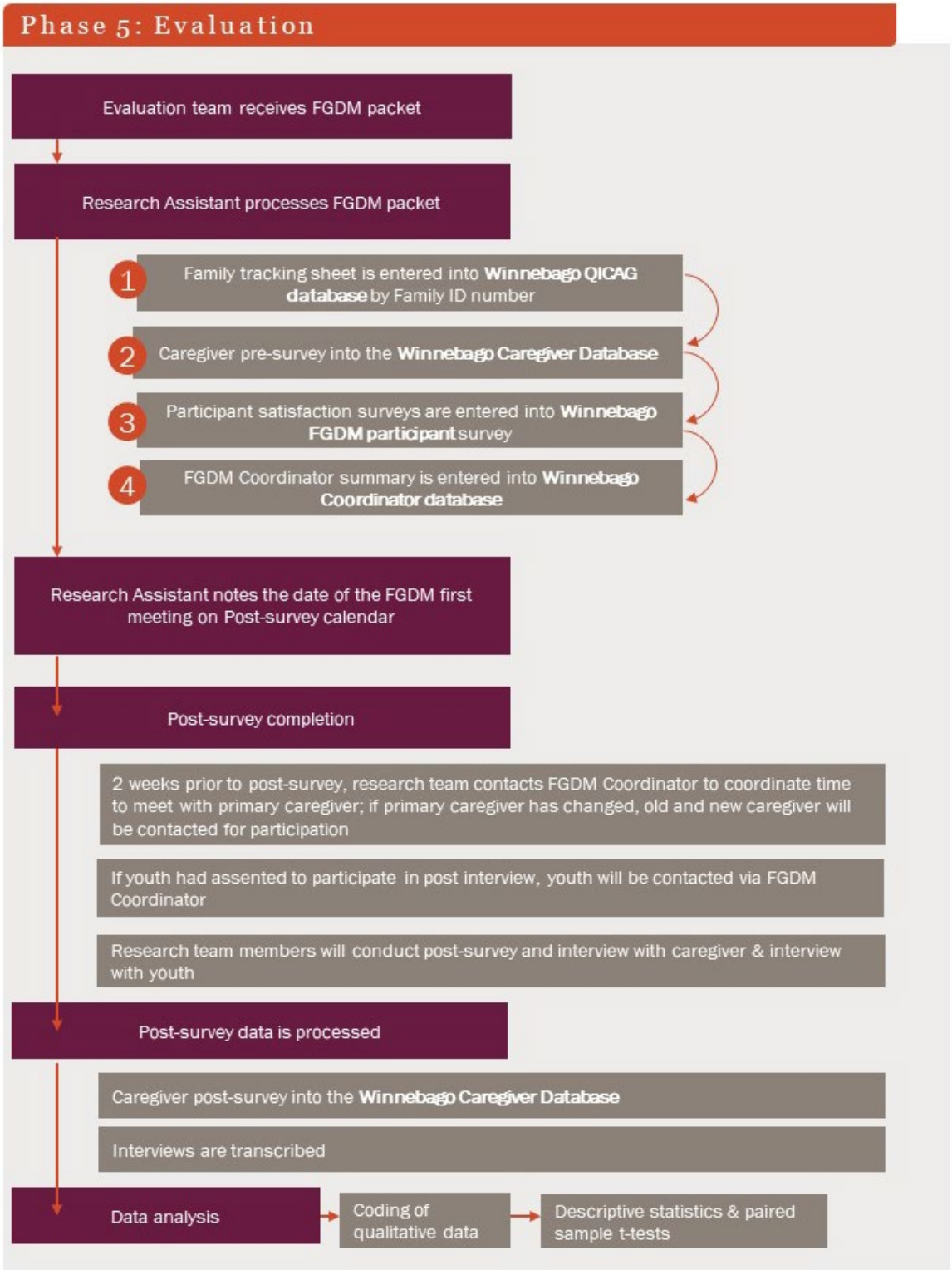
In addition to the evaluation recruitment protocols, the Winnebago site team and evaluation team worked to develop detailed procedures for collecting and storing data. Figure 2.6 details the study protocol that the site followed when holding meetings.

Figure 2.6. Evaluation Protocols for Meeting Facilitation



In addition to protocols for the meeting facilitation and data collection, the evaluation team followed protocols related to storage of data, data entry and data analysis. These procedures are detailed in Figure 2.7.

Figure 2.7. Protocols for Evaluation Phase



Measures

PROCESS MEASURES

Measures for the process evaluation included: participant satisfaction survey, worker summary, core staff survey, and weekly case notes.

Family Group Decision Making Participant Satisfaction Survey

The Participant Satisfaction Survey was a questionnaire filled out by the participants who attended a Stokį (Family Group Conference). The 25-item questionnaire asked questions about roles, the Stokį, FGDM Coordinator involvement, child and family needs, and permanency planning. This survey was designed to take 10 minutes to complete. It asked participants about their experience, reflections, and feelings after the Stokį.

FGDM Coordinator Summary Survey

After the initial Stokį, the FGDM Coordinator completed the FGDM Coordinator Summary Survey within 48 hours. This survey summarized the meeting outcomes and assessed any fidelity issues related to the FGDM model. The survey took 15-45 minutes to complete depending on the FGDM Coordinator and the complexity of the Stokį.

Surveys of Core Staff

The members of the core site staff at the Winnebago Child and Family Service Agency were asked to fill out a 20-item questionnaire about their roles and experiences on the project, and perceptions of reaching short term and long term outcomes. Given the low sample size, this survey was added at the end of the project to provide more context to the impact of the project.

Case Notes

From the beginning of the FGDM procedure where family recruitment and outreach began through to the end of the FGDM procedure of follow up, weekly reports were given by the Winnebago site FGDM Coordinators. The two FGDM Coordinators reported weekly family updates, which provided detailed case notes. These case notes were used to create case scenarios to examine patterns and themes across cases and to contribute to the process evaluation efforts of the team and provide a context of the cases with limited outcome evaluation data.

There are three measures that were used to assess outcomes. First, a caregiver survey was used to assess perceptions of the primary caregiver. The remaining outcome measures were captured in the qualitative interviews of the current primary caregiver and youth.

Caregiver Pre-Post Survey

The Caregiver pre-post survey obtains information about: demographic information and relationship questions about the child and family, family wellbeing, child wellbeing, caregiver wellbeing, and services. Standardized measures include Adverse Childhood Experiences (ACES), Behavior Problem Index (BPI), the Belonging and Emotional Security Tool (BEST), Brief Resilience Scale (BRS), Caregiver Strain Questionnaire, Education Outcomes, and Illinois Post Permanency Commitment Items.

Adverse Childhood Experiences (ACEs)

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

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 behavior. The BPI contains two subscales: the BPI Internalizing Subscale (11 items) and the BPI Externalizing Subscale (19 items) which are used to measure a child's tendency to internalize problems or externalize behaviors.

Belonging and Emotional Security Tool – Adoption and Guardianships (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).

Brief Resilience Scale (BRS)

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

Caregiver Strain Questionnaire – FC/AG22

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

Education Outcomes

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

Historical Trauma Scale

The Historical Loss and Historical Loss Associated Symptoms Scale was selected and added to the survey administered to the Winnebago Tribe because of the acknowledgment of the historical trauma that affects tribal members in Native American populations. This measure was developed and tested with American Indian parents in the Midwest. Testing of the measure indicated high internal reliability. The scale is significantly correlated with symptoms of historical loss including anxiety/depression and anger/avoidance.

The Historical Losses Scale includes 12 items related to historical trauma and unresolved grief (Whitbeck, Adams, Hoyt & Chen, 2004). The Historical Loss Scale is measured from never (1) to several times a day (6), and the Historical Loss Associated Symptoms Scale is measured from never (1) to always (5). While five cases are too few to calculate internal reliability for a scale, the analyses were run for comparison to the original research. For both scales, the Cronbach's alpha coefficients were similar to those found by Whitbeck et al. (2004). For the Historical Loss Scale, the possible range of scale values is 12-72, with higher values indicating more frequent thoughts of historical loss.

Illinois Post Permanency Commitment Items

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

Protective Factors Survey (PFS)

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

In addition to the standardized measures listed above, the Winnebago site included several study-developed questions related to caregiver support, services received, and the helpfulness of service and grief and loss.

Communication about Permanency

A series of questions asked about the child's communication about adoption/guardianship/foster care, communication with birth parents and efforts of the caregiver to become the permanent caregiver.

Grief and Loss

Caregivers were asked 20 questions to assess knowledge of grief and loss in relation to adoption and foster care. Evaluators developed these questions based on the principles of FGDM which ask families to acknowledge grief and loss within their discussions.

Service Items

Families were asked whether they used various cross-sector services in the past 6 months, and if so, how helpful those services were. Additionally, they were asked to identify the top services and supports, top services that are most needed but hard to get or not available, and the top barriers.

Caregiver Post Interview

The Caregiver Post Interview was a semi-structured interview intended to last 30-60 minutes. The interview questions focused on how the FGDM impacted the youth's permanency outcomes, the family dynamics, and opinions on whether FGDM is a good fit for the Tribe.

Youth Interview

The youth interview lasted roughly 30 minutes and was audio-recorded. Youth were asked where they are currently living, how they felt about the FGDM process and if there were changes in their life since the Family Group Conference.

Findings

This section describes the population of families that received outreach from the Winnebago Tribe, participant characteristics, process evaluation findings, outcome evaluation findings, and cost evaluation findings.

Sample Frame and Participant Profile

The Winnebago Tribe originally identified a total of 22 children at least five years old that met the criteria. The identification of these cases was based on the child/youth lacking a permanency plan after 18 months in care. It should be noted that cases could move in and out of eligibility status depending on changing circumstances and decisions from Child and Family Services (CFS) and the Tribal Court.

UPTAKE

The first three family referrals were given in the first quarter of year four, and consent for the first family was completed during that quarter. One family could not be reached, and a third did not give consent. The second round of four families were referred in the second quarter of year four, and the next four families were referred in the third quarter of that year. The final families (n=17) were referred in the last quarter of year four, for a total of 28 cases.

Of the 28 cases, four were withdrawn by the CFS caseworker or dropped as the youth outside the service area. Because youth may have run away or moved to another state or were in locked facilities, 12 cases were determined to be ineligible by the end of study recruitment (second quarter of year five), and consent was not obtained for five cases. The resulting sample consisted of seven families.

Across the seven cases, there were three successfully scheduled conferences and one successfully scheduled follow-up conference. There were an additional ten attempts to schedule conferences that were unsuccessful, and two more unsuccessful attempts to schedule follow-up conferences. Barriers to scheduling conferences children placed in residential programs/congregate care setting, discord, delays, and family and community emergencies.

ADHERENCE

There was adherence to protocols for procedures to collect and store data such as the participant satisfaction surveys and worker summary survey after the completion of the Family Group Conferences. See Figure 2.5. Evaluation Protocols for Meeting Facilitation. Additional adherence to protocols was tracked through a tracking form developed by the Winnebago site team and weekly phone calls with the Winnebago site team and the evaluation team helped ensure all issues were managed in a timely manner. Given that the sample was so small, the team was able to jointly discuss each case and ensure protocols were followed or adapted per the agreement of the site and evaluation team.

Participants

The sample included seven caregivers and seven youth who consented and agreed to participate in the research study. However, only three families completed a Stokį. Because of the low sample size, it is not appropriate to report demographics except in broad categories in order to protect participant confidentiality. Given that specific demographics could not be reported, the evaluation team decided to use a modified case study approach to provide additional context to the cases. In this section, some demographic information is reported followed by a compilation of four cases to further illustrate participant characteristics.

GENERAL DEMOGRAPHIC INFORMATION

The caregivers were both male and female, ranging in age from 37-62 years old. Their marital status included single and never married, married, divorced, and widowed. Some had a high school degree, whereas others had a 2- or 4-year college degree. More than half had income under $15,000 whereas only one had income as high as $30,000-$45,000.

The average age of the identified children at the time of referral was 15 years (ranging from 14-16), although children from ages 12-19 were eligible for referral. Four of the seven were female. Three were male. Five identified children had relative caregivers at the time of the referral, and three were reported to be in contact with a biological parent. Four of the seven cases had siblings that were impacted by their case. All of the identified youth were in congregate care at some point.

Some of the cases that were eligible for the study involved youth currently in safe environments but in need of supports. This might be due to alternative arrangements falling through, a new investigation from Child and Family Services, or a lack of knowledge of restrictions or resources on the part of the caregiver. Housing issues were a common reason for needed supports. There were many homes where the caregiver was eligible, but other adult(s) in the household were not able to pass the background check. There was also a housing shortage due to the physical conditions of the home – some issues were about age and maintenance (like cracked foundations), while others were about methamphetamine use that permeated the drywall, wood, and carpeting requiring extensive renovation to make the home safe for children.

HISTORICAL LOSS

With only seven caregivers represented in the sample, it is not possible to provide a detailed profile of risk and protective factors present in the family. However, given the complex and oppressive history native populations have with child welfare systems, the data related to historical trauma is presented here.

The Historical Loss Scale asked caregivers to rate how often they think about the following historical losses (Table 2.1). Response options were: never, yearly, monthly, weekly, daily, and several times a day. The possible scale scores range from 12 to 72, with higher values indicating more frequent thoughts of historical loss. The caregivers' responses varied from 12 to 54, with an average of 32.8. Losses with the greatest frequency of thought were: losses from the effects of alcoholism/drug addiction on our people, loss of culture, and loss of respect by children and grandchildren for elders. The least frequent thoughts were for the loss of land and the loss of families from the reservation to government relocation.

Table 2.1. Historical Loss Scale

MEASURE ITEM (1=NEVER, to 6=SEVERAL TIMES A DAY)	TOTAL N	MIN	MAX	MEAN
LOSS OF OUR LAND	6	1	2	1.17
LOSS OF OUR LANGUAGE	6	1	6	3.00
LOSING OUR TRADITIONAL SPIRITUAL WAYS	6	1	4	2.33
THE LOSS OF OUR FAMILY TIES BECAUSE OF BOARDING SCHOOLS	6	1	3	1.67
THE LOSS OF FAMILIES FROM THE RESERVATION TO GOVERNMENT RELOCATION	6	1	2	1.33
THE LOSS OF TRUST IN WHITES FROM BROKEN TREATIES	6	1	6	3.67
LOSING OUR CULTURE	6	1	6	3.00
THE LOSSES FROM THE EFFECTS OF ALCOHOLISM/DRUG ADDICTION ON OUR PEOPLE	6	1	6	3.83
LOSS OF RESPECT BY OUR CHILDREN AND GRANDCHILDREN FOR ELDERS	6	1	6	3.83
LOSS OF OUR PEOPLE THROUGH EARLY DEATH	6	1	6	3.83
LOSS OF RESPECT BY OUR CHILDREN FOR TRADITIONAL WAYS	6	1	6	3.50
TOTAL (12 TO 72)	**6**	**12**	**54**	**32.8**

The Historical Loss Associated Symptoms Scale has two subscales: anxiety and anger (Table 2.2). The anxiety subscale consists of 5 questions, with possible scale values ranging from 5 to 25. The range of values calculated from the caregiver surveys was between 5 and 13, with an average of 7.4, indicating a low level of anxiety and depression related to historical losses. Sadness or depression was the most prevalent emotion, and loss of sleep was the rarest (no one reported loss of sleep). The anger subscale possible values ranged from 7 to 35, with calculated scores between 7 and 28 (and an average of 12.8). The caregivers were most likely to report a desire to avoid places or people that remind them of historical losses, and least likely to report feeling shame.

Table 2.2. Historical Loss Associated Symptoms Scale

MEASURE ITEM (1=NEVER, 5=SEVERAL TIMES A DAY)	TOTAL N	MIN	MAX	MEAN
SADNESS OR DEPRESSION	6	1	5	2.00
ANXIETY OR NERVOUSNESS	6	1	3	1.33
LOSS OF CONCENTRATION	6	1	3	1.33
FEEL ISOLATED OR DISTANT FROM OTHER PEOPLE WHEN YOU THINK OF THESE LOSSES	6	1	4	2.00
A LOSS OF SLEEP	6	1	1	1.00
ANXIETY SUBSCALE SCORE (5 TO 25)	**6**	**5**	**13**	**7.4**
ANGER	6	1	5	2.00
UNCOMFORTABLE AROUND WHITE PEOPLE WHEN YOU THINK OF THESE LOSSES	6	1	5	1.67
SHAME WHEN YOU THINK OF THESE LOSSES	6	1	2	1.17
RAGE	6	1	3	1.67
FEARFUL OR DISTRUST THE INTENTIONS OF WHITE PEOPLE	6	1	5	1.83
FEEL LIKE IT IS HAPPENING AGAIN	6	1	5	2.00
FEEL LIKE AVOIDING PLACES OR PEOPLE THAT REMIND YOU OF THESE LOSSES	6	1	5	2.67
ANGER SUBSCALE SCORE (7 TO 35)	**6**	**7**	**28**	**12.8**

Interviews and a review of case notes resulted in four different types of cases. As previously stated, these cases do not represent a specific youth and family. Rather, they are a compilation of characteristics across cases to maintain confidentiality while also providing additional context to understand the families involved in this evaluation. The four case types are 1) youth living with a grandparent, 2) youth living with an ineligible parent, 3) youth living with a non-relative foster parent, and 4) youth living informally with a non-relative caregiver.

Youth Living with Grandmother

The most common scenario was that the youth was living with their grandmother. This aligned with what the Elders described, where the extended family took in a child whose parents were unable to raise them. Grandmothers have the role of caretaker and teacher in the Tribe (according to the Elders). However, they also struggled with their own issues, and often children had issues that were difficult for the grandparent to control, such as anger and substance abuse.

Youth Living with Ineligible Parent

This scenario was when the youth lived with an ineligible parent. The most common reason for ineligibility was substance abuse by the parent. In combination with child substance abuse, this often led to an unsafe home environment with fewer barriers to continued substance abuse. If the youth had strong attachments to that parent, it could increase the problems for that case, leading to greater acting out, disruption of community supports, and even causing the youth to run away. The parent may also be very resistant, avoiding contact with FGDM Coordinators, and not appearing to scheduled meetings.

Youth Living with Foster Parent

This scenario was when the youth lived with a non-relative, such as a foster parent. Within these cases, the foster parents were protective and wary of having strangers in their home. They also were concerned about strengthening ties between the youth and their families, and potentially opening old wounds. This was especially true with youth that were prone to self-harm.

Youth Living with Non-Relative Caregiver

A less common scenario, but one that closely aligns with the Elder interviews, is the non-relative caregiver. This caregiver is not technically a foster parent, but rather someone in the community who was in contact with a child who needed a stable home. For this to occur with a child in foster care, they have to have the support of the CFS caseworker and be eligible for guardianship by the Tribal Court (which means being able to pass the requirements for safety and stability). As the Elders stated, historically, people who are willing and able to care for a child took them in when they needed a home.

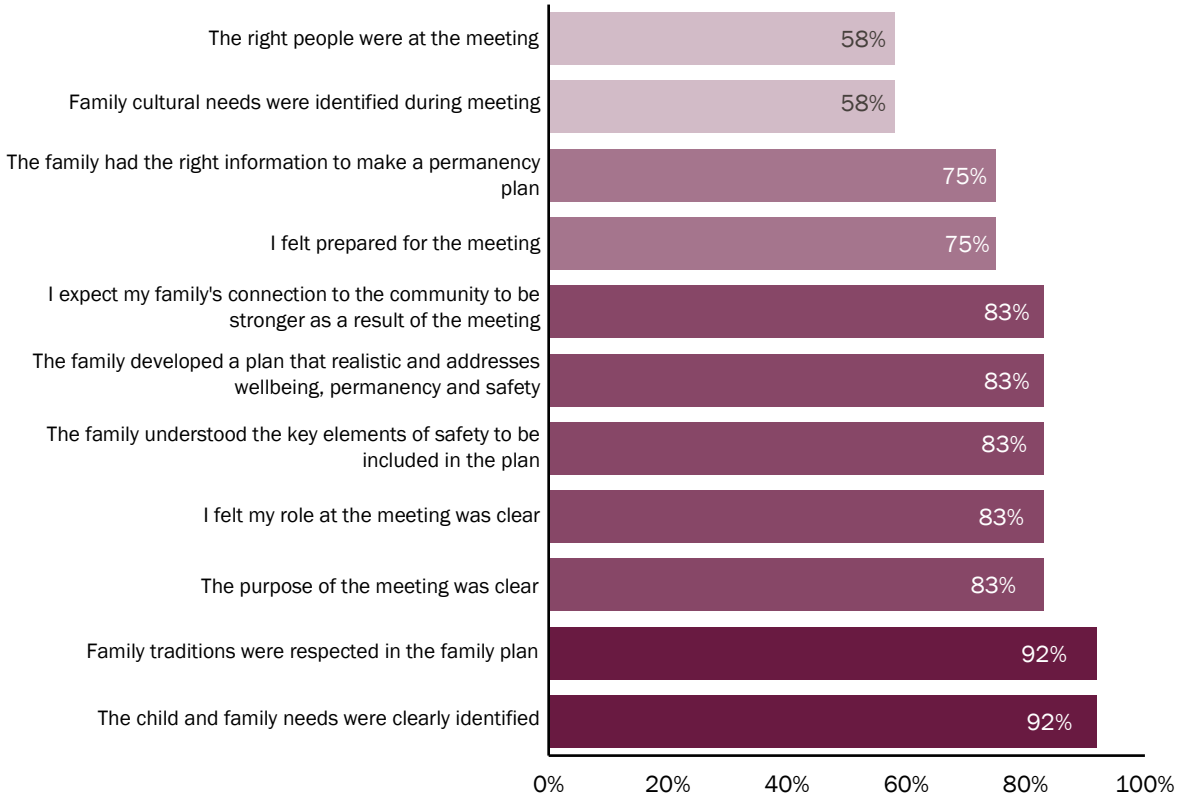
Process Evaluation

A process evaluation "determines whether program activities have been implemented as intended and resulted in certain output" (Center for Disease Control Prevention, 2015, p. 1). Initially, there were three components of the process evaluation: participant satisfaction survey, FGDM Coordinator Summary Survey, and case notes as explained on page 22. A survey of core staff as explained on page 22 was added to the process evaluation, given the low sample size and need to better understand the processes.

PARTICIPANT SATISFACTION

From the three Stokį (Family Group Conferences) that occurred, twelve participants, who were the caregivers, youth, family members, and others participating in the conference, completed the participant satisfaction survey. In general, participants reported they were satisfied with the Stokį.

Figure 2.8. Participants Who Strongly Agreed or Agreed with Statements



Participants were least satisfied with the family cultural needs being identified during the Stokį and that the right people were at the meeting. For both items, only 58% of participants were satisfied that cultural needs were met and/or the right people were at the meeting. Three-quarters of participants were satisfied and felt that they had enough information to make a good permanency hearing. Overall, 75% of participants felt they were prepared for the conference.

Most participants (83%, n=10) felt satisfied with the following factors: that the purpose of the Stokį was clear to them; that the family's understanding of the key elements of safety to be included in the plan was agreed upon; that the family developed a plan that is realistic and addresses the wellbeing, permanency, and safety of the child; and that the family's connections to the community will become stronger as a result of the Stokį.

Finally, almost all participants (91.7%, n=11) felt satisfied with the following factors: that during the Stokį, child and family needs were clearly identified; and that family traditions were respected in the family plan in a way that was consistent with the participants' cultural values and beliefs.

FIDELITY

Fidelity to the FGDM process was recorded by a survey and form the FGDM Coordinator completed after each Stokį. The FGDM Coordinator Summary Survey collected information about the six core components of the process and whether the FGDM Coordinator was aligned with those core components. The FGDM Coordinator Summary Survey form recorded information about the purpose and outcome of the meeting.

The first core component is that an independent coordinator conducts the Stokį. Two FGDM Coordinators conducted the three conferences. In each case, the FGDM Coordinator self-rated as above average or excellent in relation to understanding: empowering families, importance of groups in formulating safety and care plans, agency limitations in creating permanency plans, importance of building the family's capacity to protect its children, follow-up efforts after the initial Stokį, agency and community resources available to support the family group, and foundational knowledge of cultural competency.

The second core component is that the independent coordinator is charged with creating an environment in which transparent, honest and respectful discussion occurs. Each of the FGDM Coordinators reported that they agreed or strongly agreed with the following statements: 1) Children have a right to maintain their kinship and cultural connections throughout their lives, and 2) Children and their parents belong to a wider family system that both nurtures them and is responsible for them.

The third core component is that the child protection agency personnel recognize the family group as their key decision-making partner, and time and resources are available to convene this group. Each of the FGDM Coordinators reported that they agreed or strongly agreed with the following statements: 1) The family group, rather than the agency, is the context of child welfare and child protection resolutions; 2) All families are entitled to the respect of Winnebago Child and Family Services (CFS), and Winnebago CFS needs to make an extra effort to convey respect to those who are poor, socially excluded; and 3) Winnebago CFS has a responsibility to recognize, support, and build the family group's capacity to protect and care for their young relatives.

The fourth core component is that family groups have the opportunity to meet on their own, without the statutory authorities and other non-family members present, to work through the information they have been given and formulate their responses and plans. Each of the FGDM Coordinators reported that they agreed or strongly agreed with the following statement: Family groups know their own histories, and they use that information to construct thorough plans.

The fifth core component is that when agency concerns are adequately addressed, preference is given to the family group's plan over any other possible plan. Each of the FGDM Coordinators reported that they agreed or strongly agreed with the following statement: Active family group participation and leadership is essential for good outcomes for children, but power imbalances between family groups and child protection agency personnel must first be addressed.

The sixth and final core component is that referring agencies support family groups by providing the services and resources necessary to implement the agreed-on plans. Each of the FGDM Coordinators reported that they agreed or strongly agreed with the following statement: Winnebago CFS has a responsibility to defend family groups from unnecessary intrusion and to promote their growth and strength,

In addition to the FGDM Coordinator Survey, a meeting summary was completed after each Stokį. The meeting summary detailed the purpose of the meeting, issues the family wanted to address, decisions that were made and whether all issues were addressed. The Stokį purposes were centered on permanency options and educational needs of youth. For each family, decisions were made regarding how to support the youth and in each case, the FGDM Coordinator reported that they felt the family had addressed most of the issues.

CORE SITE STAFF PERCEPTIONS OF OVERALL PROJECT

The members of the core site staff at the Winnebago CFS were asked to fill out a 20 item questionnaire about their roles and experiences on the project, and perceptions of reaching short term and long term outcomes. The four staff who worked on the project completed the questionnaire.

Core site staff were generally positive about the project and felt as though the project helped families. Core site staff noted that their biggest success is that they were able to expand the definition of customary adoption in the Tribal Code and that they felt successful in engaging with the competencies needed to do this work.

Challenges encountered during the project related to staff turnover. There were multiple changes in the Site Implementation Managers that made it difficult for the site to move the project forward. Core site staff also reported that the structure of the project was difficult for them at times. One noted,

> **"The work is very process-driven and can feel like the site does not have as much input and flexibility that is needed to fully take ownership. Oversight and directives from consultants and funders can be overwhelming at times."**

Core site staff also noted that they felt there were cultural needs that should be considered in future projects with Tribes. A respondent noted,

> **"There are considerations that need to be considered when working with tribal communities that weren't necessarily thought about. There were times throughout the grant where we felt a cultural disconnect."**

Despite the challenges, the core site staff felt like the project will be successful in the long term for families. They noted that families had already learned about permanency options and with more time, permanency outcomes will improve.

Scheduling Issues

Four of the cases with scheduled Stokį faced barriers to scheduling. These barriers include not being able to locate the identified child on run-away status and/or family members residing in institutions and unable to participate. For the cases where the child was in an institution, the FGDM Coordinators coordinated with the institution to plan and facilitate Stokį. For example, the plan was for one child to participate via video conference, and another meeting was scheduled near the institution to make transportation of the child easier. During case consultations, common recommendations from the consultants were that Stokį should occur either before entry to an institution (if known in advance) or during their time inside, with a follow-up meeting after exiting the institution to review the case and assess progress. In one case, it was explicitly noted that if the family was doing well, the follow-up Stokį could be scheduled as a celebration instead.

Sibling Involvement

Four of the cases involved siblings of the identified children. While the siblings were not considered the focus, they were included in the planning and case consultation if also involved in the foster care system. Two cases included a sibling in a conference plan, with one facing the potential added challenge of the siblings both being institutionalized.

More Voices Desired

Similar to the feedback on the participant surveys, a theme from the review of case notes was that more voices should be included in the Stokį. Two cases specifically noted a desire to have more voices involved in the Stokį or follow-up Stokį.

Supporting Family

There were interesting themes noted regarding family supports and cultural values. First, none of the cases had identified specific needs to support the caregiver even though the youth, in many cases, had high-level needs or were in placements where the caregiver could have more support. Additionally, none of the families decided on a back-up plan in case the decisions made at the Stokį fell through. There were no notes about specific cultural additions requested by the families (such as prayer or smudging). However, families did demonstrate a commitment to the identified child. In the case of a child who had run away, it was recommended that a Stokį be held among their family/kin to help show their support and identify opportunities for permanence for when the child resurfaces. Another Stokį would be scheduled when the child was found.

Outcome Evaluation

The outcome evaluation for this project was designed to collect substantial information from caregivers that aligned with the identified outcomes of the study. However, given that the sample size includes only seven families, a quantitative analysis was not possible. Only six pre surveys and one post survey were collected from caregivers. Two interviews of youth and one caregiver interview were also completed. Thus, measuring a change in targeted outcomes is not possible using quantitative data. However, we do attempt to provide some context related to both the short- and long-term outcomes using very basic descriptive data, information from interviews, activities that occurred during implementation and insights from the case studies.

INCREASED KNOWLEDGE OF PERMANENCY OPTIONS

There is limited evidence that the FGDM program increased knowledge of permanency outcomes among families. All of the caregivers who completed the caregiver pre survey felt extremely prepared to meet the needs of the youth in their care. Three out of five youth were in contact with their birth parent at the time of the survey. Half of the caregivers said they had considered adopting or becoming the legal caregiver the youth in their care.

However, the Winnebago core site team reported common misunderstandings of caregivers involved in child welfare. For example, the interviewed caregiver reported discussing permanency options with the youth in her care and thought permanency was legal adoption. FGDM Coordinators reported on their core site staff survey that their impression is that the families going through the FGDM process were gaining a better understanding and that this helped them work with the courts. One core site staff member said,

> **"I feel our families understand more and better comprehend what the courts are asking for or what the options are."**

INCREASED PROTECTIVE FACTORS

Given the limited data, we cannot conclude that protective factors were impacted. The caregiver survey included specific questions about protective factors, but without post survey data, change cannot be calculated. However, the Winnebago site team and the youth who were interviewed reported improved protective factors.

Both youth who were interviewed described supportive members of their family that they could reach out to when in trouble. They both also reported feeling involved in the decisions about their living situations and feeling heard during the Stokį (Family Group Conference).

Additionally, Winnebago core site staff noted that involving family in the child's life helped create a sense of community. For example, the staff noted that the Stokį was hard for family members who had been disconnected with the youth. Once that family member re-engaged with the youth, there was more connection where adults assumed responsibility for being involved in the child's life. One core site staff member noted,

> **"The project increased protective factors by involving the larger extended family and support network in the child welfare case."**

INCREASED KNOWLEDGE OF WINNEBAGO SPECIFIC PATHWAYS

The final short-term outcome listed on the linear Logic Model was increased knowledge of Winnebago specific pathways for permanency. As with the other short-term outcomes, there is no evidence supporting increased knowledge given the low sample size. However, there is potential for increased knowledge. With the support of this project, the Winnebago site revised the Tribal Code to reflect culturally appropriate permanency options. Specifically, guardianship was strengthened as a permanency option, and customary adoption was clarified in the Tribal Code, as well as Ho-Chunk relationship preferences that best matches what the Tribal Elders described, and allows youth to stay where they feel like they belong. With these structures in place, the FGDM Coordinators developed a brochure of permanency options for use in the outreach and preparation phases of FGDM. Core site staff described the ongoing growth of their own knowledge, and how awareness of the program is growing in the community. Overall, the core site staff noted that this project highlighted historical issues the Tribe has had with the child welfare system. One core site staff member said,

> **"I think this project shed a light on our community's trauma and conflicted relationships with 'systems.' We have a long way to go to really engage and empower our families. It is going to take time and patience to get there."**

INCREASED CONNECTEDNESS

Increased connectedness was a desired outcome at the different levels described in the circular Logic Model. However, there is also not enough evidence to conclude that connectedness increased. For youth, the team wanted more connections. For families, they wanted more social support and trust in professionals. For their community, they wanted better community partnerships. The intervention itself helps increase connectedness for youth and families. In the case notes, there were many examples of initially resistant youth and/or families increasing the number of identified family members to be involved in the conferences. While this poses significant challenges for the FGDM Coordinator in terms of scheduling and decision making, the process increases connectedness for those involved. Further, the process of outreach and preparation, combined with broadening support networks, is helping to build greater trust in professionals and community partnerships. While the FGDM Coordinator faced distrust from some families in the process of doing their jobs, there was an increase in communication and trust as the program continued. One core site staff member noted,

> **"The children who have had conferences have felt cared about and included. For some of them, it was the first time they felt listened to."**

LONG TERM OUTCOMES

Because of the late start-up and limited time to implement the intervention, there is a no data on whether Ważokį Wošgą Gicą Wo'ųpį improved long term outcomes related to child and family wellbeing. The long term outcomes were: 1) increased permanency outcomes, 2) decreased time to finalization/time in care; 3) increased placement stability; 4) improved child and family wellbeing, and 5) improved behavioral health for children and youth. However, anecdotal evidence suggests that with more time and data, there may be changes in long term outcomes of increased permanency options with and the clarification of customary adoption and guardianship as options and the strengthening of the Tribal Code.

When asked about the long term goal of increased permanency outcomes, the core site staff reported no change in numbers, but desired outcomes that could be considered foundational for later change. One FGDM Coordinator said in the core site staff survey that they "*definitely see an increase in families coming together to support youth,*" while another staff member pointed to the greater agency of families to make decisions because of better options.

Decreased time to finalization was a goal, but the core site staff surveys and case notes point to a number of barriers outside the control of this grant. Probably the greatest barrier, as identified by a core site staff member, is the timeline imposed by the court in each case. Other barriers include the lack of stability in some placements, changed information about the family or child impacting placements, requests from caregivers for more time to commit to permanency, and child behaviors that result in facility care. As all of the youth in the intervention were in a facility for at least some part of the evaluation PERIOD, this was the most common barrier issue across cases.

Limitations

There are major limitations with this program evaluation that do not allow for any generalizability of the findings. The primary limitation is the sample size of the study. With only seven consenting caregivers and youth, there is no ability to interpret quantitative data. Qualitative data also reflects a limited number of youth and staff and thus, did not produce a rich amount of data needed for saturation.

The low sample size is reflective of the other limitations of this evaluation. First, not enough time has passed to understand the true impact of the intervention. Due to staff changes, there were significant delays in implementation. As a result, there are families who are still engaging in services and will likely engage in services in the near future. The time constraints of this evaluation did not allow enough time to capture all those families.

Even though there were seven youths and their families enrolled in the study, attrition limited the sample even further as only three families completed a Family Group Conference. Those three families are the only ones who truly completed the evaluation process and only one of the three completed a posttest. A couple of the youth were runaways or were in detention centers which made it difficult to hold family group conferences.

Cost Evaluation

The Winnebago QIC-AG project implemented an adapted version of FGDM with seven families.

Cost Evaluation Approach

The QIC-AG sites utilized a cost-effectiveness research (CER) analysis to provide information for policymakers and administrators to help maximize desired outcomes based on the associated cost of achieving them (Meunnig, 2002). Because the Winnebago site served a smaller number of youth, only basic descriptive statistics were appropriate to include in the outcome evaluation. Thus, the cost-analysis for Winnebago cannot include a cost per outcome analysis.

Assumptions, Constraints, and Conditions

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

The primary assumption underlying this cost evaluation was that the time period of implementation was long enough to achieve change in the project sites' outcome measures. We assumed that the impact of the chosen interventions would be achieved or not achieved within the timeframe of the project. However, it is likely that the intervention's true impact will not be seen until after the project period. With the Winnebago site, the federal team had ideas about timelines and benchmarks that simply did not align with the site's internal issues such as staff turnover and community pace that was more relaxed than external project timelines. As such, the intervention was not implemented with enough time to meet sample size numbers or see shifts in long term outcomes.

Another assumption is that the resource allocation captured in costs paid to sites is accurate. It is likely that staff time may be over or under-budgeted depending on the time constraints. For example, at the beginning of an intervention, more staff effort may be needed, but as a program continues, staff effort may be less intense because of the familiarity with the intervention. In the case of the Winnebago site, initial costs to run the intervention were substantial compared to the numbers of families served. With the passage of time, increased participants will likely bring those costs into a more reasonable proportion of cost per participant.

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 the Winnebago site, staff turnover at the health and human services agency impacted the program. With each change, the project team felt they were starting over with relationship and trust-building which were critical to the site.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. With the Winnebago site, cultural differences exist between federal grant requirements and tribal customs. The Winnebago tribe values balance and positivity which allows them to thoughtful and deliberate in their actions. Federal deadlines and other requirements were met at the pace of the Tribe. As such, the Tribe has established and integrated a child welfare practice that can be sustained within their community, but the numbers needed for the evaluation were lower than projected.

Cost Estimation

The next step in the cost analysis was to estimate costs the Winnebago site incurred to implement the intervention. This cost estimation includes actual costs paid to Winnebago by Spaulding for Children, on behalf of the QIC-AG.

KEY POINTS IN COST ESTIMATION

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

1. Costs should generally include all resources used and not simply the direct financial expenses spent on a program. This intervention was implemented through Winnebago's health and human services agency which had basic infrastructure including facilities, utilities, supplies, and other items. Infrastructure costs specific to the existing agency were not estimated for this cost evaluation. Rather, the specific charges to the project for facilities/office space are used. The sites also received substantial technical support from consultants and evaluators during implementation. Although the consultation was crucial to moving sites into implementation, the costs associated with the consultation will only be noted in the conclusion as additional costs for future programs to consider. Evaluation costs are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates

2. 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 Winnebago QICAG site. In other words, if funds were spent by the program, they are considered costs. Participant costs such as travel or childcare are not included because they were not provided by the program. However, other programs would need to consider those participant costs in relation to the population they intend to serve.

3. Cost estimation should include the passage of time in order to account for inflation. Given that Winnebago implemented this intervention for less than a two year period, costs did not change dramatically. The major cost that would be impacted in this short time frame is staff salary and this change is accounted for in the direct expenses that Winnebago incurred each year.

4. Both variable and fixed costs should be captured in a cost estimation. For Winnebago, 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.

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

The steps involved in the cost estimation of this analysis are described below.

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 2.3.

Collect Data on Resource Allocation

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

Estimation of Direct Costs

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

Personnel

Personnel costs totaled $31,783 for staff time allocated to the project during the implementation phase. Time for the Human Services Director (.15FTE) and Family Support Worker (.75FTE) were billed to the project during years four and five. Additionally, the site implementation manager's salary (.75FTE) was billed to the project during both installation and implementation phases for a total of $78,483. Thus, total personnel costs to the project were $110,267.

Fringe

Overall fringe for all three employees totaled $44,885. Fringe was calculated based on the Winnebago formulas for fringe rates.

Contractual Expenses

Winnebago contracted for services from seven entities. Even though the majority of these costs occurred during installation, they are included in the cost estimation because they are critical to utilizing the intervention. The Kempe Center was paid $40,835 for consultation and training in the FGDM model. The Family Services Rochester was paid $9,125 for consultation with the Winnebago staff which included observations of family group meetings and on-consultations with Family Services Rochester staff. Peter Small Bear was paid $2,740 for an on-site training on cultural congruence. The Nebraska Office of Dispute Resolution was paid $552 for basic mediation training. Coaches for Mediation was paid $2,650 to provide local expertise and mentorship in implementing FGDM meetings. The law offices of Frederiks Peebles & Morgan were paid $2,500 for a consultation to ensure that any materials and curriculum that are developed align with Tribal Code. Finally, $50 was paid to an entity for cultural consultation.

Gift Cards

Gift cards were provided to participants for completing surveys and interviews. Caregivers who completed a survey and interview were provided a $50 gift card. Family members who attended the meeting and completed a satisfaction survey were provided a $20 gift card. Youth who completed a post interview were provided a $20 gift card. A total of $2,206 was spent on gift card incentives.

Materials and Supplies

Over the implementation period, $7,828 was spent on program supplies specific to the operation of the intervention, including $32 for food for a meeting; $1,991 for FGDM supplies; and $5,805 for general supplies.

Travel

Over implementation and installation, $23,786.21 was paid for travel. A large portion of these funds was used to pay for travel costs to attend trainings.

Facilities/Office Space

A total of $19,133 was paid for facilities-related costs that are directly related to the office space for project-related staff. Existing facilities did not have space for family group meetings. Additional space had to be rented to facilitate meetings in a home-like environment.

Other Direct Charges

Other direct charges include all non-personnel direct costs that do not fit into categories listed above such as postage ($610), phones ($1,650), professional development ($6,916), and other non-specified expenses ($417).

Estimation of Indirect Costs

Indirect costs for this site were billed in a lump sum that totaled $18,282. 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 Winnebago site involved a tribal human service agency which had some infrastructure. Because the evaluation team assumed that other interested child welfare agencies would also have the infrastructure in place to run programs, we did not attempt to portion out the infrastructure costs that another agency would likely need. Likewise, we assumed that indirect costs will vary greatly by state due to the 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.

Table 2.3. Costs for Winnebago

	IMPLEMENTATION			INSTALLATION	TOTAL
	FY 2019*	FY 2018	FY 2017**	FY 2017***	
PERSONNEL					
SITE INFORMATION MANAGER	$9,180	$23,055	$31,397	$14,852	$78,484
HUMAN SERVICE DIRECTOR	$2,632	$11,467			$14,099
FAMILY SUPPORT WORKER	$6,564	$11,121			$17,684.72
FRINGE	$6,649	$18,345	$14,618	$5,273	$44,885
NON-PERSONNEL INDIRECT EXPENSES					
CONTRACTED SERVICES: KEMPE	$1,706	$10,501	$5,561	$23,066	$40,835
CONTRACTED SERVICES: FSR	$500	$8,625			$9,125
CONTRACTED SERVICES: PETER SMALL BEAR				$2,740	$2,740
CONTRACTUAL SERVICES: NEBRASKA ODR				$552	$552
CONTRACTUAL SERVICES: COACHES FOR MEDIATION				$2,650	$2,650
CONTRACTED SERVICES: FREDERIKS PEEBLES & MORGAN				$2,500	$2,500
CONTRACTUAL CULTURAL CONSULTATION		$50			$50
PROGRAM SUPPLIES: FGDM MATERIALS		$1,991			$1,991
PROGRAM SUPPLIES (FOOD FOR INTERVENTION)		$32			$32
PROGRAM SUPPLIES (GENERAL)	$1,227	$1,395		$3,600	$6,222
GIFT CARD INCENTIVES		$206		$2,000	$2,206
TELEPHONE	$444	$1,206			$1,650
POSTAGE	$34	$576			$610
PROFESSIONAL DEVELOPMENT	$3,521	$3,395			$6,916
FACILITIES/OFFICE SPACE	$1,851	$8,254		$9,029	$19,133
TRAVEL	$4,467	$11,764		$7,556	$23,786
INDIRECT COSTS	$6,459	$11,824			$18,283
TOTAL	**$45,233**	**$123,808**	**$51,576**	**$73,817**	**$294,434**

* FY2019 tHRU 3/30/19 ONLY

**FY2017 IMPLEMENATION BEGAN 9/1/2017

***FY2017 INSTALLATION ENDED 8/31/17

Summary of Costs

Total implementation costs for Winnebago were $220,617 and installation costs related to project training and database set up were $73,818. Altogether in total, the costs for the Winnebago project were $268,359.

Cost Calculations

Using the estimates of costs above, cost per participant was calculated.

COST PER PARTICIPANT

Based on the total costs of $294,434 and 7 children, the cost per participant for this intervention was $42,062.

COST-EFFECTIVENESS ESTIMATION

Because there were no positive findings from the outcome evaluation, a cost-effectiveness estimation could not be calculated.

Sensitivity Analysis

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

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

For this sensitivity analysis, costs that are most likely not needed have been removed from the cost calculation. Inclusion or exclusion of costs in a sensitivity analysis such as this one is subjective. A decision was made based on the following question: Is this expense critical to the functioning of the intervention? Another agency would want to adjust costs specific to their program needs. The following exclusions were made for this sensitivity analysis.

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

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

3. Program supplies not related to FGDM materials were excluded.

4. All travel costs were excluded. Travel was primarily to off-site annual and quarterly meetings.

5. Fees related to office space rental were excluded. The site had to locate a sufficient space for the family group conferences. However, other sites would likely have the space available. Additionally, rental space varies significantly by area and other agencies would need to adjust for their own community and agency needs.

6. Other direct charges not necessary for implementation of the intervention were also excluded.

7. 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 2.4 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $124,235 which amounted to $17,748 per participant. If the site had reached its expected number of 40 participants, the cost per participant would have been $3,106.

Table 2.4. Sensitivity Analysis: Adjusted Costs for Winnebago

	IMPLEMENTATION			INSTALLATION	TOTAL
	FY 2019	FY 2018	FY 2017	FY 2017	
PERSONNEL					
SITE INFORMATION MANAGER	$9,180	$23,055	$31,397	$14,852	$78,484
HUMAN SERVICE DIRECTOR	$2,632	$11,467			$14,099
FAMILY SUPPORT WORKER	$6,564	$11,121			$17,684.72
FRINGE	$6,649	$18,345	$14,618	$5,273	$44,885
NON-PERSONNEL INDIRECT EXPENSES					
CONTRACTED SERVICES: KEMPE	$1,706	$10,501	$5,561	$23,066	$40,835
CONTRACTED SERVICES: FSR	$500	$8,625			$9,125
CONTRACTED SERVICES: PETER SMALL BEAR				$2,740	$2,740
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CONTRACTUAL SERVICES: COACHES FOR MEDIATION				$2,650	$2,650
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CONTRACTUAL CULTURAL CONSULTATION		$50			$50
PROGRAM SUPPLIES: FGDM MATERIALS		$1,991			$1,991
PROGRAM SUPPLIES (FOOD FOR INTERVENTION)		$32			$32
PROGRAM SUPPLIES (GENERAL)	$1,227	$1,395		$3,600	$6,222
GIFT CARD INCENTIVES		$206		$2,000	$2,206
TELEPHONE	$444	$1,206			$1,650
POSTAGE	$34	$576			$610
PROFESSIONAL DEVELOPMENT	$3,521	$3,395			$6,916
FACILITIES/OFFICE SPACE	$1,851	$8,254		$9,029	$19,133
TRAVEL	$4,467	$11,764		$7,556	$23,786
INDIRECT COSTS	$6,459	$11,824			$18,283
TOTAL	$45,233	$123,808	$51,576	$73,817	$294,434

* FY2019 tHRU 3/30/19 ONLY

**FY2017 IMPLEMENATION BEGAN 9/1/2017

***FY2017 INSTALLATION ENDED 8/31/17

Cost Evaluation Summary

Based on the total costs of $294,434 and 7 children, the cost per participant for this intervention was $42,062. However, a sensitivity analysis showed that removing non-essential costs resulted in a reduced total cost of the project at $124,235 which amounted to $17,748 per participant. If the site had reached its expected number of 40 participants, the cost per participant would have been $3,106.

Discussion

The Winnebago Tribe, including Tribal Elders and Winnebago community members, designed the Winnebago adapted intervention of FGDM: Wažokį Wošgą Gicą Wo'ųpį (pronounced *Wha-zho-kee Wo-shga Gi-cha Wo-oo-pi*). The Tribe chose this intervention because there are tribal children and youth who need permanent family units, but the process of finding and engaging tribal families requires culturally competent social work practices that engage families to make decisions about their children. The adapted FGDM model served seven caregivers and youth. Due to limited project enrollment, there were no primary outcomes that could be reported. But there were many lessons learned that would enhance culturally responsive process evaluation and would be useful for other Tribes interested in implementing FGDM model. In addition, the cost evaluation cannot be interpreted as a true representation of the cost of the intervention because of the difficulties encountered in staff turnover, low enrollment, and insufficient time to observe intervention effects.

The primary lessons learned relate to cultural connectedness with the Tribe. When working cross-culturally, it is important to ensure that the words and terms used connote a common meaning, and when they do not, it is important to develop language that supports a shared understanding of the need, practices, and concepts. When adapting an intervention for a specific culture, it is important to build partnerships that are inclusive and transparent by fostering and developing an ongoing dialogue with stakeholders. Engaging in a "By the Tribe, for the Tribe" process not only enhances and strengthens tribal sovereignty and existing relationships but also supports new relationships built upon a common understanding of the project, resulting in establishing trust, respect, and buy-in. The Winnebago Team engaged in ongoing communication with the Winnebago Tribal Elders, the community, service providers, Ho-Chunk Renaissance (a language support and cultural etiquette service provider), legal counsel, the Winnebago Tribal Court, and the intervention purveyor. From an evaluation perspective, the Logic Model created by the Winnebago Team included short-term outcomes specific to the "Winnebago Pathway" conceptual framework that includes knowledge of kinship roles and responsibilities. Subsequently, the Winnebago Team also wanted to include a circular Logic Model, which is a more holistic approach that includes family and community outcomes such as improving professional relationships and developing community collaborations.

In working with a tribe, it is important to ensure that the laws, codes, policies, procedures and so forth support the planned intervention. One of the first challenges this site experienced was a cultural difference between tribal practice and the larger child welfare practices. It is common for parental rights to be terminated under standard (European) child welfare practices, but this goes against tribal beliefs. Customary adoption recognizes the extension of parental rights and adoption is more about placement stability. Native children permanently belong to the Tribe, as explained by the Elders. A major accomplishment of the Winnebago Tribe was the strengthening and clarification of the Tribal Code that was facilitated by the site team. It enhanced and clarified customary adoption and guardianship as permanency options and strengthened the guardianship code.

Finally, it is important to ensure that staff and families are familiar with resources available to support families moving toward or sustaining permanency and that resources are available to specific clan networks. There are over 5,000 enrolled members of the Winnebago Tribe of Nebraska, but fewer than 800 live on the reservation in North Thurston County. Because of the small community size, many people are related – in fact, most people are when taking into consideration the Winnebago kinship and clan networks. While this can be a good thing, it can also be a challenge as staff try to avoid conflicts of interest, or when a tragedy strikes in the community and many need time off. This requires as much flexibility as possible to deal with the most pressing issues as they arise.

References

Behnke, M., Smith, V. C., Abuse, C. on S., & Newborn, C. on F. A. (2013). Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus. *Pediatrics*, *131*(3), e1009–e1024. https://doi.org/10.1542/peds.2012-3931

Brannan, A. M., Heflinger, C. A., & Bickman, L. (1997). The Caregiver Strain Questionnaire: Measuring the Impact on the Family of Living with a Child with Serious Emotional Disturbance. *Journal of Emotional and Behavioral Disorders*, *5*(4), 212–222.

Calculating the Costs of Child Welfare Services Workgroup. (2013). *Cost analysis in program evaluation: A guide for child welfare researchers and service providers*. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: a self-report measure of protective factors against child maltreatment. *Child Abuse & Neglect*, *34*(10), 762–772. https://doi.org/10.1016/j.chiabu.2010.03.003

Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration. (1993). *Feasibility, Alternatives, And Cost/Benefit Analysis Guide*. Washington DC. Retrieved from http://archive.acf.hhs.gov/programs/cb/systems/sacwis/cbaguide/c1intro.htm

DeVellis, R. F. (2003). Scale development: theory and applications (2nd ed. Vol. 26). Thousand Oaks, CA: Sage Publications.

Dillman, D.A., Smyth, J.D., & Christian, L.M. (2014) Reducing people's reluctance to respond to surveys. In Internet, phone, mail and mixed-mode surveys: The tailored design methods (4th edition; pp 19-55). Hoboken, New Jersey: John Wiley & Sons, Inc.

Fan, W., & Yan, Z. (2010). Factors affecting response rates of the web survey: A systematic review. *Computers in Human Behavior*, *26*(2), 132–139. https://doi.org/10.1016/j.chb.2009.10.015

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Framework Workgroup. *A framework to design, test, spread, and sustain effective practice in child welfare.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Frey, L., Cushing, G., Freundlich, M., & Brenner, E. (2008). Achieving permanency for youth in foster care: assessing and strengthening emotional security. *Child & Family Social Work*, *13*(2), 218–226. https://doi.org/10.1111/j.1365-2206.2007.00539.x

Kempe Center, (2016). *Six core elements of Family Group Decision Making*. Denver, Colorado: National Center on Family Group Decision Making. Kempe Center, University of Colorado, Department of Pediatrics.

Liao, M., & Testa, M. (2016). Postadoption and Guardianship: An Evaluation of the Adoption Preservation, Assessment, and Linkage Program. *Research on Social Work Practice*, *26*(6), 675–685. https://doi.org/10.1177/1049731514564600

Liao, M., & White, K. R. (2014). Post-permanency service needs, service utilization, and placement discontinuity for kinship versus non-kinship families. *Children and Youth Services* Review, *44*, 370–378. https://doi.org/10.1016/j.childyouth.2014.07.007

Meunnig, P. (2002). *Designing and conducting cost-effectiveness analyses in medicine and health care*. San Francisco: Jossey-Bass.

Peterson, J. L., & Zill, N. (1986). Marital Disruption, Parent-Child Relationships, and Behavior Problems in Children. *Journal of Marriage and Family*, *48*(2), 295–307. https://doi.org/10.2307/352397

Richardson, W., Wilson, M. Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, 123(3), A12.

Rolock, N. (2015). Post-permanency continuity: What happens after adoption and guardianship from foster care? *Journal of Public Child Welfare*, 9:2, 153-173, doi:10.1080/15548732.2015.1021986

Rolock, N. & White, K. R. (2016). Post-permanency discontinuity: A longitudinal examination of outcomes for foster youth after adoption or guardianship. *Children and Youth Services Review*, 70, 419-427. doi:10.1016/j.childyouth.2016.10.025

Rolock, N. & White, K. R. (2017). Continuity for children after guardianship versus adoption with kin: Approximating the right counterfactual. *Child Abuse and Neglect*, 72, 32-44.

Sandoval-Hernandez, A. (n.d.). *Factors and conditions that promote academic resilience: A* cross-*country perspective*. Retrieved from https://www.academia.edu/1707789/Factors_and_conditions_that_promote_academic_resilience_A_cross-country_perspective

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. *International Journal of Behavioral Medicine*, *15*(3), 194–200. https://doi.org/10.1080/10705500802222972

Springer, J. F., & Phillips, J. (2006). The IOM Model: A Tool for prevention planning and implementation. Prevention Tactic 8:13. Sacramento, California: Department of Alcohol and Drug Programs.

Testa, M. & Poertner, J. (Eds.). (2010). *Fostering accountability: Using evidence to guide and improve child welfare policy*. New York, NY: Oxford University Press.

Testa, M. F., Snyder, S. M., Wu, Q., Rolock, N., & Liao, M. (2015). Adoption and guardianship: A moderated mediation analysis of predictors of post-permanency continuity. *The American Journal of Orthopsychiatry*, *85*(2), 107–118. https://doi.org/10.1037/ort0000019

Whitback, L.B., Adams, G.W., Hoyt, D.R. & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, 33(3/4).

White, K.R. (2016). Placement discontinuity for older children and adolescents who exit foster care through adoption or guardianship: A systematic review. *Child and Adolescent Social Work Journal*, 33(4), 377-394. doi:10.1007/s10560-015-0425-1

Winnebago Tribal Code (2015). Title 4, Article 7. Nebraska: Winnebago Tribe of Nebraska.

Winnebago Tribe of Nebraska (2015). http://www.winnebagotribe.com/

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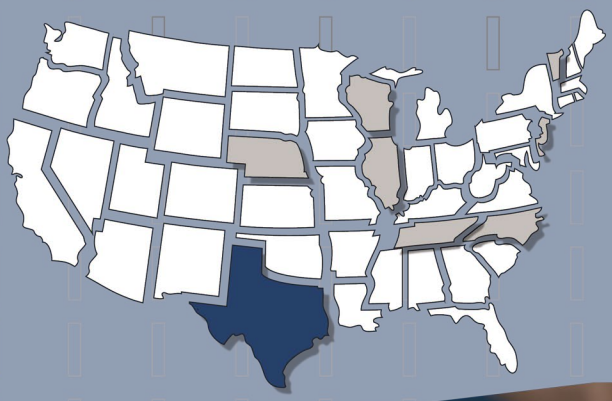
Evaluation Results from

Texas



Final Evaluation Report

September 2019

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

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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Report Authors

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

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

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

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

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

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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Evaluation Results from Texas

PROJECT PARTNERS

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

CONTINUUM PHASE

Focused Services

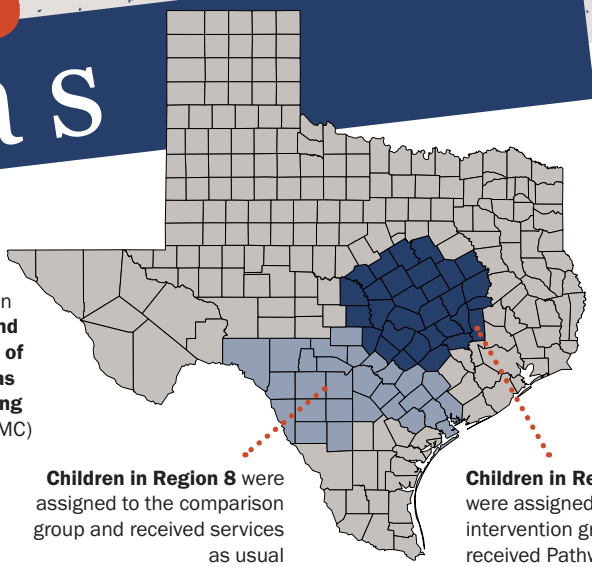
INTERVENTION

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

STUDY DESIGN

Quasi-Experimental

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



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

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

RESEARCH QUESTION

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

Findings

PARTICIPATION

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

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

GRIEF AND LOSS

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

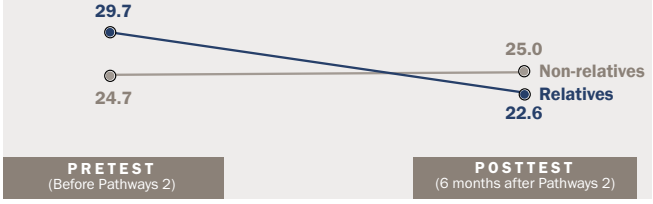
CHILD BEHAVIOR

SURVEYSESSIONS

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

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

HIGHER SCORE = MORE BEHAVIOR CHALLENGES



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

Six month after attending Pathways 2...

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

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

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

RECOMMENDATION

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

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

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Jack, Joseph and Morton Mandel School of Applied Social Sciences Case Western Reserve University

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

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

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

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

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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.

Executive Summary

Overview

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

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

- More permanent families will be identified;
- Families will be ready and prepared to become parents of these children through adoption or permanent managing conservatorship; and
- The children will be ready for legal permanence.

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

Intervention

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

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

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

Primary Research Question

The primary research question was:

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

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

Key Findings and Discussion

RECRUITMENT AND FIDELITY

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

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

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

PRIMARY OUTCOMES

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

- Loss is a part of life for children who do not live with their birth parents.
- Children lose a part of their identity through adoption and permanence.
- Children have lifelong connections to their birth families and permanent families.

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

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

INTERVENTION SPECIFIC OUTCOMES

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

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

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

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

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

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

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

- **Offer and encourage kinship families to attend Pathways to Permanence 2.** Pathways 2 had a greater impact on child behavior after six months for relative families compared to non-relative families. This findings has significant implications for kinship families, particularly in regions where a high percentage of children are placed in kinship care.
- **Offer Pathways 2 as a trauma-informed training to help prepare and support families.** In Texas, there is a focus on improving and expanding existing trauma-informed care trainings and services throughout the state. Increasing awareness about Pathways 2 and offering this training to families as an additional trauma-informed training option supports this goal. Ideally, any licensed caregiver would also have the opportunity to receive credit-hours that could be used towards their annual training requirements.
- **Provide free childcare during Pathways 2 trainings.** Almost half (45%) of caregivers in this study reported that they would not have attended Pathways 2 had there not been free childcare. Another fourth (25%) were unsure whether or not they could have attended. Having free childcare, among all other factors, seemed to be the most important factor in determining whether or not a family could attend Pathways 2.
- **Develop a Pathways 2 Train the Trainer Model in Texas.** Lastly, to increase the likelihood of sustainability, we suggest that at least two facilitators in Texas receive the Pathways 2 "Train the Trainer" training that would allow them to train future Pathways 2 facilitators in Texas.

Cross-Site Summary

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

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

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

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

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

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

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

Chapter 3

TEXAS: PATHWAYS TO PERMANENCE 2

Table of Contents

List of Tables and Figures

Site Background

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

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

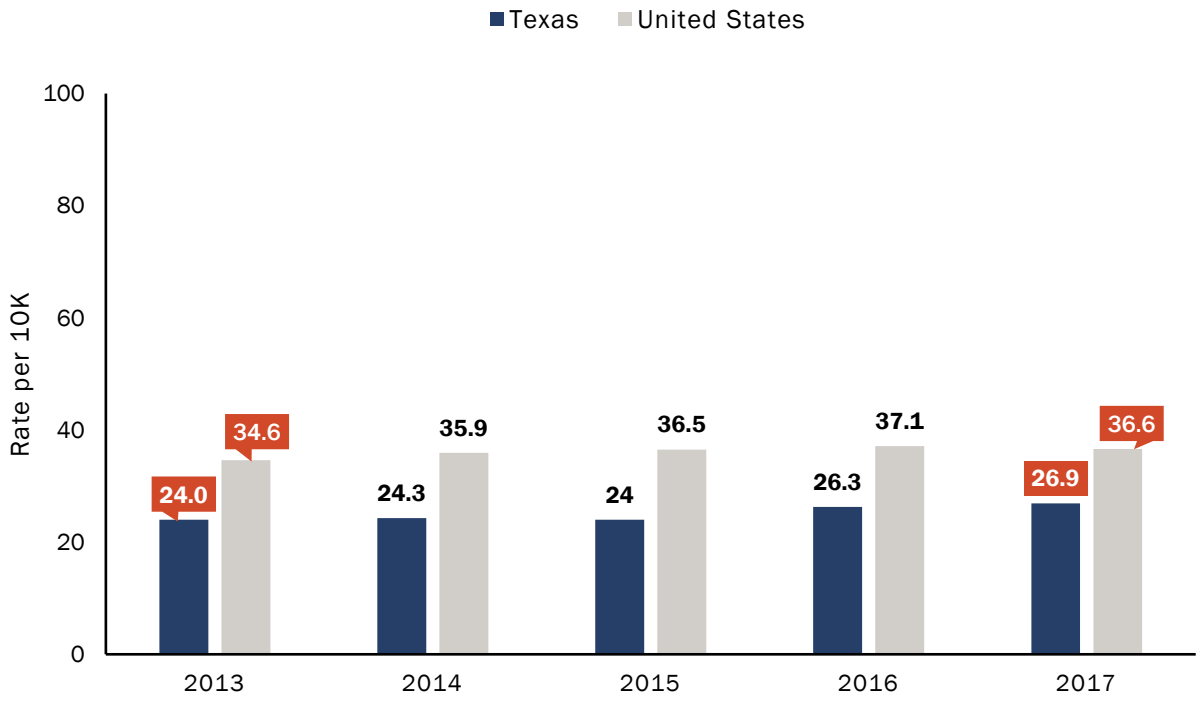
A fundamental belief in Texas is that all children who are removed from their families are exposed to trauma, grief, and loss. When children are exposed to trauma, grief, and loss, they may experience increased emotional, behavioral and mental health needs that can delay permanence.

National Data: Putting Texas in Context

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

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

Figure 3.1. Texas Foster Care Entry per Capita Rate (2013-2017)

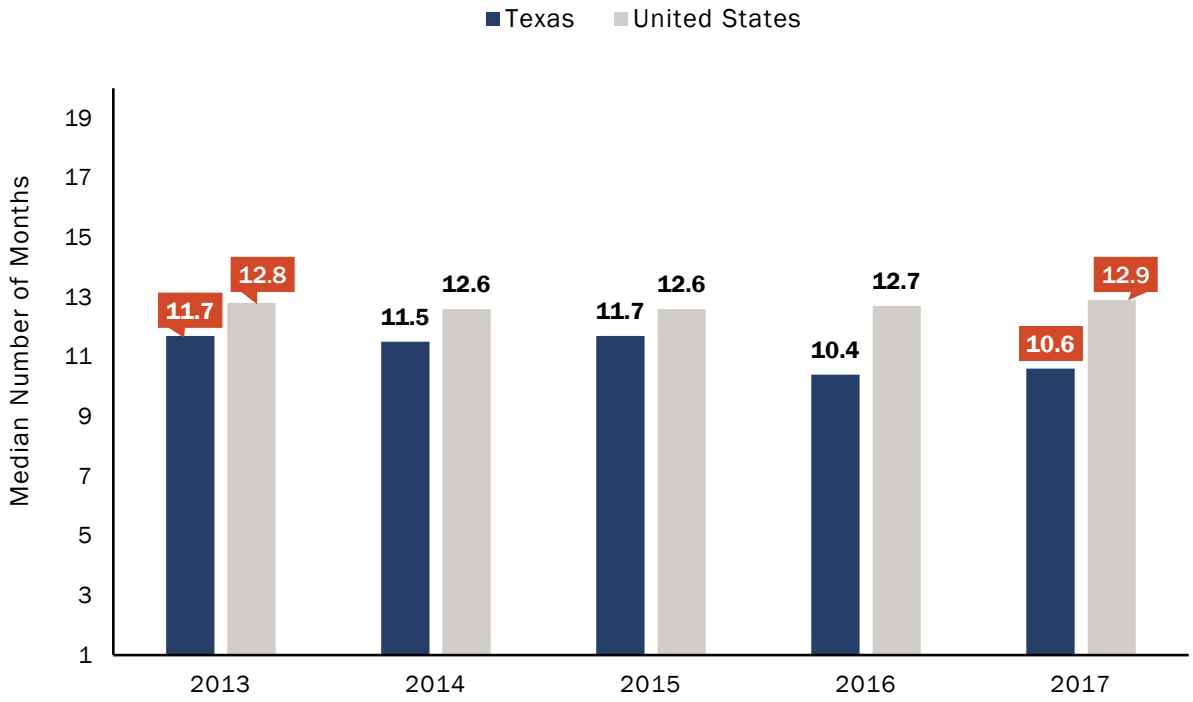


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

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

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

Figure 3.2. Texas Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)

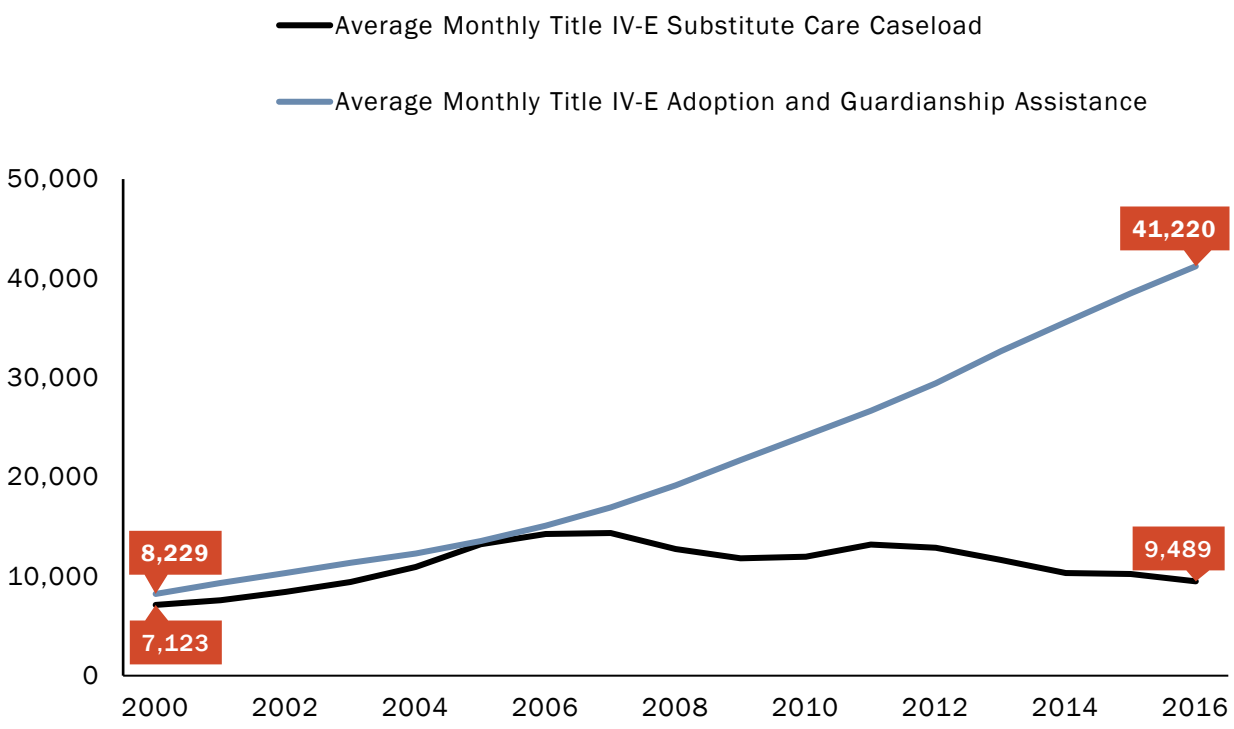


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

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

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

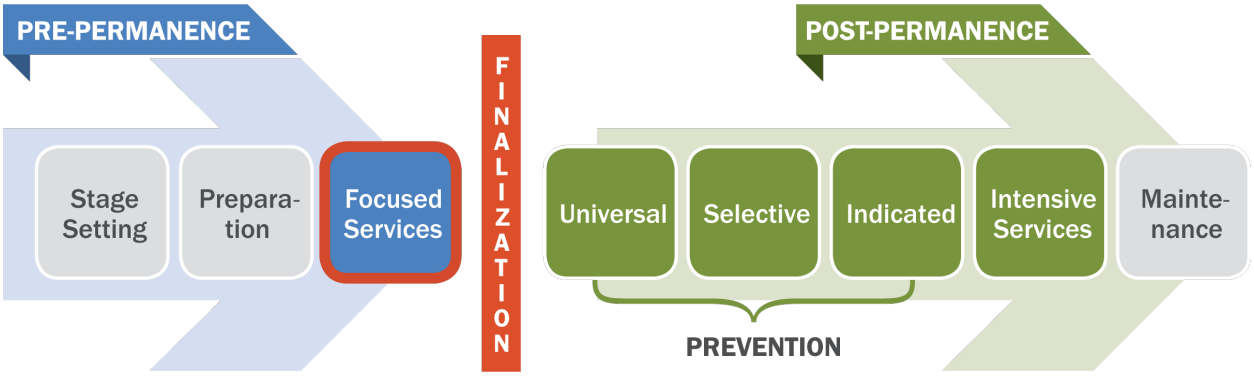
Figure 3.3. Texas Caseloads



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

QIC-AG Permanency Continuum Interval

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



Primary Research Question

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

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

Target Population

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

- Children with reunification, transfer of PMC, or joint TMC (primary or concurrent) with a biological parent (including Home and Community-Based Services (HCS) placements in which a biological parent was a guardian)
- Children who were on runaway status at the time of screening
- Children who did not have an active caregiver who was willing to have the child(ren) return home if the child was living in an unauthorized placement, residential treatment center, juvenile justice setting, or emergency shelters at the time of screening
- Children placed in agency run group homes where staff rotate care
- Children with a finalization hearing scheduled within 60 days of screening
- Children with caregivers who did not speak English

Intervention

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

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

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

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

ABOUT PATHWAYS 2 SESSIONS

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

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

Session 2: Lifelong Issues in Permanence

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

Session 3: Childhood Development

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

Session 4: Creating Positive Attachments, Part 1

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

Session 5: Creating Positive Attachments, Part 2

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

Session 6: Parenting the Child of Abuse and Neglect

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

Session 7: Parenting the Child with Drug & Alcohol Exposure

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

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

Use of Experienced Facilitators

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

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

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

Pathways 2 Core Beliefs and Values

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

Every child deserves a family;

Children must have permanence to achieve their full potential;

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

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

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

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

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

Experiential Delivery of Material

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

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

Engagement and Participation

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

Opportunities to Practice and Apply Techniques

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

INTERVENTION ADAPTATIONS

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

- Technical assistance calls were provided by the developer;
- The developer created timing agendas and a "tip sheet" for each session that supported facilitators in their preparation for delivery of session content; and
- The developer established a Facilitator Videoconference Observation process (non-classroom setting) to assess the capabilities of newly trained facilitators and to provide additional skill development and coaching recommendations.

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

Comparison

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

Outcomes

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

- Improved family relationships;
- Increased caregiver resiliency;
- Decreased caregiver strain;
- Increased caregiver knowledge in dealing with childhood trauma, grief, and loss;
- Improved ability for caregivers to respond to challenging behaviors;
- Increased caregiver commitment;
- Increased permanency outcomes; and
- Decreased time to finalization and time in care.

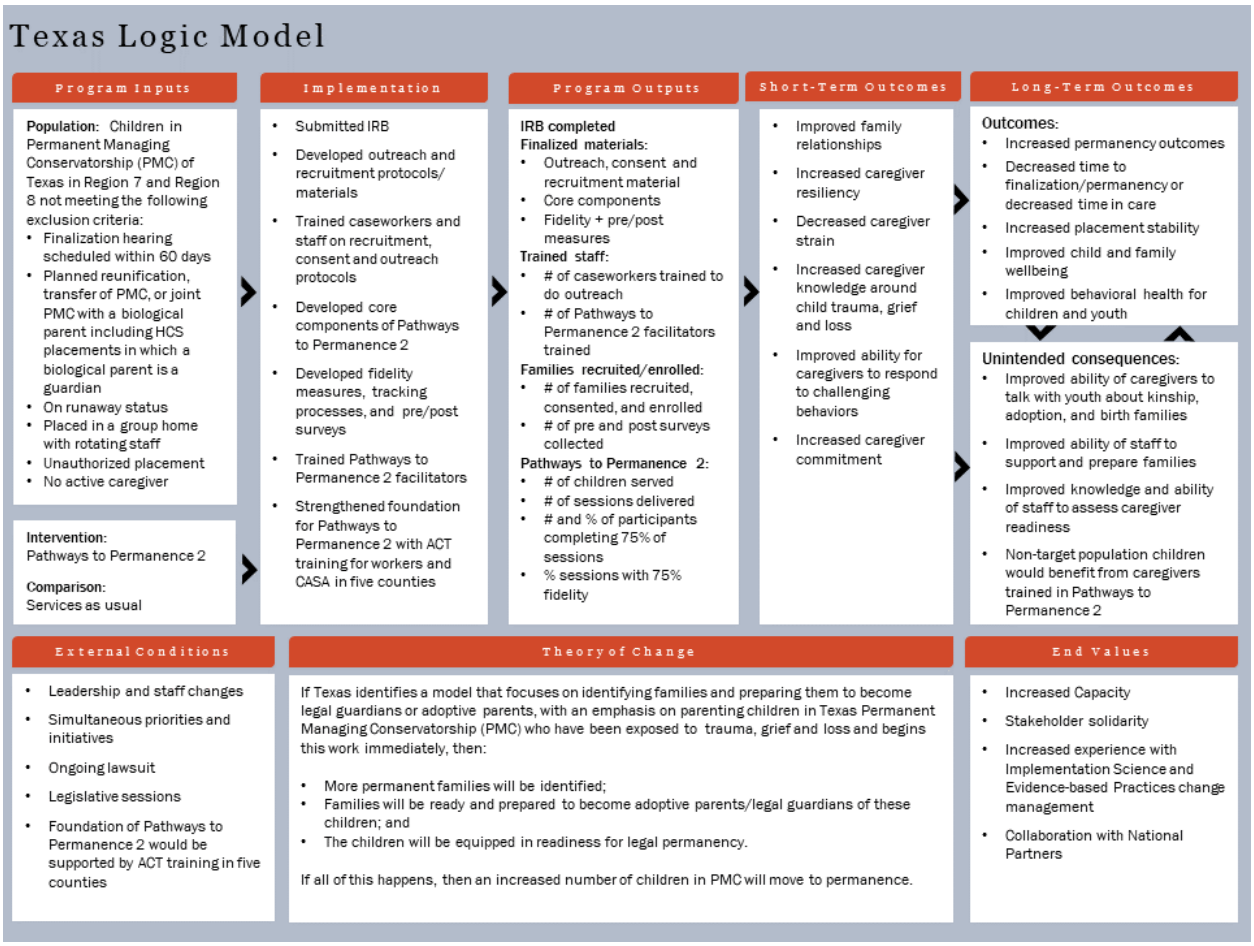
Long-term outcomes, set *a priori* by the project, included:

- Improved placement stability;
- Improved child and family well being; and
- Improved behavioral health for children and youth.

Logic Model

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

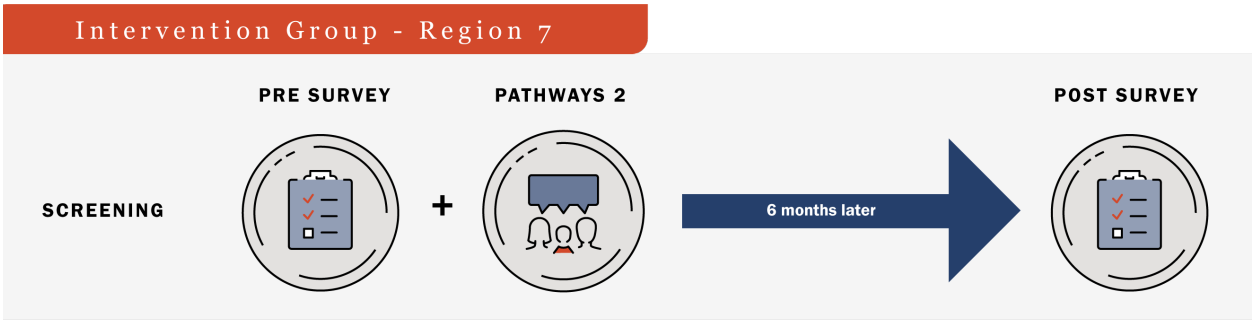
Figure 3.4. Texas Logic Model



Evaluation Design & Methods

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

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



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

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

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

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

Table 3.1. Implementation Cycle Tasks and Timeframes by Region

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

Procedures

USABILITY

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

SCREENING AND RECRUITMENT

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

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

Region 7 Recruitment for Pathways 2 (Intervention)

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

Region 8 Recruitment for Survey (Comparison)

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

INFORMED CONSENT

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

SURVEYS

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

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

CHILDCARE, TRAVEL GIFT CARD, FOOD, AND TRAINING HOURS

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

INCENTIVES

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

FIDELITY

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

Measures

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

FIDELITY MEASURES

Table 3.2. Pathways to Permanence 2 Fidelity Measures

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

Administrative Data

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

Adverse Childhood Experiences (ACEs)

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

Behavior Problems Index (BPI)

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

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

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

Brief Resilience Scale (BRS)

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

Caregiver Strain Questionnaire – FC/AG22

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

Education Outcomes

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

Illinois Post Permanency Commitment Items

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

Protective Factors Survey (PFS)

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

Service Items

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

Missing Data

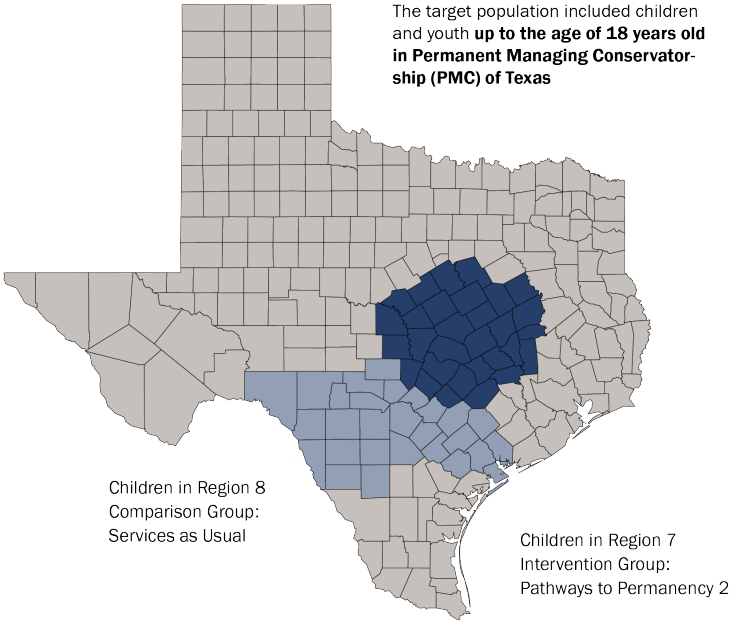
Missing data imputation was done by replacing any item missing value with the respondent's mean on all observed items, only when more than 75% of the total scale items were responded. The summary scale values (total and subscale scores) were calculated after imputation. When 25% or more items were missing,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

Findings

Sample Frame and Participant Profile

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

DEMOGRAPHICS BY REGION



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

In December 2017, there were 3,851 children in DFPS conservatorship placed in Region 7 care and 4,733 children placed in Region 8. At this time, there were significant differences in the living arrangements of children in DFPS care. Most notably, the proportion of children placed in private Child Placing Agency homes and independent foster care homes was higher in Region 8 (35%) compared to Region 7 (29%), while the proportion of children in Kinship homes was significantly higher in Region 7 (54%) compared to Region 8 (42%), $\chi 2$ (6, N=8,584) = 187.43, p <.001.

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

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

CHARACTERISTICS OF THE SAMPLE FRAME

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

Table 3.3. Sample Frame Characteristics by Region

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

ABOUT PARTICIPANTS

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

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

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

Baseline Differences

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

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

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

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

Process Evaluation

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

FIDELITY LOGS

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

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

- **93%** of content was taught as suggested;
- **4%** of content was taught with changes; and
- **3%** of the content was not taught.

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

OBSERVATIONS

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

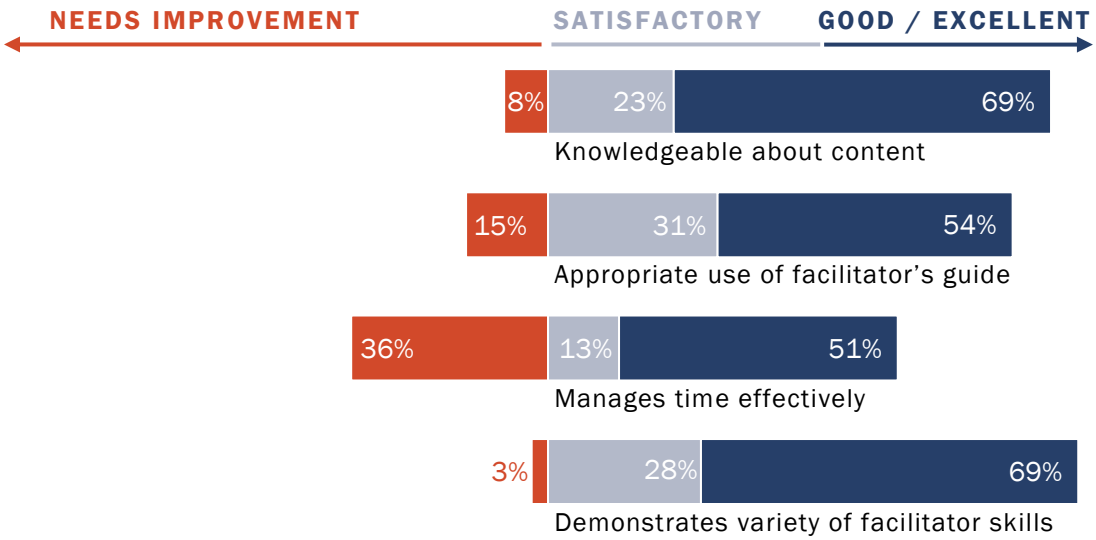
1. Use of experienced facilitators;
2. Experiential delivery of material;
3. Engagement and participation; and
4. Provided opportunities to apply and practice.

Core Components

Use of Experienced Facilitators

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

Figure 3.5. Core Component Ratings: Use of Experienced Facilitators



Experiential Delivery of the Material

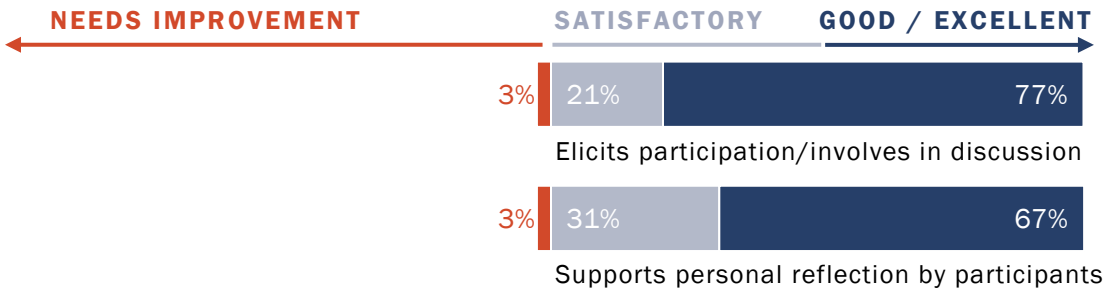
Facilitators were rated on their use of activities during sessions as "needs improvement," "satisfactory," or "good or excellent." Additionally, evaluators tracked whether or not at least six participants attended each session and whether each session was taught in sequential order.

- **73%** of facilitators were rated as satisfactory or above on their use of activities during observed sessions.
- **63%** of all sessions had at least six participants.
- **100%** of sessions were taught in the correct sequential order.

Engagement and Participation

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

Figure 3.6. Core Component Ratings: Engagement and Participation



Opportunities to Apply and Practice

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

- **78%** of facilitators were rated as satisfactory or above on their ability to review and emphasize homework.
- **100%** of observed sessions were held at least one week apart and no longer than one month apart.

Strengths and Positive Behaviors

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

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

Skills to Improve

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

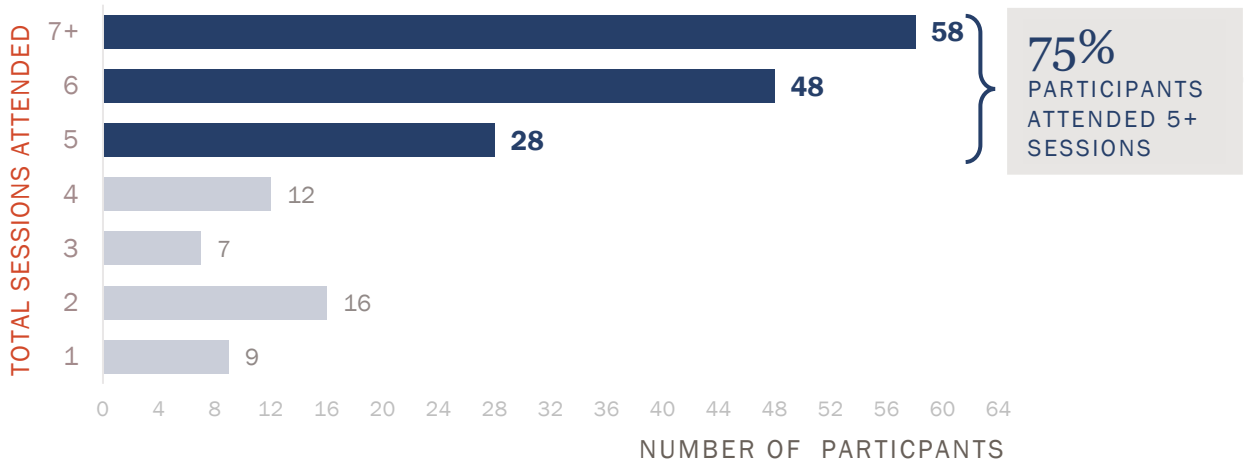
SKILL TO IMPROVE	EXPLANATION
TIME MANAGEMENT	Facilitators had difficulty managing time. Facilitators should review TIP sheets, prioritize and teach material through activities, identify key messages in each section, and determine ways to condense material when needed.
CO-FACILITATOR SKILLS	Facilitators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

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

PARTICIPANT ATTENDANCE

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

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



PARTICIPANT EVALUATION DATA

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

Highlights from Participant Evaluations

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

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

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

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

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

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

PRIMARY OUTCOMES

Grief and Loss

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

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

- Loss is a part of life for children who do not live with their birth parents.
- Children lose a part of their identity through adoption and permanence.
- Children have lifelong connections to their birth families and permanent families.

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

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

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

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

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

Child and Family Wellbeing

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

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

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

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

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

Placement Stability and Permanency

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

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

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

PATHWAYS 2 PARTICIPANT OUTCOMES AT PRE AND POST

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

Grief and Loss

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

Table 3.8. Grief and Loss Items at Pre and Post

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

"I realized that my son and daughter will both be impacted by not being with their birth parents even though they were placed in our home when they were both very young."

-Participant, 6M Post Survey

Child and Family Wellbeing

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

Behavior Problems

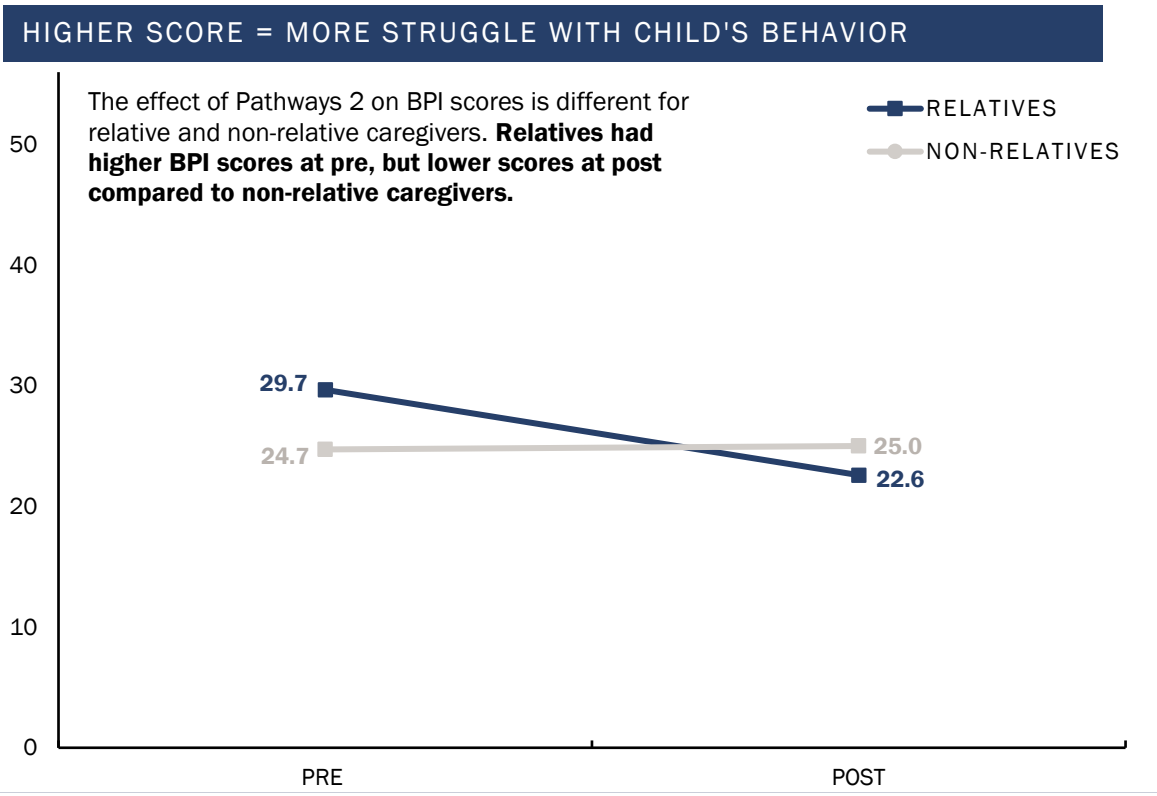
We evaluated a child's level of behavior problems using the Behavior Problems Index, a measure consisting of two subscales that measure the frequency, range, and type of childhood behavior problems children ages four and older may exhibit (Peterson & Zill, 1986) The Internalizing Subscale (11 items)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

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

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

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

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



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

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

Family Wellbeing, Commitment, and Caregiver Strain

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

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

Table 3.10. Child Wellbeing Indicators at Pre and Post

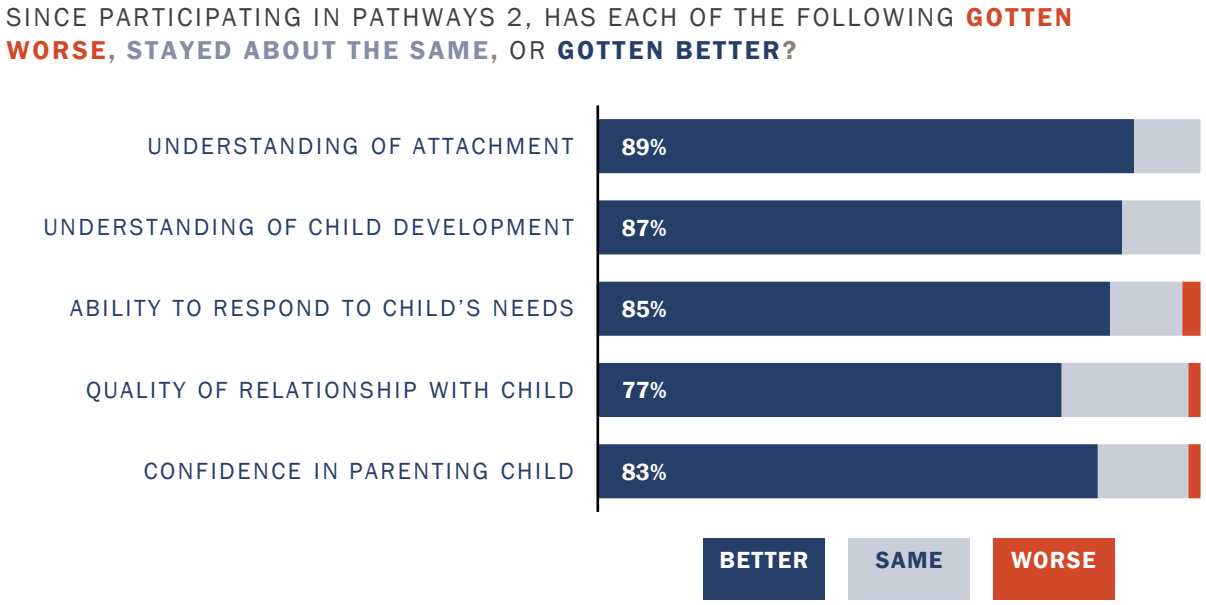
MEASURE	SCALE	PRE SCORE		POST SCORE		*t*	*df*	*p*
		M	SD	M	SD			
HIGHER SCORES = MORE CONCERN								
CAREGIVER STRAIN (CGSQ-FA22)	1 - 5	2.09	0.71	2.20	0.79	1.83	104	0.070
CGSQ-FA OBJECTIVE STRAIN	1 - 5	2.02	0.80	2.14	0.88	1.66	104	0.100
CGSQ-FA SUBJECTIVE STRAIN	1 - 5	2.16	0.72	2.26	0.82	1.59	104	0.115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

Program Impact

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

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

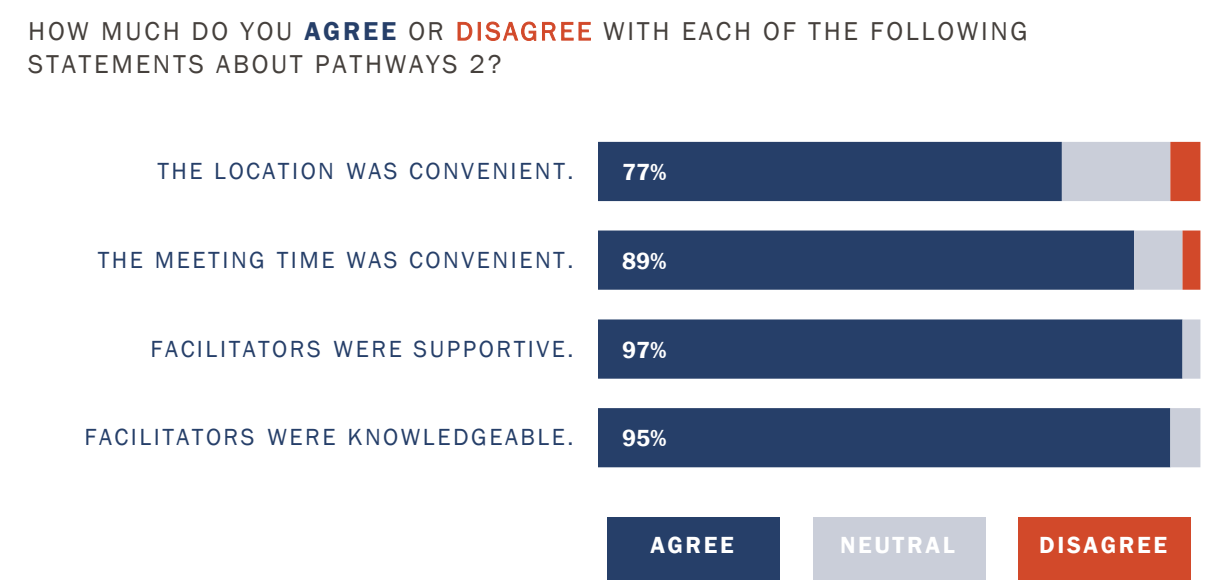
Figure 3.9. Perceived Impact of Participating in Pathways 2



Program Satisfaction

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

Figure 3.10. Caregiver Satisfaction with Location, Times and Facilitators



Participant Feedback on Factors That May Impact Participation

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

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

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

Additional Quotes from Caregivers on the Impact of Pathways 2

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

How Pathways to Permanency 2 has impacted my family

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

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

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

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

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

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

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

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

Limitations

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

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

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

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

Cost Evaluation

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

Cost Evaluation Approach

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

Assumptions, Constraints, and Conditions

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

ASSUMPTIONS

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

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

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

CONSTRAINTS

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

CONDITIONS

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

Cost Estimation

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

KEY POINTS IN COST ESTIMATION

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

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

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

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

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

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

COST ESTIMATION STEPS

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

Collect Data on Resource Costs

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

Collect Data on Resource Allocation

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

Estimation of Direct Costs

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

Personnel

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

Table 3.12. Costs for Texas

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

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

Fringe

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

Contractual Expenses

Texas contracted for services from five entities.

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

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

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

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

Gift Cards

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

Materials and Supplies

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

Travel

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

Facilities/Office Space

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

Other Direct Charges

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

Estimation of Indirect Costs

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

IT Support

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

Other

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

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

Summary of Costs

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

Cost Calculations

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

COST PER PARTICIPANT

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

COST TO EFFECTIVENESS CALCULATION

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

COST AVOIDANCE CALCULATION

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

Sensitivity Analysis

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

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

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

The following exclusions were made for this sensitivity analysis:

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

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

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

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

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

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

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

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

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

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

Table 3.13. Sensitivity Analysis: Adjusted Costs for Texas

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

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

Cost Evaluation Summary

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

Discussion

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

- Loss is a part of life for children who do not live with their birth parents.
- Children lose a part of their identity through adoption and permanence.
- Children have lifelong connections to their birth families and permanent families.

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

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

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

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

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

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

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

References

Brannan, A. M., Heflinger, C. A., & Bickman, L. (1997). The Caregiver Strain Questionnaire: Measuring the Impact on the Family of Living with a Child with Serious Emotional Disturbance. Journal of Emotional and Behavioral Disorders, 5(4), 212–222.

Calculating the Costs of Child Welfare Services Workgroup. (2013). *Cost analysis in program evaluation: A guide for child welfare researchers and service providers*. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: a self-report measure of protective factors against child maltreatment. Child Abuse & Neglect, 34(10), 762–772. https://doi.org/10.1016/j.chiabu.2010.03.003

Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration. (1993). *Feasibility, Alternatives, And Cost/Benefit Analysis Guide*. Washington DC. Retrieved from http://archive.acf.hhs.gov/programs/cb/systems/sacwis/cbaguide/c1intro.htm

Framework Workgroup. *A framework to design, test, spread, and sustain effective practice in child welfare.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Felitti, V., Anda, R., & et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258.

Frey, L., Cushing, G., Freundlich, M., & Brenner, E. (2008). Achieving permanency for youth in foster care: assessing and strengthening emotional security. Child & Family Social Work, 13(2), 218–226. https://doi.org/10.1111/j.1365-2206.2007.00539.x

Meunnig, P. (2002). *Designing and conducting cost-effectiveness analyses in medicine and health care.* San Francisco: Jossey-Bass.

Richardson, W., Wilson, M. Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, 123(3), A12.

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. International Journal of Behavioral Medicine, 15(3), 194–200. https://doi.org/10.1080/10705500802222972

Testa, M. F., Snyder, S. M., Wu, Q., Rolock, N., & Liao, M. (2015). Adoption and guardianship: A moderated mediation analysis of predictors of post-permanency continuity. The American Journal of Orthopsychiatry, 85(2), 107–118. https://doi.org/10.1037/ort0000019

White, K.R. (2016). Placement discontinuity for older children and adolescents who exit foster care through adoption or guardianship: A systematic review. Child and Adolescent Social Work Journal, 33(4), 377-394. doi:10.1007/s10560-015-0425-1

Appendices

Appendix A. Pathways 2 Core Components

CORE COMPONENT #1: USE OF EXPERIENCED FACILITATORS

Facilitator Knowledge

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

- Education
- Work History
- Trainer/Facilitator History
- Parent Group Facilitation History
- Social/Therapeutic or Direct Service Delivery History
- Personal experience as a member of the adoption/permanency constellation

Facilitator Skills

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

- Establish a safe learning environment;
- Make materials "jurisdiction-relevant";
- Negotiate participant agreements;
- Use effective communication skills;
    - Able to facilitate rather than simply direct discussion,
    - Able to respect differences of opinions and facilitate discussions involving strongly stated opinions,
    - Able to challenge participants to practice and apply techniques to real-life situations;
- Respect the roles and responsibilities of co-facilitators;
- Have a broad understanding of the lifetime impact of adoption/permanency;
- Have knowledge of normative child development as well as disrupted development;
- Be able to facilitate sometimes challenging discussions surrounding cultural competency;
- Have the ability to assess their own personal strengths and areas for growth in permanency-related work.

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

Core Beliefs and Values of Facilitators

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

- Permanency in a family is at the center of the core beliefs;
- Every child deserves a family;
- Children must have permanency to achieve their full potential;
- Children and adolescents need families for a lifetime, not just for childhood;
- Healthy, functional families can provide a stabilizing and healing environment for previously traumatized and abused children;
- Keeping children's previous, positive connections facilitates and deepens the attachment to the new caregivers;
- Adoption, foster care and relative caregiving involve complex issues requiring specialized training for the caregivers;
- Children and their families must receive interventions that are culturally competent and built on strength-based, family systems models.

CORE COMPONENT #2: EXPERIENTIAL DELIVERY OF MATERIAL

Use of Activities During Sessions

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

Sequential Order of Sessions

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

Class Size

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

Facilitators Elicit Participation

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

Participant Involvement in Discussions

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

Personal Reflection by Participants

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

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

Timing of sessions in the series

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

Participants who are actively parenting

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

Homework assignments

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

Appendix B. Implementation Timeline

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

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

Appendix C. Characteristics of Children in Substitute Care by Region

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

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

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

Appendix D. Propensity Score Matching Results

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

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

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

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

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

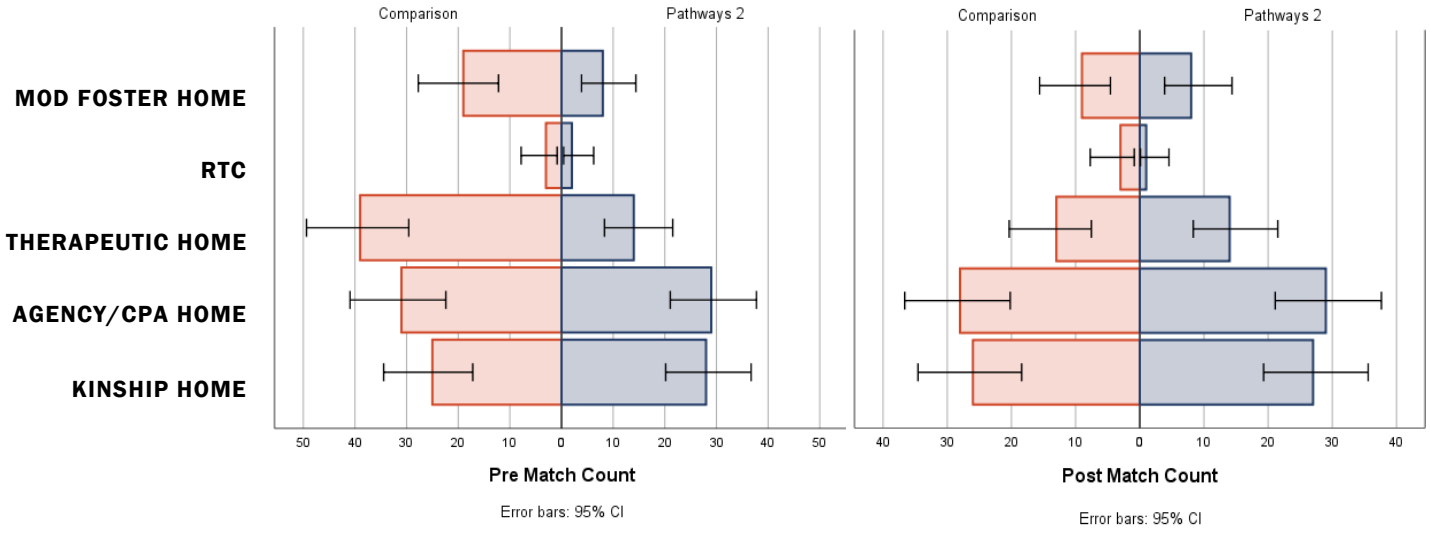
*There were four caregivers who served as alternate caregivers in the Pathways 2 group. These caregivers were not caring for a child in their home, but rather supporting a family who did. For this reason, we excluded them in this analysis and used the remaining 81 caregivers.

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

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

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

Figure 3.11. Living Arrangements of Child Before and After Matching



Appendix E: Knowledge of Grief and Loss

INTERVENTION VS MATCHED COMPARISON GROUP

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

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

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

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

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

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

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

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

Appendix F. Mixed Linear Models

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

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

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

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

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

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

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

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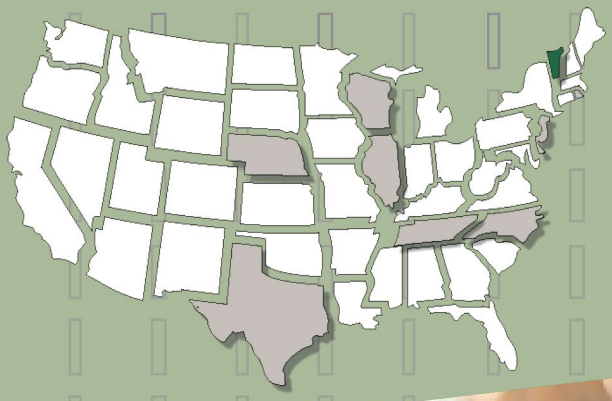
Evaluation Results from

Vermont



Final Evaluation Report

September 2019

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

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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Report Authors

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

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

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

Valerie Wood, PhD | Research Assistant Professor
Center on Disabilty and Community Inclusion (CDCI)
Department of Education, College of Education and Social Services
University of Vermont

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

Jessica Strolin-Goltzman, PhD | Professor
Department of Education, College of Education and Social Services
University of Vermont

Kelly Melekis PhD |Associate Professor
Skidmore College

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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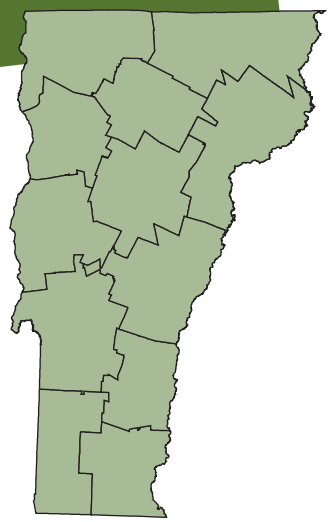
We would like to acknowledge the staff at the Vermont Department for Children and Family Services - Family Services Division, Lund, the site team leaders and Site Implementation Manager (SIM), who guided this work, in addition to their other roles within the agencies they work. Your partnership made this project a success.

The QIC-AG site consultants worked closely with the evaluation team to ensure the project work was implemented with integrity. Thank you for the collegial team work.

Evaluation Results from Vermont



PROJECT PARTNERS

QIC-AG partnered with the **Vermont Department for Children and Family Services, Family Services Division (DCF/FSD)** and **Lund**.

CONTINUUM PHASE

Universal

INTERVENTION

The **Vermont Permanency Survey** was developed to:

1. Identify the strengths and challenges of families formed through adoption and guardianship;
2. Learn from families about their support and service needs; and
3. Recommend ways to deliver data-driven, relevant and timely prevention and intervention services.

STUDY DESIGN

Descriptive

The target population included **all families with children in the state of Vermont** whose parents or guardians **received an Adoption or Guardianship Assistance Agreement Subsidy.**

Surveys were collected in cycles based on FSD district about 6 months apart. Altogether, 1,470 families were asked to participate across the state.

809
PARTICIPANTS
(55% OF FAMILIES RESPONDED)

RESEARCH QUESTION

Will families with children in the state of Vermont whose parents or guardians currently receive an Adoption or Guardianship Assistance Agreement Subsidy experience a reduction in post permanency discontinuity and improved child and family wellbeing if families are provided assertive outreach to complete a survey?

Findings

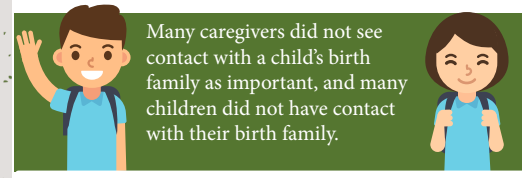
FAMILY WELLBEING

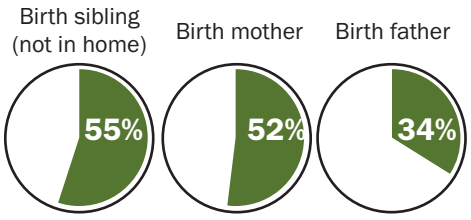
98% of caregivers were committed to their child for life

91% had never thought about ending adoption or guardianship

86% said that adoption/guardianship had a positive impact on their family

BIRTH FAMILY CONTACT

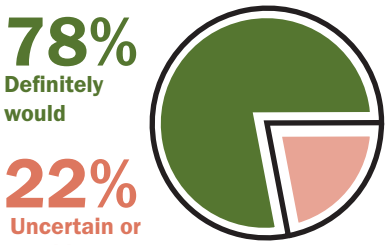




% WITH CONTACT IN LAST 6 MONTHS WHEN CONTACT WAS POSSIBLE

OVERALL, FAMILIES ARE THRIVING! HOWEVER, SOME FAMILIES MAY NEED MORE SUPPORT.

If you knew then what you know now, do you think you still would have adopted or assumed guardianship of your child?



Caregivers who were **UNCERTAIN** or **WOULD NOT**, on average:

- had older children with more behavior challenges;
- felt less confident in meeting their child's needs
- had more difficulty coping in times of stress;
- experienced higher levels of strain attributed to parenting; and
- were less likely to be related to their child

compared to families who said they '**DEFINITELY WOULD.**'

RECOMMENDATIONS

1. Some families may benefit from additional follow-up with timely, adoption-competent and trauma-informed services. Services should assess and support the entire family (not just the child) and be offered to families throughout their journey.

2. Routine follow-up with families, particularly as children get older, may be helpful in preventing future discontinuity.

3. Caregivers may need additional training and support to help them talk to their children about healthy connections with their birth family members.

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

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Jack, Joseph and Morton Mandel School of Applied Social Sciences Case Western Reserve University

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

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

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

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

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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.

Executive Summary

Overview

The Vermont Department for Children and Family Services, Family Services Division (DCF/FSD) is the public child welfare and juvenile justice agency responsible for the delivery of child welfare services. FSD works with private agencies throughout Vermont to deliver both pre and post permanency services and supports to families formed through adoption and guardianship. The National Quality Improvement Center for Adoption and Guardianship Support (QIC-AG) partnered with FSD, representatives from Lund, a local private agency, and the University of Vermont on this project.

The QIC-AG site team in Vermont recognized that identifying the needs and strengths of adoptive and guardianship families who may be at an increased risk for discontinuity was important prior to providing early outreach. To that end, the site team developed the Vermont Permanency Survey to identify the strengths, risks, and needs of families post permanency.

Implemented at the Universal Interval of the QIC-AG Permanency Continuum Framework, the Theory of Change for QIC-AG project was that if the system of care in Vermont prioritized early outreach to all adoptive and guardianship families then they would be able to:

- Identify families who are doing well, and understand the strengths and protective factors associated with those families; and

- Develop a viable process for the early identification of families who are facing challenges and may be at increased risk of post permanency discontinuity. In doing so, Vermont will have an opportunity to intervene and provide families services and supports to reduce familial stress and increase protective factors.

Intervention

The Vermont Permanency Survey included validated measures and items that focused on family wellbeing, child wellbeing, caregiver wellbeing, adoption and guardianship experiences, community services, and demographics. The Vermont Permanency Survey was located in the **Develop and Test** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. Developed for this project, it used the following process:

1. Determine survey areas of inquiry
2. Select measures/generate questions
3. Refine/select questions
4. Format survey administration
5. Conduct a focus group
6. Pilot test and finalize survey

We used assertive outreach methods including 1) sending an introductory letter to families prior to administering the survey and 2) sending multiple reminders to increase survey response rates. Other outreach efforts that may have impacted response rates included a participant's familiarity with the agency sending the survey, time of year at which the survey was distributed, whether the area being surveyed was primarily urban or rural, and whether the survey was sent electronically or by mail.

Primary Research Question

The primary research question for this study was:

Will families with children in the state of Vermont whose parents or guardians currently receive an Adoption or Guardianship Assistance Agreement Subsidy experience a reduction in post permanency discontinuity and improved child and family wellbeing if families are provided assertive outreach to complete a survey?

Using a descriptive cross-sectional design, all families with children in the state of Vermont whose parents or guardians were receiving an Adoption or Guardianship Assistance Agreement Subsidy were invited to participate in the study. Parents and guardians were asked to answer questions about one child in their home, referred to as the "identified child." The identified child was randomly selected by the evaluators when parents or guardians were receiving a subsidy for more than one child.

Key Findings and Discussion

Overall, a total of 809 caregivers (55%) completed the survey. The majority of families formed through adoption and guardianship in Vermont were doing well: 98% of caregivers were committed to their child for life, 91% had never thought about ending their adoption or guardianship, and 86% rated the impact of their adoption as positive.

Caregivers who reported that they would definitely adopt their child again had higher levels of resilience, open communication, perseverance in time of crisis, and more positive parent-child interactions compared to caregivers who indicated they were uncertain or definitely would not adopt again. They also 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 finalization and used fewer services in the past six months

While most families were doing well, there were some families at greater risk for discontinuity. These families may benefit from additional follow-up with timely, relevant services from post permanency providers. Services should assess and support the entire family (not just the child) to help strengthen protective factors and reduce risk factors for post permanency discontinuity. These services should be available to families prior to finalization and continue throughout their journey. Checking in with families routinely, particularly as children get older, may help to prevent discontinuity.

Caregivers may also need additional training and support around talking to children about adoption, guardianship and birth families with their children. Providers may want to help families understand why birth families matter and how to help their child maintain connections to their birth family.

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 4

VERMONT PERMANENCY SURVEY

Table of Contents

List of Figures & Tables

Site Background

The Vermont Department for Children and Family Services, Family Services Division (FSD) was the lead agency for the QIC-AG project in Vermont. FSD is the public child welfare and juvenile justice agency responsible for the delivery of child welfare services through 12 district offices. FSD works with private agencies to deliver both pre and post permanency services and supports to families formed through adoption and guardianship. For this project, FSD partnered with Lund, Spaulding for Children, The University of Texas at Austin (UT), and University of Vermont (UVM) to learn from families formed through adoption and guardianship.

FSD identified a need to prioritize early outreach to families formed through adoption and guardianship in order to determine the needs and strengths of families as well as identify families who may be at an increased risk for discontinuity. The Vermont Permanency Survey was developed and sent to all families with children in the state of Vermont whose parents or guardians received an adoption or guardianship assistance agreement subsidy. The purpose of the Vermont Permanency Survey was to:

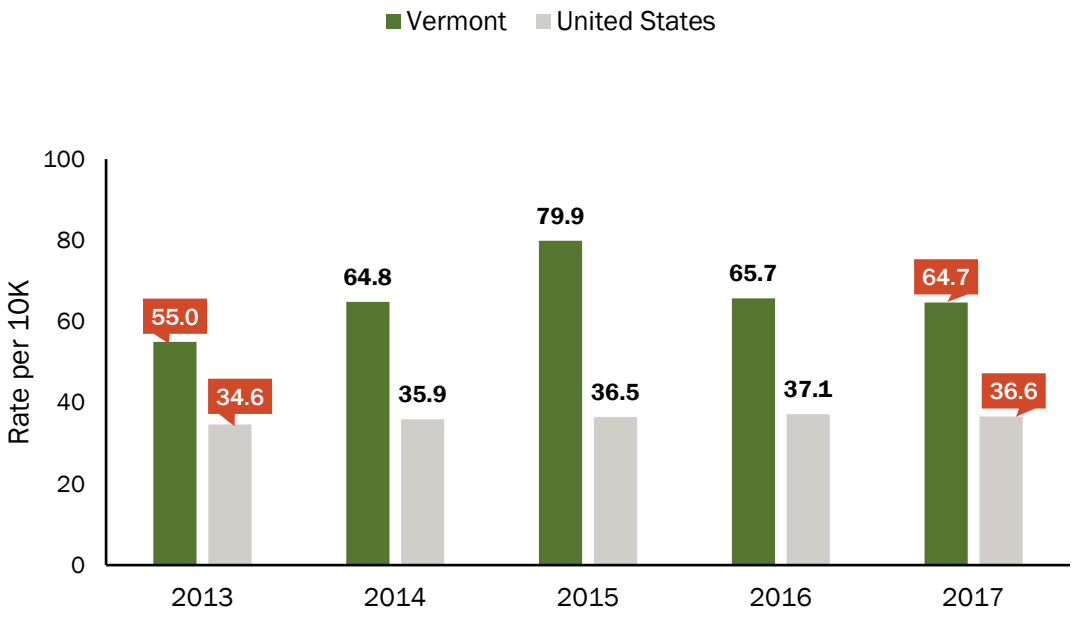
1. Identify and understand the strengths of families who are doing well;
2. Develop a valid process that allows for the early identification of families who are struggling or may be at increased risk of discontinuity;
3. Develop a better understanding of the profile of those adoptive and guardianship families who respond with varying degrees of assertive outreach;
4. Determine on-going service, support, and training needs of families post permanency by district;
5. Provide system of care feedback; and
6. Determine methods to increase response rates.

Because surveys traditionally generate low response rates, Vermont sought to engage families and increase response rates using assertive outreach methods. With increased response rates, Vermont was able to use the survey results to inform future outreach strategies, pre permanency practices, and subsequent post permanency supports.

National Data: Putting Vermont in Context

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

Figure 4.1. Vermont Foster Care Entry per Capita Rate (2013-2017)

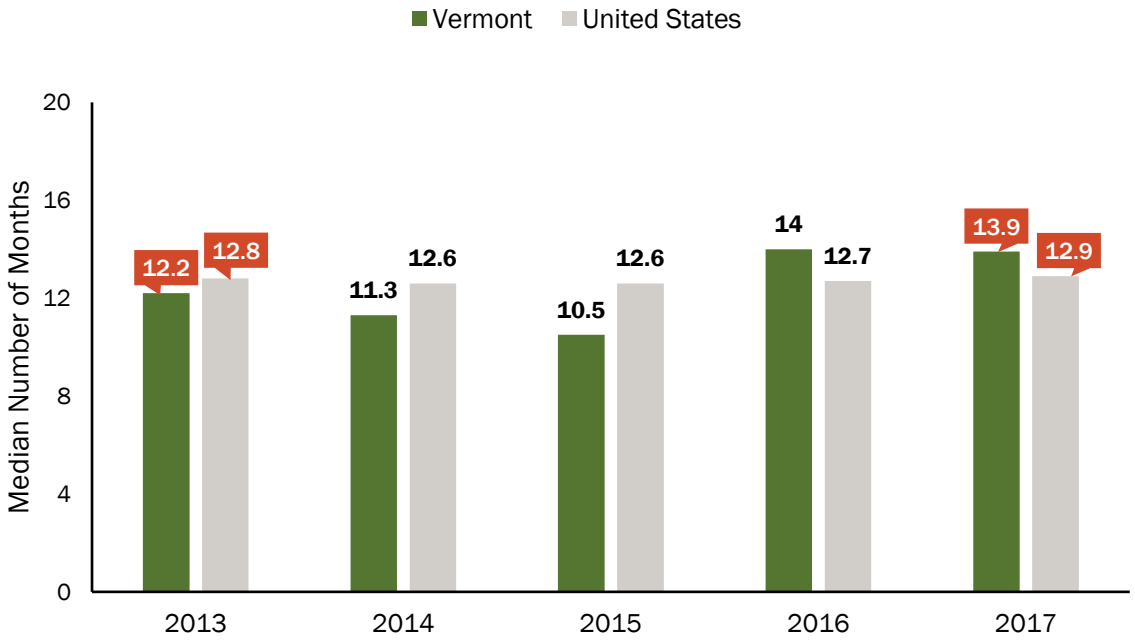


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

As displayed in Figure 4.1, between Fiscal Years 2013 and 2017, the rate[1] of children entering foster care in Vermont and the U.S. increased. Between 2013 and 2017, the state's foster care entry rate increased from 55.0 per 10K (677 children) to 64.7 per 10K (756 children). This per capita rate is 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, although increases over the past five years occurred at both the state and national levels, a greater number of children, per capita, entered foster care in Vermont than in the U.S.

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

Figure 4.2. Vermont Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)



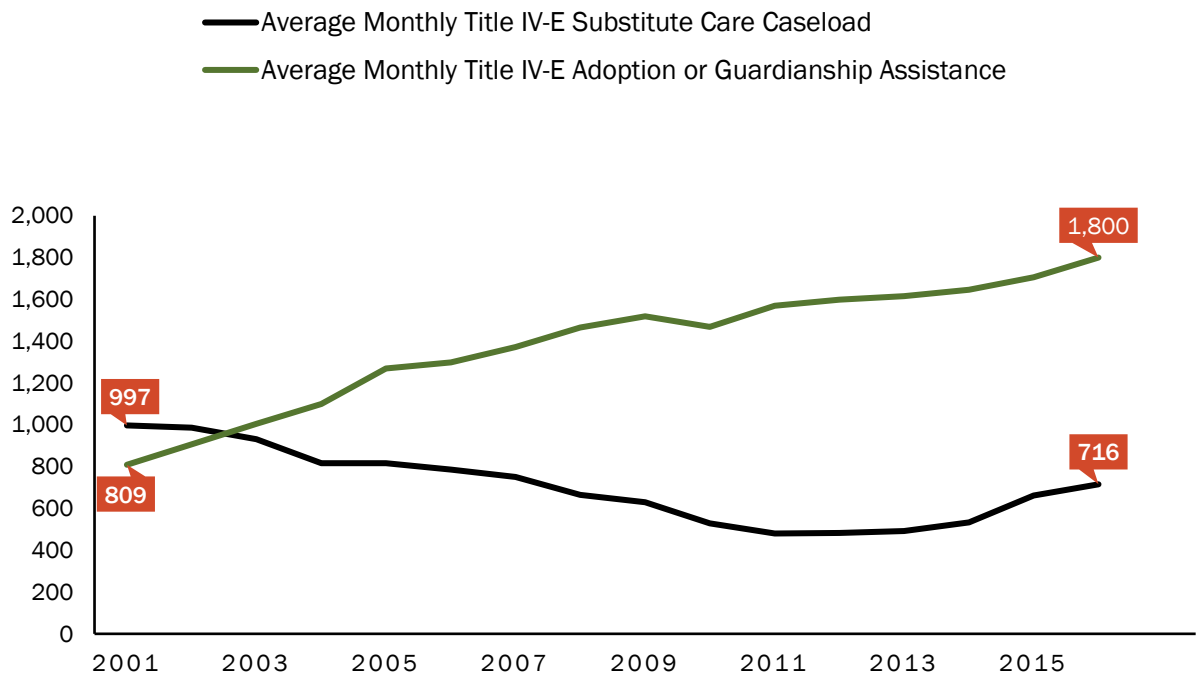
Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

Between 2013 and 2017, the median length of stay for children in foster care at the end of each year (shown in Figure 4.2) for Vermont increased from 12.2 months in 2013 to 13.9 months in 2017 while in the U.S. it increased slightly from 12.8 months in 2013 to 12.9 months in 2017.

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

Nationally, we have seen a shift in the number and proportion of children living in IV-E supported foster care and IV-E funded adoptive or guardianship homes. As shown in Figure 4.3, the number of children in Vermont in IV-E funded foster care and the number of children in IV-E funded adoptive and guardianship homes was approximately the same in 2000 (997 and 809, respectively), yet by 2016 these numbers had significantly diverged. In 2016 there were 716 children in IV-E funded substitute care and 1800 children in IV-E funded adoptive and guardianship homes.

Figure 4.3. Vermont Caseloads



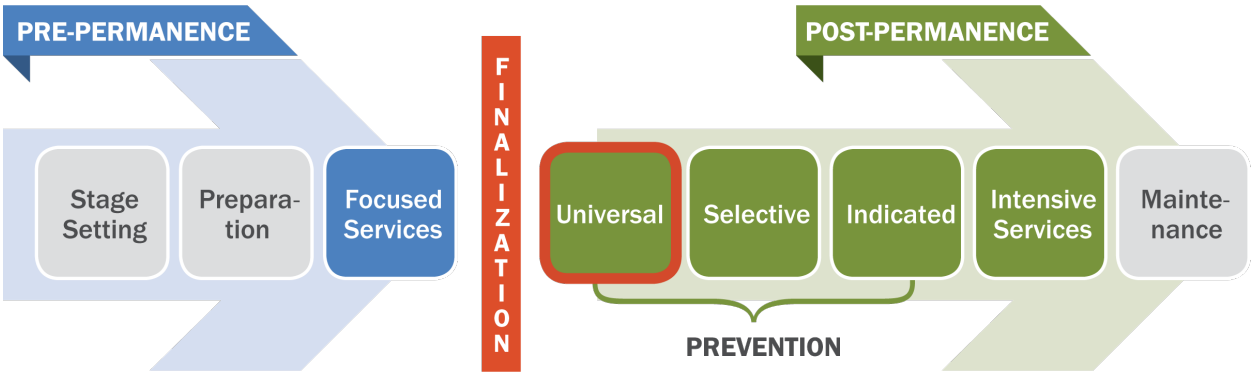
Data sources: Title IV-E numbers: U. S. Department of Health and Human Services / Administration for Children and Families, compiled data from states' Title IV-E Programs Quarterly Financial Reports, Forms IV-E-1 (for years prior to 2011) and CB-496 (for 2011 and later).

QIC-AG Permanency Continuum Interval

Vermont implemented an intervention within the **Universal** Interval of the QIC-AG Permanency Continuum Framework. **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.

Figure 4.4. Vermont QIC-AG Permanency Continuum



Primary Research Question

Will families with children in the state of Vermont whose parents or guardians currently receive an Adoption or Guardianship Assistance Agreement Subsidy experience a reduction in post permanency discontinuity and improved child and family wellbeing if families are provided assertive outreach to complete a survey?

Target Population

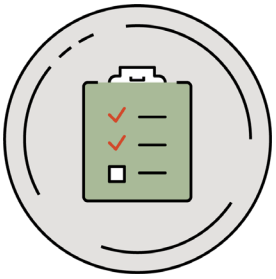
All families with children in the state of Vermont whose parents or guardians received an Adoption or Guardianship Assistance Agreement Subsidy were included in the target population. These families were identified using the Vermont Adoption and Guardianship Assistance Subsidy Database. Families formed through non-subsidized guardianship were excluded from this study.

Families identified in Vermont who adopted a child through a private agency, either domestically or intercountry, were included as a sub-population of this study; however, they were considered a separate population. These families were recruited through agencies and organizations who served families formed through private domestic or intercountry adoption (Please refer to the Vermont Private and Intercountry Adoptions Report in the Appendix for more information).

Intervention

When the Vermont site first expressed interest in the "Universal" category, Spaulding directed the team towards implementing a survey as the intervention. This recommendation was based on the history of Illinois conducting a survey that showed patterns in risk associated with discontinuity, specifically around commitment. Additionally, the Vermont site identified a need to prioritize early outreach to help determine the needs, risks, and strengths of families post permanency in order to provide timely and relevant services and supports.

VERMONT PERMANENCY SURVEY



The Vermont site developed the Vermont Permanency Survey that sought to identify the strengths, risks, and needs of families post permanency. The survey used validated measures and items that focused on the following areas of inquiry: family wellbeing, child wellbeing, caregiver wellbeing, adoption and guardianship experiences, community services, and demographics. The survey was implemented over five cycles. The first cycle was usability testing. After completing usability testing in Cycle 1, the survey was sent over four additional recruitment cycles (Cycles 2-5) starting in January 2016 and ending in October 2018. Recruitment for cycles 2-4 were based on the district in which a family lived at the time of the cycle. The last cycle recruited families who finalized their adoption or guardianship after their area was initially surveyed. Families who did not respond to the initial survey also received one more outreach attempt.

This intervention began in the Develop and Test phase of the Children's Bureau Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare. The Develop and Test phase should result in "a set of specific practices, program components, and intervention guidelines that do not require adjustment, have been defined well enough that others can replicate them, and show an initial improvement in outcomes that can most likely be traced to the intervention" (Framework Workgroup, 2014, p. 11).

The Vermont intervention comprised five core components:

1. Survey development
2. Family and child identification
3. Information tracking and transfer
4. Assertive outreach
5. Data collection, analysis, and reporting

We have provided additional information on how we developed the Vermont Survey and decided on Assertive Outreach strategies:

Survey Development

1. **Determine survey areas of inquiry.** The Vermont site identified key areas of inquiry that were consistent with their theory of change and addressed short and long-term outcomes for this project. These areas focused on family wellbeing, child wellbeing, caregiver wellbeing, adoption and guardianship experiences, and community services. Assessing for components of child, caregiver and family wellbeing allows child welfare and partner agencies to identify and gather information to understand factors that impact the family's safety, permanency, and stability. Determining the most important services, the most needed services and the barriers that interfere with service provision inform the current strengths and areas for growth within the system of care.

2. **Select measures/generate questions.** A variety of validated measures under each area of inquiry were identified to support short-term outcomes. Questions not answered by the measures were added if agreed upon by the larger team.

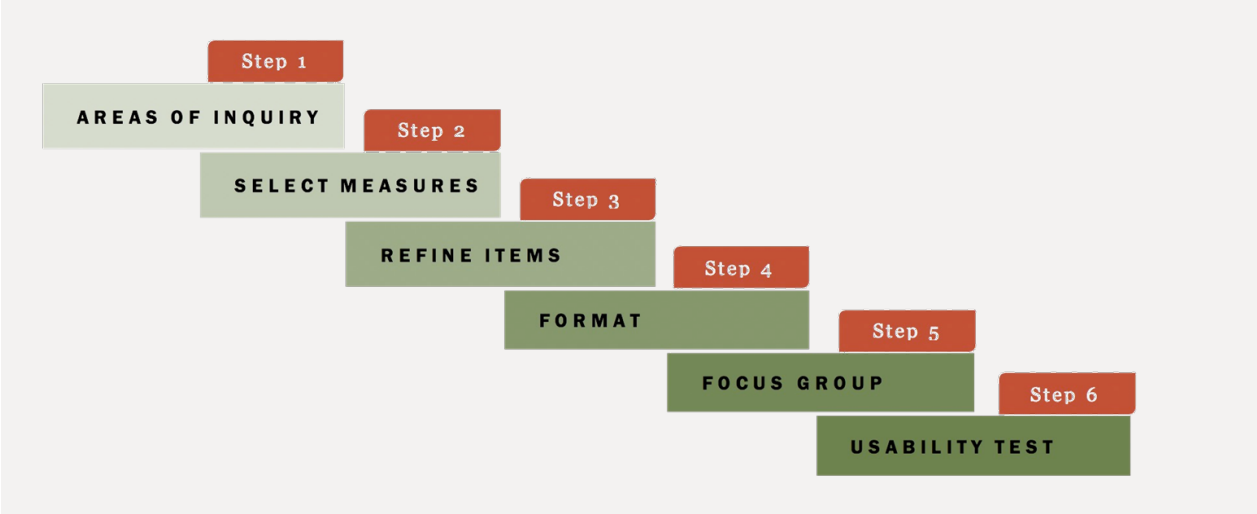
3. **Refine/select questions.** All questions and measures under each area of inquiry were reviewed by the Vermont site team and stakeholders. Key questions and measures were selected to keep in the survey while others were removed to make the survey a manageable length for caregivers. Additionally, some measures were adapted with permission from the purveyors to meet the needs of the Vermont site.

4. **Format survey administration.** The survey was formatted to be administrated by paper and electronically using REDCap.

5. **Conduct a focus group.** A focus group was conducted to help with the adaptation of some scales.

6. **Pilot test and finalize survey.** The survey was piloted with stakeholders, some families, and students to test the length, clarity, and relevance of the survey. Lastly, the Vermont site ran a stress test on the electronic version of the survey to ensure skip patterns and questions were displayed as intended.

Figure 4.5. Vermont Survey Development Process



Assertive Outreach

In order to increase survey response rates and engage families with post permanency services, the Vermont team established assertive outreach methods (methods used to reach and connect with families). Assertive outreach methods were reviewed and adapted after each cycle of survey implementation. Outreach strategies were based on previous research (Dillman, Smyth & Christian, 2014) and on the capacity of the State of Vermont to reach families.

In 2010, Fan & Yan conducted a meta-analysis on factors influencing response rates in web surveys and found:

- Response rates are influenced by factors including topics, length, ordering, and format of the web survey during survey design and development;
- Response rates are impacted by survey delivery factors such as sampling methods, contact delivery modes, invitation designs, informed consent methods, pre-notification letters, reminders, and incentives;
- Survey completion and response rates are impacted by factors such as an individual's level of computer knowledge or web-use and whether an alternative method to take the survey is available; and
- Survey return will impact response rates if various technical failures occur.

Based on this research, the Vermont site included an introductory letter and multiple contact attempts in their initial assertive outreach method. The introductory letter clearly stated the purpose of the survey, asked participants for their help, provided organizational logos and letterhead to establish trust, and used pieces of social exchange theories to decrease the cost of participation to participants while increasing potential benefits.

Outcomes

The following short-term outcomes were evaluated using the Vermont Permanency Survey in addition to the tracking of post permanency services through the Vermont Department for Children and Families- Family Service Division.

- Earlier identification of families post permanency who are struggling and/or who may be at risk of discontinuity
- Increased identification of post permanency service needs by region and system of care provider type
- Improved ability to share information on post permanency needs, risks and protective factors within the Vermont system of care
- Improved capacity to deliver data-driven, relevant and timely prevention and intervention services to families post permanency
- Increased understanding of the profiles of families who respond with varying degrees of assertive outreach

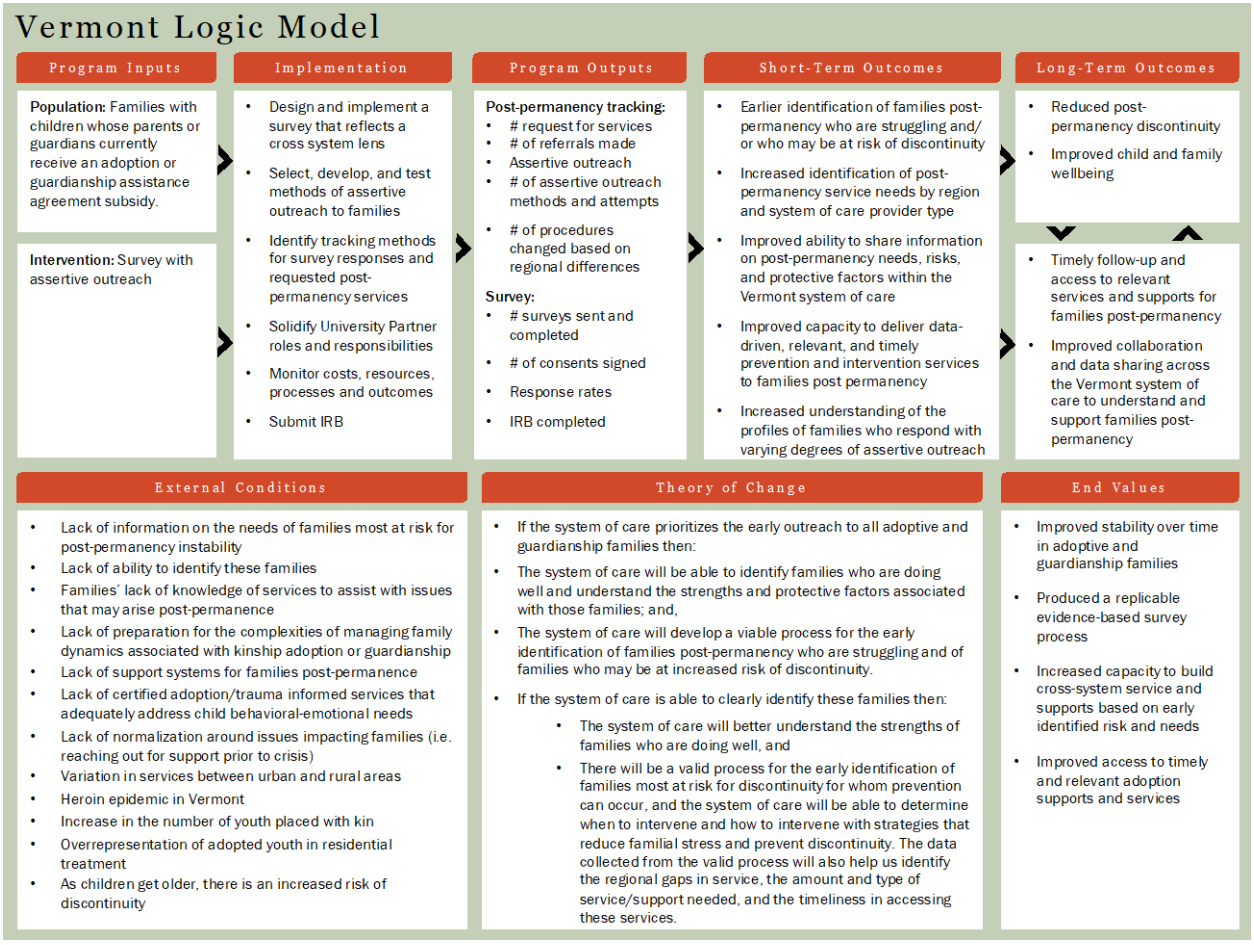
The following outcomes were evaluated using the Vermont post permanency survey linked to the tracking of post permanency services through FSD and AFCARS data:

- Reduced post permanency discontinuity;
- Improved child and family wellbeing;
- Timely follow-up and access to relevant services and supports for families post permanency; and
- Improved cross-system collaboration and data sharing to understand and support families post permanency.

Logic Model

The logic model (see Figure 4.6) 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 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 4.6. Vermont Logic Model



Evaluation Design & Methods

A descriptive cross-sectional design was conducted to understand and gather information on the needs, risks, and strengths of families formed through adoption and guardianship. All families in the target population were invited to participate in this study. Families were identified using the Vermont Adoption and Guardianship Assistance Agreement Subsidy database. Parents and guardians were asked to answer questions about one child in their home, referred to as the "identified child." The identified child was randomly selected by the evaluators when parents or guardians were receiving a subsidy for more than one child.

The evaluation design and protocol were reviewed by the Institutional Review Board (IRB) at The University of Texas at Austin, University of Vermont and Vermont Agency of Human Services.

Procedures

USABILITY

As the first step in implementation, a usability test was conducted in Vermont. During usability (Cycle 1), the survey was distributed to a random sample 51 families (36 families with emails and 15 families without emails) in order to test the survey and initial assertive outreach strategy. Findings from usability indicated a need to make small adjustments to the way variables were labeled in the survey, determine a better process to randomly selecting the "identified child" when a family had multiple children who were adopted or in guardianship, fix minor errors in how families were tracked and increase Vermont's capacity to outreach to families electronically.

RECRUITMENT

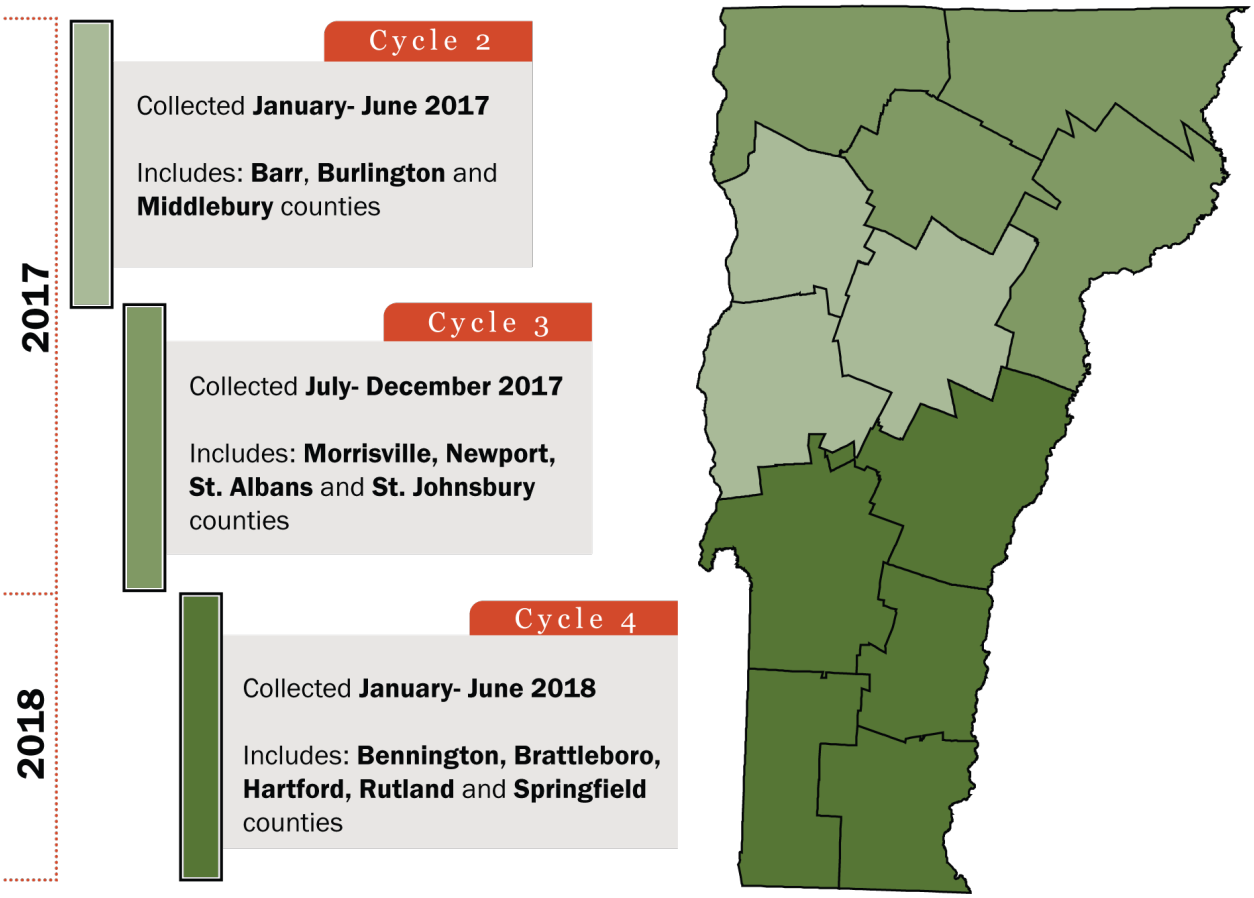
After completing usability testing in Cycle 1, the Vermont site chose to implement the survey over four recruitment cycles (Cycles 2-5) where each cycle occurred approximately six months apart. Implementing cycles in this way allowed for the Vermont team to disseminate findings between cycles to the participating districts. Additionally, a question at the end of the survey asked families if they wanted to be contacted about post permanency services. Initially, the Vermont site team was worried that they might not have the capacity to respond if too many caregivers indicated they did want to be contacted by post permanency services. Therefore, families were recruited in cycles.

At the beginning of each cycle, families were identified using the Vermont Adoption and Guardianship Assistance Subsidy database. Family contact information was pulled from this database and placed into a Family Tracking Workbook. All families with children in the state of Vermont whose parents or guardians received an adoption or guardianship assistance agreement subsidy were included in the target population. Families formed through non-subsidized guardianship were excluded from this study.

Cycles 2-4

In the first three cycles following usability (Cycles 2-4), recruitment was based on the FSD district in which a family lived. Between three and five districts were grouped together into three cycles based on their geographical proximity and total number of children in the target population. In grouping this way, the groups were roughly equivalent in size. Families with children in the target population who resided in those selected group of districts during a cycle were sent the post permanency survey through assertive outreach.

Figure 4.7. Cycles 2-4 District Recruitment Areas



Cycle 5

Cycle 5 was the last survey implementation cycle implemented. It began in July 2018 and closed in September 2018. There were two distinct samples targeted in this cycle (5A and 5B). Families who were not included in previous cycles but eligible for the survey in June 2018 were included in Cycle 5A. These families included 1) families who finalized their adoption or guardianship after the survey has been implemented in their area, and 2) families who moved into a district after the survey has been implemented in their area. These families received the survey with assertive outreach.

Cycle 5B included non-responders (any caregivers living in a previously surveyed district who did not begin the survey). Non-responders were provided with one additional opportunity to complete the survey. Please note that partial responders, or participants who began the survey but did not complete it, and participants who declined to take the survey were not included in this sample.

Lastly, caregivers who did not respond to survey during cycle 5 received an email or postcard asking them to indicate any reasons they were not interested in taking the survey at that time (see the Appendix).

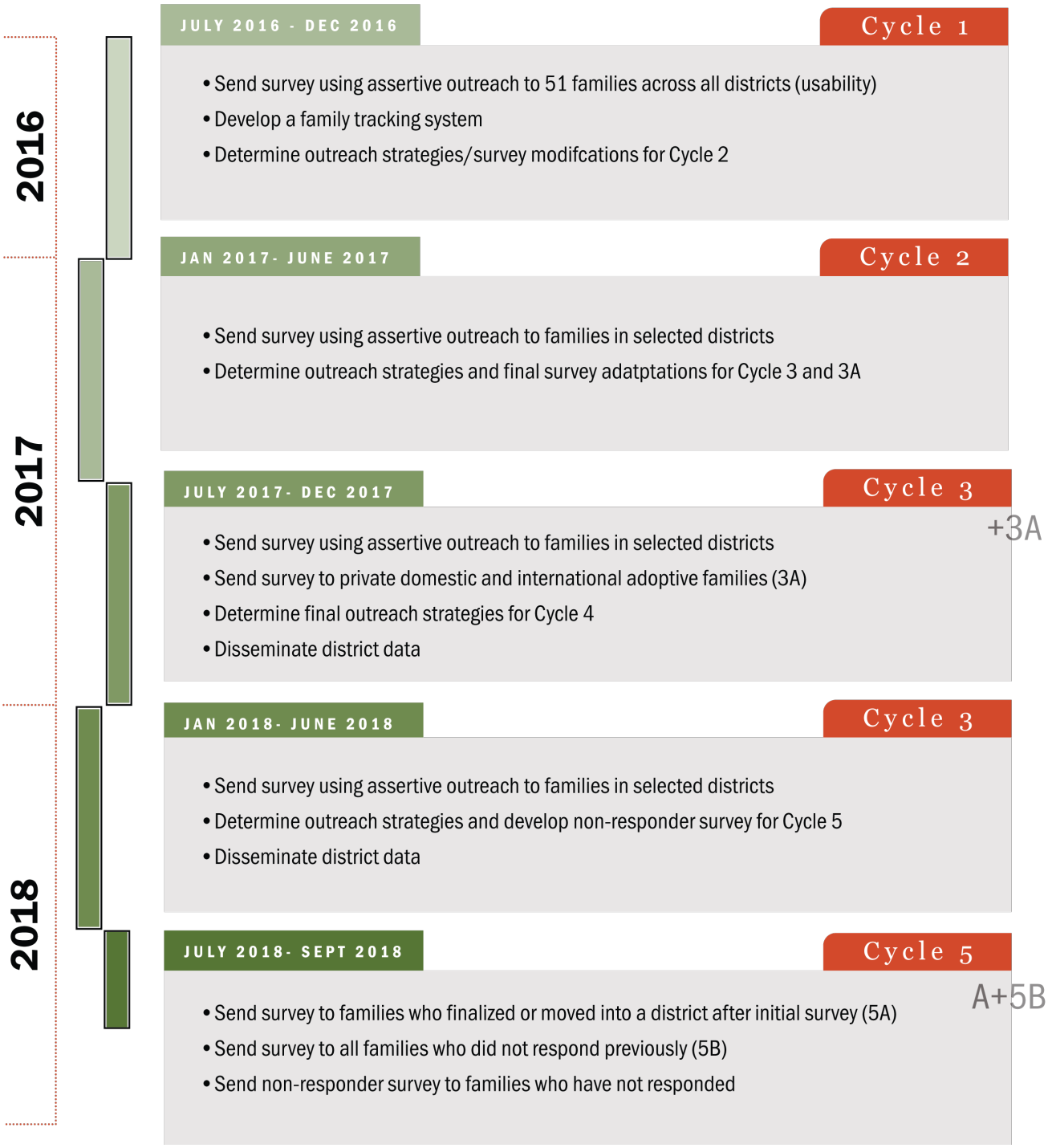
Overall, a total of 1470 families were asked to participate and answer questions about an "identified child," a child for whom they were receiving an adoption or guardianship agreement subsidy. When a family had more than one child in their home, evaluators randomly assigned the "identified child,"

Private Domestic and Intercountry Adoptions

In addition to implementing the survey with families in the target population, the Vermont site team decided to implement the survey with families formed through private domestic and intercountry adoption. Implementation of the survey with this population occurred at the same time as cycle 3 and was referred to as cycle 3A. In cycle 3A, the Vermont site team outreached to agencies and organizations who served families formed through private domestic 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 FSD if they were interested in participating.

Figure 4.8 displays the timeframe and tasks completed for each cycle.

Figure 4.8. Cycle Timeframe and Implementation Tasks



During the initial implementation of the Vermont Permanency Survey, the Vermont site mailed introductory letters about the survey to all participants. For families with emails, an introductory email with the survey link, two reminder emails, and a paper copy of the survey were sent. For families without emails, the first paper survey was sent one week after the introductory letter and the second was sent almost three weeks after the initial survey.

Table 4.1. Initial Assertive Outreach Strategy in Cycle 1

DAY	DATE	TIME	GROUP	TASK
1	Tues 10/25		Electronic & Paper	Mail an intro letter to all families in cycle
8	Tues 11/1	9:30 AM	Electronic	Send an email with the survey link
8	Tues 11/1		Paper	Send a paper survey to families without emails
17	Tues 11/10	2:00 PM	Electronic	Send a reminder email to non-respondents
24	Thurs 11/17		Electronic & Paper	Send a paper survey to non-respondents
38	Thurs 12/1	1:00 PM	Electronic	Send a final email to non-respondents
45	Fri 12/9		Electronic & Paper	Close survey

Adaptations to Assertive Outreach

From the initial cycle to cycle 4, assertive outreach strategies were adjusted slightly to increase overall participation. By cycle 4, Lexus Nexus was being used to identify additional email addresses because caregivers with emails were responding to the survey at a higher rate. Two outreach periods by phone were added, one to families with emails and one to families without emails. This strategy was added to create another connection point with families, collect new contact info when needed, and resend the survey based on the preference of the family. Lastly, an additional reminder email and letter were added to the assertive outreach protocol (see Table 4.2.).

Table 4.2. Final Assertive Outreach Strategy in Cycle 4

DAY	DATE	TIME	GROUP	TASK
PRIOR TO STARTING THE CYCLE LEXUS NEXUS WAS USED TO FIND EMAILS				
1	Mon 1/22		Electronic & Paper	Mail an intro letter to all families in cycle
8	Mon 1/29	9:30 AM	Electronic	Send an email with the survey link
10	Wed 1/31		Paper	Send a paper survey to families without emails
18	Thurs 2/8	2:00 PM	Electronic	Send a reminder email to non-respondents
24-30*	Wed 2/14 – Tues 2/20		Electronic	Call non-respondents with emails. Send an email or paper survey depending on the caregiver's preference. If not able to contact, send a paper survey.
31- 38*	Wed 2/21 – Mon 2/26		Paper	Call non-respondents without emails. Send an email or paper survey depending on the caregiver's preference. If not able to contact, send a second paper survey.
45*	Wed 3/7	2:00 PM	Electronic	Send a reminder email to non-respondents
50	Mon 3/12		Paper	Send a paper reminder letter to non-respondents
59	Wed 3/21	6:30 AM	Electronic	Send a final reminder email to non-respondents
78	Fri 4/9		Electronic & Paper	Close survey

*These assertive outreach steps were added to increase response rates

Incentives

All families who participated and completed the survey received a $20 gift card.

Adherence

A survey protocol was developed to address all communication with survey participants, follow-up requests, and tracking to ensure assertive outreach was followed with fidelity. REDCap was programmed to automatically send out reminder emails to non-responders based on assertive outreach protocols. Lastly, the survey itself also built in validation checks to ensure the quality of data entry.

Measures

PROCESS MEASURES

For each cycle, we assessed adherence to the assertive outreach protocols. The following information was tracked:

- Number of surveys sent via email and mail
- Number of caregivers who responded to initial outreach and number who responded to additional follow up
- Number of respondents called
- Number and dates of survey responses

DESCRIPTIVE AND OUTCOME MEASURES

The Vermont site included the following measures in the Vermont Permanency Survey:

Administrative Data

The Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) databases dated back to 2000 were used to assess differences in families who responded to the survey and those who did not. Federal law and regulation require state child welfare agencies to collect case-level information on all children for whom the agency is responsible for placement, care, or supervision and on children adopted under the auspices of the agency. These data are derived from the Vermont AFCARS and NCANDS submissions to the Administration for Children and Families of the Department of Health and Human Services (ACF). Some of the information in these reports includes demographic information, the number of removal episodes a child has experienced, the number of placements in the current removal episode, as well as the current placement setting.

Adverse Childhood Experiences (ACEs)

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

Behavior 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 problem 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 Guardianships (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).

Brief Resilience Scale (BRS)

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

Caregiver Strain Questionnaire – FC/AG22

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

Education Outcomes

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

Illinois Post Permanency Commitment Items

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

Protective Factors Survey (PFS)

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

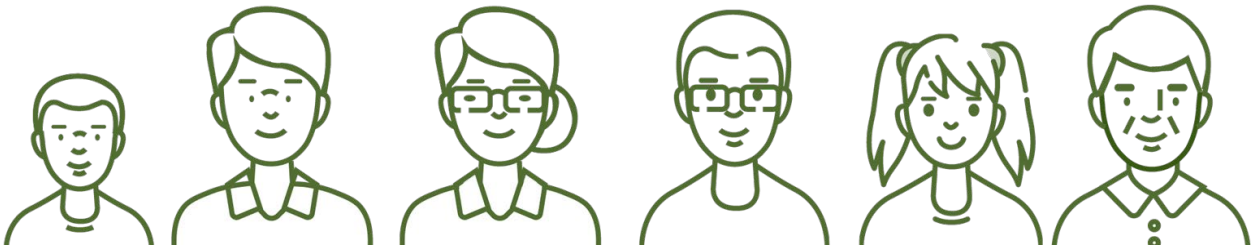
Service Items

Families were asked whether they used various cross-sector services in the past 6 months, and if so, how helpful those services were. Additionally, they were asked to identify the top services and supports, top services that are most needed but hard to get or not available, and the top barriers.

Findings

Sample Frame and Participant Profile

This section describes the population of Vermont families formed through adoption and guardianship. First, response rates by cycle and assertive outreach method (either paper or email) are provided. Next, the characteristics of respondents and non-respondents are discussed. Lastly, the general characteristics of the 809 survey respondents are reported.



UPTAKE

The sample size and overall response rates by assertive outreach method are displayed in Table 4.3. Response rates for families who received the survey electronically were higher than those who were mailed the survey with the exception of cycle 5A, families who were recently formed through adoption or guardianship. Cycle 5B represents families who did not respond to assertive outreach efforts in an earlier cycle. By sending the survey once more to non-respondents at a later time, an additional 49 surveys were collected. Overall, a total of 809 (55%) participants completed the survey across all cycles. The lowest rates were obtained in cycle 3 when the survey was sent in July.

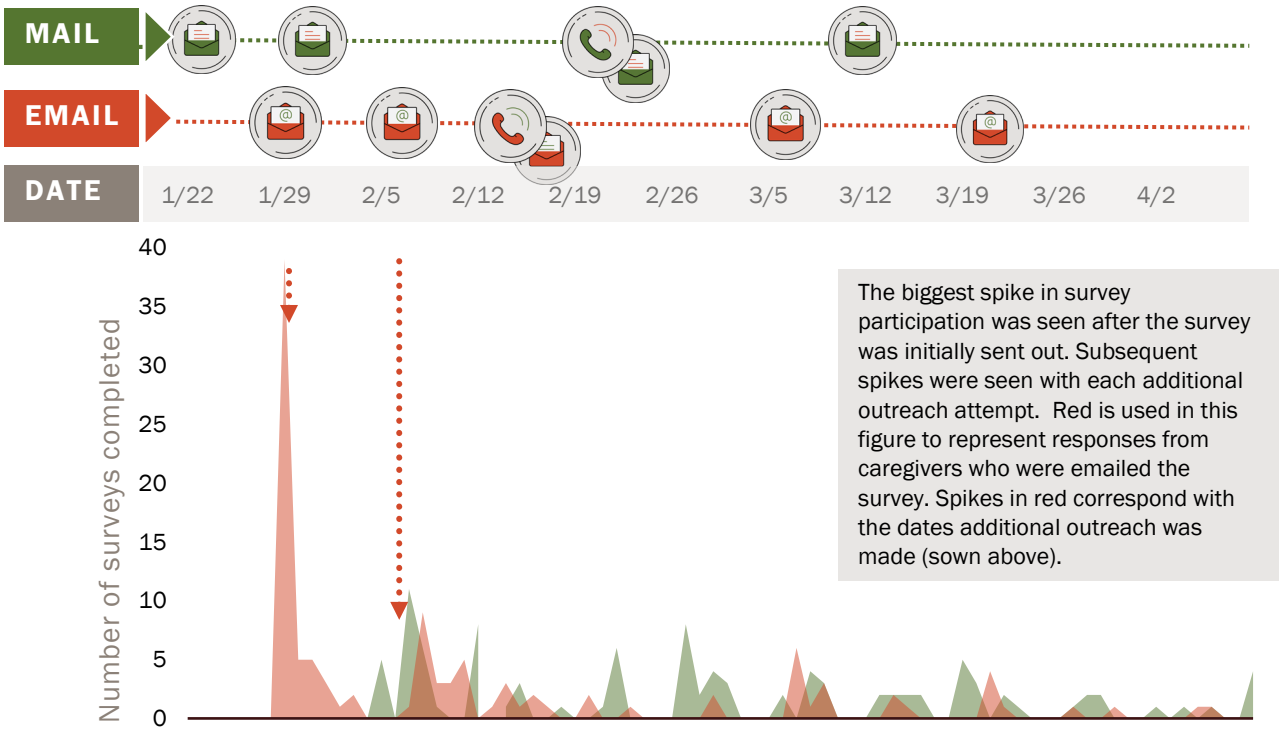
Table 4.3 Response Rates for Families Who Received the Survey

	SAMPLE			PARTICIPANTS			RESPONSE RATES		
	Total	Email	Paper	Total	Email	Paper	Total	Email	Paper
CYCLE 2	454	188	266	255	121	134	56%	64%	50%
CYCLE 3	369	138	231	166	74	92	45%	54%	40%
CYCLE 4	429	205	224	220	111	109	51%	54%	49%
CYCLE 5A	210	168	42	119	93	26	57%	55%	62%
CYCLE 5B	520	158	362	49	20	29	9%	13%	8%
ALL	1470	699	763	809	419	390	55%	60%	51%

We know from prior research that sending a pre-notification letter and making multiple assertive outreach attempts improves response rates (Fan & Yan, 2010). This finding was supported in the current study as well. Other factors may have also impacted response rates, including a participant's familiarity with the agency sending the survey, time of year at which the survey is distributed, whether the area being surveyed is primarily urban or rural, and whether the survey is sent electronically or by mail. Response rates were lower in June compared to January, most likely because children go on summer break in June. Response rates were highest in cycle 2, which included Burlington, Barre, and Middlebury. These districts were more urban compared to districts in other cycles. Additionally, Lund, the agency who sent the survey, is located in Burlington, so families may have been more familiar with this agency. Lastly, response rates were higher for families who received the survey electronically.

Figure 4.9 represents how participants in cycle 4 (finalized assertive outreach strategy) responded over time and by response type.

Figure 4.9. Cycle 4 Response Rates over Time by Type of Outreach



ADHERENCE

Adherence to the assertive outreach protocols was tracked to see if strategies were implemented as intended. Adherence variables provided information on the type and timing of the assertive outreach strategies used each cycle. Adherence to outreach protocols was high, particularly for caregivers who received the survey via email because REDCap was programmed to automatically send out reminder emails on specific dates. Assertive outreach protocols for caregivers receiving the survey by mail was also typically followed across the cycles. Occasionally, dates were shifted to adjust for holidays and/or to provide additional time to get all materials together.

Using Administrative Data: Characteristics of Respondents and Non-Respondents

We matched AFCARS administrative data to all families we asked to participate in the survey. By matching these families, we were able to determine if there were any differences in the characteristics of families who responded to the survey and those who did not. For instance, were families more likely to respond if they had a child with a specific characteristic (e.g., gender, race) or if their child had a different experience in foster care (multiple placements, long lengths of stay)? There were 809 families who completed the survey, and 556 (69%) of these families were able to match to AFCARS data. There were 661 families who did not complete the survey, and 501 (76%) of these families were able to be matched to AFCARS data. Please note that the AFCARS data was pulled around the same time cycle 5A (finalized after the survey had been sent in their district) was collected. Therefore, these families may not yet be represented in AFCARS data.

Results, summarized in Table 4.4, found statistically significant differences between those caregivers responded to the survey and those who did not in the number of times a child moved while in foster care and whether the child had a disability. Caregivers of a child with a disability (identified child) made up a smaller proportion of those who responded to the survey (5%) than those who did not respond to the survey (8%), $\chi^2(1, N=1057) = 6.71, p=.010$. Similarly, caregivers with a child who had moved three or more times in foster care made up a smaller proportion of those who responded to the survey (30%) than those who did not respond to the survey (36%), $\chi^2(1, N=1057) = 3.91, p=.048$. There were no significant differences in a child's race, ethnicity, gender, age at permanence, or mean time in foster care for caregivers that responded and those that did not. There were also no significant differences in a caregiver's age at permanence for caregivers that responded and those that did not.

Table 4.4. Characteristics of Respondents and Non-Respondents Matched to AFCARS Data

	RESPONDENTS 556 of 809 (69%) matched AFCARS	NON-RESPONDENTS 501 of 661 (76%) matched AFCARS	BIVARIATE COMPARISON (Respondents vs non-respondents)		
	%	%	χ^2	*df*	*p*
CHILD HAS DISABILITY	5%	8%	6.71	1	0.010**
3+ MOVES IN FOSTER CARE	30%	36%	3.91	1	0.048*
CHILD'S RACE			5.48	5	0.360
WHITE	98%	96%			
BLACK	1%	2%			
OTHER	1%	2%			
CHILD IS HISPANIC /LATINO	1%	1%	0.70	1	0.403
CHILD IS FEMALE	50%	47%	1.16	1	0.282
	M (SD)	M (SD)	*t*	*df*	*p*
CHILD'S AGE AT PERMANENCE	5.87 (3.97)	6.28 (4.22)	1.60	1055	0.109
CAREGIVER'S AGE AT PERMANENCE	46.46 (10.46)	45.96 (10.05)	-0.77	993	0.440
MEAN YEARS IN FOSTER CARE	2.51 (2.51)	2.51 (1.79)	-0.06	1055	0.950

Using Survey Data: Characteristics of Survey Respondents

The Vermont Permanency Survey was sent to 1470 caregivers, in which 809 (55%) caregivers responded. The 809 caregivers who completed the survey represent 809 unique family households. Most households (76%) had two adult caregivers living at home. Additionally, 175 households were single-parent homes (22%) and twenty-eight households had more than two adult caregivers (3%). Caregivers reported between zero and seven children under 21 who were currently living at home. Table 4.5 provides an overview of the demographic information of the participating caregivers. Most caregivers were female (90%), White (92%), attended at least some college education (78%) and were married (76%). The average age of participating caregivers was 49.69 years old.

Table 4.5. Characteristics of Survey Participants

CAREGIVER CHARACTERISTICS				
			N	%
MARRIED OR LIVING WITH A PARTNER			772	76%
CAREGIVER IS HISPANIC OR LATINO			764	1%
CAREGIVER IS FEMALE			775	90%
CAREGIVER'S RACE			762	
WHITE				92%
BLACK				3%
OTHER				5%
CAREGIVER IS HETEROSEXUAL			523	89%
ATTENDED AT LEAST SOME COLLEGE			774	77%
HOUSEHOLD INCOME			754	
$30,000 OR LESS				15%
$30,001 TO $40,000				16%
$45,001 TO $60,000				19%
$60,001 TO $75,000				12%
$75,001 TO $90,000				13%
$90,001 TO $105,000				10%
MORE THAN $105,000				15%
	Total N	Min	Max	M (SD)
MEAN AGE OF CAREGIVER (YEARS)	754	25	85	49.69(10.10)

For families formed through adoption and guardianship with more than one child in their home, a specific child was randomly selected and was referred to as the "identified child" for the purposes of the survey. Caregivers were asked to think about their "identified child" as they answered the survey. Table 4.6 provides an overview of these children. The majority of caregivers (96%) fostered their child prior to finalization, 27% were related to their child, and 34% had a relationship with their child prior to that child being removed from their birth parents home. For caregivers who were related to their child, the majority were grandparents (67%) and aunts/uncles (38%). The average age of the identified child was 10.81 years old. The average age at the time of finalization was 5.29 years old, and the mean number of years a child was in a caregiver's home prior to finalization was 1.73 years.

Table 4.6. Characteristics of Identified Child

IDENTIFIED CHILD CHARACTERISTICS				
			N	%
CAREGIVER FOSTERED CHILD PRIOR TO ADOPTION OR GUARDIANSHIP			797	96%
CHILD HAD RELATIONSHIP WITH CAREGIVER PRIOR TO REMOVAL			796	34%
CHILD IS RELATED TO CAREGIVER			800	27%
CHILD HAD PREVIOUSLY BEEN ADOPTED OR IN LEGAL GUARDIANSHIP			801	8%
CHILD IS ADOPTED			805	98%
CHILD IS HISPANIC OR LATINO			786	3%
CHILD IS FEMALE			803	49%
CHILD'S RACE			792	
WHITE				88%
BLACK				3%
OTHER				9%
RACIAL MATCH BETWEEN CAREGIVER AND CHILD			762	92%
CHILD IS HETEROSEXUAL			539	63%
	Total N	**Min**	**Max**	**M (SD)**
MEAN AGE OF CHILD (YEARS)	807	1	21	10.81(5.21)
MEAN AGE OF CHILD AT TIME OF FINALIZATION	791	0	17	5.29 (3.95)
MEAN YEARS IN HOME PRIOR TO FINALIZATION	788	0	15	1.73 (1.5)

Table 4.7. Child's Age by Time since Finalization

	TIME SINCE FINALIZATION				
CHILD'S AGE	<2 Years	2-4 Years	5-9 Years	10+ Years	Total
0-3 YEARS OLD	70	9	0	0	79
4-7 YEARS OLD	74	64	19	0	157
8-12 YEARS OLD	51	63	78	19	211
13 OR OLDER	37	43	83	170	333
TOTAL	232	179	180	189	780*

* Twenty-nine caregivers did not provide information on the date of their adoption finalization.

Outcome Evaluation

In this section, we first provide the overall findings on the wellbeing of families formed through adoption and guardianship. Next, we assess the following short-term outcomes (STO):

- Outcome 1: Earlier identification of families post permanency who are struggling and/or who may be at risk of discontinuity
- Outcome 2: Increased identification of post permanency service needs by region and system of care provider type
- Outcome 3: Improved ability to share information on post permanency needs, risks and protective factors within the Vermont system of care
- Outcome 4: Improved capacity to deliver data-driven, relevant and timely prevention and intervention services to families post permanency
- Outcome 5: Increased understanding of the profiles of families who respond with varying degrees of assertive outreach was already discussed under the Participant section of Findings.

Lastly, we explore a subset of questions that focus on communication around adoption and guardianship and birth family contact.

This section summarizes family wellbeing, caregiver wellbeing and child wellbeing across all participants. Overall, survey data indicated that the majority of families formed through adoption and guardianship are doing well. However, some families may be experiencing challenges that place them at greater risk for discontinuity. These families may benefit from timely, relevant services.

Family Wellbeing

We asked caregivers about several family, caregiver and child wellbeing indicators. In terms of family wellbeing, we focused on the relationship between caregivers and children, a caregiver's commitment to their child for life, their overall adoption or guardianship experience, and family functioning.

- **98%** agreed or strongly agreed they are committed to their child for life, no matter what
- **95%** said their relationship with their child has either stayed the same or improved over the past 6 months
- **91%** have never thought about ending their adoption of guardianship
- **86%** rated the impact of adoption on their family as positive (60% rated it as extremely positive)
- **78%** would definitely adopt or assume guardianship of their child again if they knew then what they know now
- **77%** would recommend adoption or guardianship to others

We measured family functioning and attachment using two subscales from the Family Protective Survey (PFS): 1) Family Functioning/Resilience and 2) Nurturing and Attachment. Higher scores on the Family Functioning/Resilience Subscale indicate more open communication within the family and a greater ability to persevere or manage problems in times of crisis. On the Nurturing and Attachment Subscale, higher scores indicate a higher level of emotional bonding and positive interaction between the parent and child. Mean scores for both subscales are reported in Table 4.8.

Lastly, we used the Belonging and Emotional Security Tool (BEST) to assess the shared sense of belonging and the degree to which a caregiver has claimed their child either emotionally or legally. Higher scores are protective and indicate a greater sense of belonging and a higher level of caregiver commitment. Total scale and subscale scores are reported in Table 4.8.

Table 4.8. Family Wellbeing Indicators

MEASURE	SCALE RANGE	N	MIN	MAX	M	SD
PFS FAMILY FUNCTIONING	1 – 7	805	2.40	7.00	5.97	0.79
PFS NURTURING ATTACHMENT	1 – 7	807	1.00	7.00	5.98	0.96
BEST-AG	20 –100	808	20	100	95.61	7.69
BEST-AG EMOTIONAL SECURITY	13 – 65	808	13	65	61.61	5.60
BEST-AG CLAIMING	7 – 35	808	7	35	34.00	2.37

Caregiver Wellbeing

Caregivers were asked about their history of adverse experiences in childhood (ACEs) and how those experiences impact parenting their child now. On average, caregivers reported having two ACEs before the age of 18. The two most common ACEs were living with someone who had a problem with alcohol or substance use, having parents who separated or divorced, and/or living with a parent or adult who often insulted them or put them down. When caregivers reflected on how ACEs impacted their parenting now, there was no consistent response. A few example quotes that reflect a range of responses are listed below:

> **"The negative experiences I had as a child have made me a stronger, kinder, more loving parent. My top priority since I have become a parent is to make sure my children feel supported, important, worthy, safe and loved."**

> **"My mother made it clear that she did not want me and offered me little affection and never considered my thoughts or feelings. I try to listen; I understand childhood resentment and anger; I never want my child to feel insignificant or unwanted. I was not allowed or was not given the opportunity to do many things (sports, camp, music) so I work hard so my son has opportunities to try things and to learn new things."**

> **"I can relate to the loss of a parent and a craving to know more about my origins."**

> **"I sometimes respond in anger rather than taking time to calm down before addressing a situation."**

> **"I may be a little overprotective."**

We also looked at the ability of caregivers to cope and respond to stressful events in their lives. Mean scores on the Brief Resilience Scale (BRS) are reported in Table 4.9. Scores between 1.00 and 2.99 indicate low resilience, scores between 3.00 and 4.30 indicate normal resilience, and scores ranging from 4.31 to 5.00 indicate high resilience (Smith et al., 2013, p.177). The mean BRS score indicated the majority of caregivers had normal (62%) or high (31%) resilience.

We asked caregivers about their confidence in meeting the needs of their child and their ability to understand their child. Overall, 81% of participating caregivers reported being "very confident" or "extremely confident" that they could meet the needs of the identified child. A total of 68% of caregivers reported that in the past month they either "never" or "less than once a week" felt they just did not understand their child.

Lastly, we assessed a caregiver's level of strain, or the extent to which a caregiver experiences additional demands, responsibilities, and difficulties, as a result of parenting their child for whom they have legal guardianship or who was adopted. The mean overall strain, subjective strain, and objective strain scores are reported in Table 4.9. Scores can range from one to five, and higher scores indicate higher levels of strain. The mean caregiver strain score (1.97) was relatively low. The mean objective strain score (1.75) was lower than the subjective strain score (2.15) experienced by caregivers.

Table 4.9. Mean Caregiver Resilience and Caregiver Strain Scores

MEASURE	SCALE RANGE	N	MIN	MAX	M	SD
CAREGIVER STRAIN (CGSQ-FA22)	1 – 5	802	1.00	4.50	1.97	0.71
OBJECTIVE STRAIN	1 – 5	801	1.00	5.00	1.75	0.82
SUBJECTIVE STRAIN	1 – 5	802	1.00	4.58	2.15	0.73
CAREGIVER RESILIENCE	1 – 5	802	2.00	5.00	3.96	0.67

Child Wellbeing

Social, Emotional and Behavioral Wellbeing

In addition to caregiver wellbeing and family wellbeing, we also assessed child wellbeing. We used the Behavior Problem Index to examine the frequency, range, and type of childhood behavior problems children ages four and older may exhibit (Peterson & Zill, 1986). Higher scores indicate more challenges. (See Table 4.10 below.) Overall, the average total BPI score was 18.24 out of 56.

Table 4.10. Child Behavioral Wellbeing

MEASURE	SCALE RANGE	N	MIN	MAX	M	SD
BEHAVIOR PROBLEM INDEX (BPI)	0 – 56	722	0	53	18.24	12.57
BPI EXTERNALIZING BEHAVIORS	0 – 38	722	0	37	13.16	9.26
BPI INTERNALIZING BEHAVIORS	0 – 22	722	0	21	6.07	4.59

Using the CANS as a reference point, the Vermont team developed ten items to measure the social and emotional wellbeing of children (see Table 4.11 below). These items, when summed together, strongly correlated with the BPI, had good internal consistency (Cronbach's alpha=.91) and may be a potential tool to evaluate social and emotional wellbeing in the future. Further evaluation should be conducted to evaluate these items as a scale.

Table 4.11. Social and Emotional Wellbeing

ITEM	N	%	%
HOW MUCH…		Not at all, a little, moderately	A lot or a great deal
DOES YOUR CHILD GET ALONG WITH OTHER ADULTS?	804	24%	76%
IS YOUR CHILD LIKED BY OTHER CHILDREN?	788	48%	52%
HOW EASY OR HARD IS IT FOR YOUR CHILD TO…		Somewhat hard, very hard	Somewhat easy, very easy
FIND THINGS THEY LIKE ABOUT THEMSELVES?	757	35%	65%
MAKE FRIENDS?	791	39%	61%
ASK FOR HELP?	798	43%	57%
BOUNCE BACK QUICKLY WHEN THINGS DON'T GO THEIR WAY?	797	45%	55%
STAY CALM WHEN FACED WITH A CHALLENGE?	796	63%	37%
HOW OFTEN DOES YOUR CHILD…		Never to about half of the time	Most of the time, always
HELP OTHERS?	785	44%	56%
SHOW INTEREST OR CURIOSITY IN LEARNING NEW THINGS?	802	33%	66%
HOW…		Not at all, a little, moderately	Very, extremely
OPTIMISTIC IS YOUR CHILD ABOUT THEIR FUTURE?	677	44%	66%

Educational Wellbeing

In terms of educational wellbeing, schools provide a source of support through crucial relationships with teachers and peers (Sandoval-Hernandez & Cortes, 2012). Strong, supportive relationships with adults and peers in an academic setting allow children to explore different activities and identify areas they might excel. There were 617 of the 809 children in school at the time of the survey (Kindergarten through 12th grade/no assigned grade level), and according to caregivers, **83% of these children had at least one teacher at school who really understood their child's needs.** Additionally, we found that youth were involved in afterschool activities, in particular sports or athletics (64%), art, dance or music class (49%) and academic tutoring and support (45%). About one third (36%) of children were involved in volunteer work (see Table 4.12 below).

Table 4.12. Participation in Afterschool Activities

AFTERSCHOOL ACTIVITY	N	%
ACADEMIC TUTORING/SUPPORT	598	44.6
SPORTS OR ATHLETIC ACTIVITIES	601	64.1
MARTIAL ARTS	586	7.8
ART, DANCE, OR MUSIC CLASS	595	48.6
CLUBS OR ORGANIZATIONS	595	40.0
RELIGIOUS YOUTH GROUP	590	17.8
RELIGIOUS INSTRUCTION/SUNDAY SCHOOL	589	24.8
VOLUNTEER WORK	593	35.9
PART-TIME JOB	586	16.4
UNPAID INTERNSHIP	576	3.5

While children had supportive relationships at school and participated in afterschool activities, there were also some children who struggled more than others. According to caregivers, about half of the children were performing "good" or "excellent" in math (52%), 26% were performing "fair," and 22% were performing "poor" or "very poor." Similarly, 58% of children were performing "good" or "excellent" in reading and language arts, 27% were performing "fair," and 22% were performing "very poor," or "poor." About half (44%) of the children had an IEP (see Table 4.13).

During the past six months, 18% of children repeated a grade and 9% changed schools for reasons other than grade promotion. In terms of discipline, 12% of children had received an in-school suspension over the past six months, 8% had received an out of school suspension, and 2% had been expelled (see Table 4.13).

In terms of school services, 63% of caregivers reported that schools met the needs of their child over the past six months. When asked to identify the most important and most needed services, caregivers mentioned the following school-based services: special education, mentoring and increased awareness or competency of school staff as being critical to families formed through adoption and guardianship. Barriers mentioned specific too schools included schools and teachers not being trauma-informed and system-level barriers including challenges navigating the school system to get needed supports.

Table 4.13. Special Education, School Performance and Discipline

EDUCATIONAL WELLBEING	N	%
HAS 504 PLAN	576	21%
HAS AN IEP	592	44%
HAS AT LEAST ONE TEACHER WHO REALLY UNDERSTANDS THEIR NEEDS	603	83%
"GOOD" OR "EXCELLENT" PERFORMANCE IN MATH	605	52%
"GOOD" OR "EXCELLENT" PERFORMANCE IN READING & LANGUAGE ARTS	604	58%
HAS REPEATED A GRADE	587	18%
HAS CHANGED SCHOOLS FOR REASONS OTHER THAN GRADE PROMOTION	601	9%
RECEIVED AN IN-SCHOOL SUSPENSION	601	12%
RECEIVED AN OUT-OF-SCHOOL SUSPENSION	604	8%
BEEN EXPELLED FROM SCHOOL	600	2%
HAS RECEIVED AWARDS, CERTIFICATES OR MADE HONOR ROLL	601	43%
HAS HELD A LEADERSHIP POSITION IN A CLUB OR ORGANIZATION	601	13%

Health Issues that Impact Daily Functioning

Initially, we asked caregivers if their child had a physical health issue that impacted his or her daily functioning. Caregivers included other types of health issues in their responses, including but not limited to, mental health, food challenges, and disabilities. As a result, several items were added to the survey beginning in cycle three. Most commonly, caregivers reported their child had a mental health issue (38%), sibling conflicts (24%), and food issues (23%). (See Table 4.14.) When asked about prenatal exposure to substances, about one-third of parents were unsure. Of the caregivers who knew, the majority (81%) indicated their child had been prenatally exposed. This finding is particularly relevant because prenatal drug exposure can have a negative, long-term impact on child behavior, cognition, and achievement. In school-age children and adolescence, in utero exposure has been linked to negative, externalizing behaviors, impulsivity, hyperactivity, problems with cognition and executive functioning, disrupted school experiences, and mental health outcomes (Behnke et al., 2013).

Table 4.14. Health Issues that Impact Daily Functioning

HEALTH ISSUE	N	%
PHYSICAL HEALTH	800	19%
MENTAL HEALTH	549*	38%
SIBLING CONFLICTS	469*	24%
FOOD CHALLENGES	548*	23%
PHYSICAL DISABILITY	547*	8%
SUBSTANCE USE	548*	3%
PRENATAL EXPOSURE TO ALCOHOL OR OTHER SUBSTANCES	357*	81%
INTELLECTUAL DISABILITY	540*	17%

Relationship between Family, Caregiver and Child Wellbeing Indicators

Because prior research has shown that the Behavior Problem Index and six Illinois Commitment Items play a role in understanding post permanency discontinuity (Liao & Testa, 2016; Liao & White, 2014; Testa, Snyder, Wu, Rolock, & Liao, 2015), we looked at the relationship of these variables with the following measures: Protective Factors Survey, Belonging and Emotional Security Tool, Brief Resiliency Survey, and the Caregiver Strain Questionnaire – (adapted for Foster and Adoptive Families).

All relationships between items and measures were significant; however, some were stronger than others. We found a strong relationship between behavior problems and caregiver strain and moderate relationships between commitment, and 1) emotional bonding and positive child interactions, and 2) a shared sense of family belonging. A negative moderate relationship was found between commitment and strain. (See Table 4.15).

Table 4.15. Correlations of BPI and Commitment Items with Other Measures

MEASURE OR ITEM	CGSQ-FA22	BRS	PFS-NA	PFS-FF	BEST
BEHAVIOR PROBLEM INDEX	0.62**	-0.34**	-0.43**	-0.21**	-0.31**
IN THE PAST MONTH, HOW OFTEN DID YOU JUST NOT UNDERSTAND YOU CHILD?	0.49**	-0.29**	-0.51**	-0.32**	-0.36**
HOW CONFIDENT ARE YOU THAT YOU CAN MEET YOUR CHILD'S NEEDS?	-0.49**	0.33**	0.54**	0.36**	0.41**
HOW WOULD YOU RATE THE IMPACT OF ADOPTION ON YOUR FAMILY?	-0.48**	0.26**	0.57**	0.32**	0.53**
GIVEN YOUR EXPERIENCE, WOULD YOU RECOMMEND ADOPTION TO OTHERS?	-0.44**	0.23**	0.37**	0.26**	0.37**
IF YOU KNEW THEN WHAT YOU KNOW NOW, DO YOU THINK YOU STILL WOULD HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF YOUR CHILD?	-0.45**	0.21**	0.50**	0.18**	0.50**
HOW OFTEN HAVE YOU THOUGHT ABOUT ENDING THIS ADOPTION OR GUARDIANSHIP?	0.32**	-0.14**	-0.39**	-0.17**	-0.43**

**p<.001

CORRELATION	STRENGTH AND DIRECTION OF RELATIONSHIP
-0.6 to 1.0	Strong, negative
-0.40 to -0.59	Moderate, negative
-0.20 to -0.39	Weak, negative
0.20 to 0.39	Weak, positive
0.40 to 0.59	Moderate, positive
0.6 to 1.0	Strong, positive

Reliable and valid measures are needed in post permanency research. By looking at the relationship between variables we know are connected to post permanency discontinuity and other wellbeing measures, we begin to identify potential measures that may help us understand the characteristics of families at risk for discontinuity. In addition, all measures used in this study showed high internal consistency (i.e., Cronbach's alphas greater than .70; DeVellis, 2003). The Cronbach's alpha for each scale is shown in Table 4.16 below.

Table 4.16. Reliability of Survey Measures

SCALE	CRONBACH'S ALPHA
BEHAVIOR PROBLEM INDEX	0.95
BELONGING AND EMOTIONAL SECURITY TOOL	0.94
CAREGIVER STRAIN QUESTIONNAIRE – FOSTER CARE AND ADOPTION (22 ITEMS)	0.93
PROTECTIVE FACTORS SURVEY - NURTURING ATTACHMENT	0.89
PROTECTIVE FACTORS SURVEY - FAMILY FUNCTIONING	0.87
BRIEF RESILIENCE SCALE	0.87

ADOPTION AND GUARDIANSHIP SPECIFIC FINDINGS

Communication around Adoption and Guardianship

We asked caregivers, "How comfortable or uncomfortable are you answering your child's questions about his or her birth parents history?" and "In the past 6 months, how often did you bring up adoption or guardianship with your child?" The majority of caregivers indicated they were very comfortable (67%) or somewhat comfortable (25%) answering questions about their child's birth family history. However, most caregivers never (32%) or rarely (41%) talked about adoption or guardianship with their child (See Table 4.17.)

Table 4.17. Caregiver's Level of Comfort by How Often They Brought up Adoption or Guardianship

		LEVEL OF COMFORT TALKING ABOUT A CHILD'S BIRTH FAMILY HISTORY				% PARENT
		Very Uncomfortable	Somewhat uncomfortable	Somewhat comfortable	Very comfortable	
% PARENT BROUGHT UP ADOPTION OR GUARDIANSHIP WITH CHILD	Never	1%	2%	7%	22%	32%
	< Monthly	1%	2%	10%	28%	41%
	Monthly	0%	1%	4%	12%	18%
	Weekly	0%	0%	2%	4%	7%
	Daily	0%	0%	0%	1%	1%
% LEVEL OF COMFORT		2%	5%	25%	67%	100%

We also looked at the comparison between how often parents bring up adoption or guardianship and how often children initiate that conversation. Findings showed that both caregivers and children were not initiating conversations around adoption and guardianship. A total of 37% of parents indicated they never initiated conversation and 38% of parents brought up adoption or guardianship on a less than monthly basis (see Table 4.18). Similarly, 33% of children never brought up adoption or guardianship and 41% brought it up less than monthly.

Table 4.18. Conversations about Adoption and Guardianship: Child-Initiated vs. Caregiver-Initiated

		% CHILD (AGE 4+) BROUGHT UP ADOPTION OR GUARDIANSHIP IN CONVERSATION					% PARENT
		Never	< Monthly	Monthly	Weekly	Daily	
% PARENT BROUGHT UP ADOPTION OR GUARDIANSHIP WITH CHILD	Never	26%	8%	2%	1%	0%	37%
	< Monthly	6%	27%	5%	1%	0%	38%
	Monthly	1%	5%	8%	1%	0%	15%
	Weekly	1%	1%	3%	4%	0%	9%
	Daily	0%	0%	1%	0%	1%	1%
% CHILD		33%	41%	18%	6%	1%	100%

Birth Family Contact

This section focuses on the relationship between families formed through adoption and guardianship and birth families. We wanted to understand whether or not children had contact with their birth family, the type of contact, and how important contact was to caregivers. We found that 31% of caregivers indicated that contact was not possible between their child and their child's birth mother while 45% indicated contact was not possible between their child and their child's birth father.

We asked caregivers who felt contact was possible how important is it to them that their child has contact with his or her birth parents. The majority (42%) of caregivers reported that contact with their child's birth mother was not at all important while even more (54%) caregivers indicated that contact with their child's birth father was not at all important. (See table below). In the past six months, 48% of children had no contact with their birth mother and 66% had no contact with their birth father. The most common form of contact for both birth parents was through visitation or phone/Skype/FaceTime. A summary of birth parent contact is presented in Table 4.19 below.

Table 4.19. Birth Parents: Is Contact Important? Did It Happen?

SERVICE SECTOR	CONTACT NOT POSSIBLE			CONTACT NOT IMPORTANT			NO CONTACT IN PAST 6 MONTHS		
	N	n_1	%	N	n_2	%	N	n_3	%
BIRTH MOTHER	797	244	31%	553	230	42%	549	265	48%
BIRTH FATHER	794	358	45%	436	236	54%	436	287	66%

A total of 628 out of 809 caregivers (78%) indicated that their child had at least one birth sibling living outside of their home. Caregivers generally placed more importance on contact with birth siblings. Almost half (43%) indicated contact was either "very" or "extremely" important; however, 19% of caregivers still indicated birth sibling connections outside of the home were not at all important. Moreover, in the past six months, 45% of children had no form of contact with their birth siblings outside of their home. For those who did have contact, visitation was the most common type of contact reported. A summary of birth sibling contact is presented in Table 4.20 below.

Table 4.20. Birth Siblings: Is Contact Important? Did It Happen?

	BIRTH SIBLINGS OUTSIDE HOME			CONTACT NOT IMPORTANT			NO CONTACT IN PAST 6 MONTHS		
	N	n_1	%	N	n_2	%	N	n_3	%
BIRTH SIBLINGS	809	628	78%	618	119	19%	622	281	45%

Kinship Families

Lastly, we compared child and family wellbeing outcomes for caregivers who were biologically related to their child (kinship) and those who were not biologically related to their child (non-kin). There were 215 caregivers who indicated they were biologically related to their child (27%). Overall, kinship caregivers reported lower levels of caregiver strain and fewer child behavioral problems compared to non-kin caregivers. Kinship caregivers also had higher levels of nurturing and attachment and emotional security compared to non-kin; however, caregiver commitment was not significantly different between the two groups. (See Table 4.21 below.)

Table 4.21. Child & Family Wellbeing for Kinship and Non-Kin Caregivers

		KINSHIP	NON-KIN	KIN VS NON-KIN		
MEASURE	**Range**	**M**	**M**	***t***	***df***	***p***
ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN						
BEHAVIOR PROBLEM INDEX	0 - 56	15.68	19.22	-3.35	712	0.001
BPI EXTERNALIZING BEHAVIORS	0 - 38	13.86	11.34	-3.22	712	0.001
BPI INTERNALIZING BEHAVIORS	0 - 22	5.15	6.42	-3.28	712	0.001
CAREGIVER STRAIN (CGSQ-FA22)	1 - 5	1.84	2.02	-3.09	791	0.002
CGSQ-AG OBJECTIVE STRAIN	1 - 5	1.63	1.80	-2.55	790	0.011
CGSQ-AG SUBJECTIVE STRAIN	1 - 5	2.02	2.20	-3.19	791	0.001
MEASURE	**Range**	**M**	**M**	***t***	***df***	***p***
ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN						
PFS FAMILY FUNCTIONING	1 - 7	5.99	5.97	0.27	328.11	0.786
PFS NURTURING ATTACHMENT	1 - 7	6.22	5.89	5.00	498.69	<0.001
BEST-AG OVERALL	20 - 100	96.48	95.33	1.96	413.81	0.051
BEST-AG EMOTIONAL SECURITY	13 - 65	62.41	61.34	2.57	448.54	0.011
BEST-AG COMMITMENT	7 - 35	34.07	33.97	0.50	797	0.617

Outcome 1. Earlier Identification of Families Who May Be at Risk of Discontinuity

In order to understand the characteristics of families who are doing well and those who may be at risk for discontinuity, we compared caregivers who indicated that if they knew then what they know now, they "definitely would have" adopted or assumed guardianship of their child again vs. caregivers who responded they "probably would, might or might not, probably would not, or definitely would not." This question is part of the Illinois Post Permanency Commitment items that have been shown to be related to post permanency discontinuity (Liao & Testa, 2016; Liao & White, 2014; Testa, Snyder, Wu, Rolock, & Liao, 2015).

Table 4.22 examines differences in child, caregiver and family wellbeing measures for caregivers who would definitely adopt or assume guardianship again and those who were uncertain or would not. Overall, we found differences between those who definitely would adopt again and those who were less certain or would not on all wellbeing indicators with the exception of caregiver ACES.

Table 4.22. Differences in Wellbeing Indicators by Adopt Again Status

		ADOPT AGAIN?		BIVARIATE COMPARISON		
		UNCERTAIN WOULD NOT	DEFINITELY WOULD	(UNCERTAIN/WOULD NOT VS DEFINITELY WOULD)		
MEASURE	**Range**	**M**	**M**	***t***	***df***	***p***
ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN						
BEHAVIOR PROBLEM INDEX	0 - 56	26.45	14.95	11.51	760	<.001
BPI EXTERNALIZING BEHAVIORS	0 - 38	19.06	10.79	10.02	760	<.001
BPI INTERNALIZING BEHAVIORS	0 - 22	8.70	4.99	11.17	760	<.001
CAREGIVER STRAIN (CGSQ-FA22)	1 - 5	2.55	1.80	12.80*	258	<.001
CGSQ-AG OBJECTIVE STRAIN	1 - 5	2.35	1.58	10.28*	236	<.001
CGSQ-AG SUBJECTIVE STRAIN	1 - 5	2.72	1.99	12.77	792	<.001
CAREGIVER ACES	1 - 11	2.18	2.34	-0.83	769	0.406
MEASURE	**Range**	**M**	**M**	***t***	***df***	***p***
ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN						
PFS FAMILY FUNCTIONING	1 - 7	5.60	6.07	-7.21	788	<.001
PFS NURTURING ATTACHMENT	1 - 7	5.10	6.22	-12.92*	228	<.001
BEST-AG OVERALL	20 - 100	89.43	97.31	-9.80*	207	<.001
BEST-AG EMOTIONAL SECURITY	13 - 65	56.77	92.95	-10.61*	205	<.001
BEST-AG COMMITMENT	7 - 35	32.67	34.37	-6.74*	214	<.001

*Variance not assumed to be equal – Standard error of the difference of means was calculated using Satterthwaite's method rather than the pooled variance estimator method.

Caregivers who would definitely adopt their child again had higher levels of resilience, open communication, perseverance in time of crisis, and more positive parent-child interactions compared to caregivers who indicated they were uncertain or definitely would not adopt again. They had less strain attributed to parenting their child, more confidence to meet their child's needs, felt more prepared at the time of their finalization, and used fewer services in the past six months. Additionally, these caregivers were more likely to be related to their child or have a relationship with their child prior to their child's removal from his or her birth family's home. The number of ACEs a caregiver experienced growing up and the current age of the caregiver were not significantly different between the two groups.

The average age of the child for caregivers who would definitely adopt their child again was 10 years old, whereas the average age of the child for uncertain caregivers or caregivers who would definitely not adopt again was 13 years old. Based on what caregivers reported, children of caregivers who would definitely adopt again had fewer behavioral challenges, performed better in school, were more likely to stay calm when faced with a challenge, felt more optimistic about their future, found it easier to make friends, and had a teacher who understood their needs.

Outcome 2. Increased Identification of Post Permanency Service Needs by District and System of Care Provider Type

For STO 2, we report findings on what caregivers had to say about services and supports for families formed through adoption and guardianship in Vermont. We explore pre and post permanency service use across the Vermont system of care. We also summarize the services and supports caregivers felt were most important, those that were most needed but hard to get or not available, and the top barriers to getting supports and services.

Pre Permanency Service Use

Overall, 77% of caregivers felt prepared at the time of finalization and 61% of caregivers rated DCF as "good" or "very good" in preparing them to meet the needs of their child.

Caregivers were asked about their family's participation in eight pre permanency services. If a family had participated in service, the caregiver was then asked to rate the helpfulness of that service. Pre permanency service use ranged from zero to eight services. Table 4.23 provides a summary of pre permanency service use. Based on caregiver's responses, the most commonly used pre permanency services included Lund Finalization Case Managers and Fostering to Forever Training through Vermont DCF. The least commonly used services were the Adoption Learning Partnership Online Training, Vermont Kin as Parents, and the Transracial Cross-Cultural Training. About one-third of caregivers had not heard of the Adoption Learning Partnership or RPC+: Trauma-Informed Resource Parenting Curriculum. It is important to note that RPC+ is a newer curriculum that was being rolled out to districts during this project period.

The most highly rated pre permanency services included the Lund Project Family's Pre Permanency Counselor and the Lund Finalization Case Manager. The RPC+: Trauma-Informed Resource Parenting Curriculum and Transracial Cross-Cultural Training were the most highly rated trainings, but fewer caregivers attended these trainings.

Table 4.23. Pre Permanency Service Use

		NOT AWARE OF		NOT USED		USED		% FOUND VERY HELPFUL
	N	n_1	%	n_2	%	n_3	%	
FOSTERING TO FOREVER TRAINING THROUGH DCF	783	104	13%	143	18%	536	69%	45%
LUND FINALIZATION CASE MANAGER	766	98	13%	164	21%	504	66%	79%
LUND PROJECT FAMILY'S PERMANENCY COUNSELOR	768	173	22%	288	38%	307	40%	72%
VFAFA TRAININGS/CONFERENCES*	436	92	21%	147	34%	197	45%	54%
SHARED PARENTING MEETINGS	774	127	16%	373	49%	274	35%	18%
RPC+: TRAUMA-INFORMED RESOURCE PARENTING CURRICULUM	774	233	30%	392	51%	149	19%	63%
VERMONT KIN AS PARENTS	777	127	16%	552	71%	98	13%	61%
ADOPTION LEARNING PARTNERSHIP ONLINE TRAINING	774	244	32%	440	57%	90	11%	40%
TRANSRACIAL CROSS-CULTURAL TRAINING	768	127	17%	616	80%	25	3%	65%

*Not asked in cycle 2

Post Permanency Service Use over Past Six Months

Table 4.24 displays services and supports used over the past six months by at least 10% of families.

Table 4.24. Service Use in Past 6 Months by Cross System Sector

FAMILY SUPPORT SERVICES	N	FREQ	%
FAMILY COUNSELING	796	213	27
CASE MANAGEMENT SERVICE COORDINATION	798	99	12
DCF SOCIAL WORK SERVICES	796	85	11
Note: Less than 10% of participants reported using online support/blogs, agency support services, intensive family-based services, family safety planning, or LGBTQ support services over the past six months,			
SCHOOL/CHILD CARE SERVICES	**N**	**FREQ**	**%**
REGULAR CHILD CARE SERVICES	796	178	22
AFTERSCHOOL PROGRAM	796	159	20
SCHOOL-BASED CLINICIAN	796	152	19
BEHAVIOR SUPPORT SERVICES	796	139	18
Note: Less than 10% of participants reported their child using alternative school or mentoring over the past six months.			
MEDICAL SERVICES FOR CHILD	**N**	**FREQ**	**%**
ROUTINE MEDICAL CARE	796	626	78.6
MEDICATION MANAGEMENT	796	199	25
SPEECH OR OCCUPATIONAL THERAPY	796	124	15.5
Note: Less than 10% of participants reported their child using developmental disability case management services, physical disability services, services for children who are deaf or hard of hearing, services for children who are blind or visually impaired, or other developmental disabilities services (including personal care or family managed respite) over the past six months.			
MENTAL HEALTH SERVICES	**N**	**FREQ**	**%**
INDIVIDUAL COUNSELING FOR CHILD	796	336	42
INDIVIDUAL COUNSELING FOR CAREGIVER	796	177	22
PSYCHOLOGICAL ASSESSMENT FOR CHILD	796	129	16
PSYCHIATRIC MEDICATION FOR CHILD	796	126	16
CARE COORDINATION/CASE MANAGEMENT FOR CHILD	796	78	10
Note: Less than 10% of participants reported their child using a coordinated service pan/ACT 264, group counseling, or substance abuse treatment over the past six months. Less than 10% of caregivers reported using group counseling, psychiatric medication, or substance abuse treatment over the past six months.			
POST PERMANENCY SERVICES	**N**	**FREQ**	**%**
ADOPTION/GUARDIANSHIP SUBSIDY	796	354	44.5
POST PERMANENCY SERVICES	796	145	18.2
VERMONT ADOPTION REGISTRY	796	88	11.1
Note: Less than 10% of participants reported using a parent support group, post permanency trainings, the Vermont Adoption Consortium (VAC) resource library, post permanency newsletter, trauma assessments for their child in the past six months. Less than 10% of caregivers reported attending a conference for families formed through adoption and guardianship.			

We also asked caregivers, "In the past 6 months, how often have the following services in your community met the needs of your family?" Participants had the option to mark whether or not they used services from each service sector and, if so, how often they met their needs (See Table 4.25 below). Overall, medical services, school services, and child mental health services were the most commonly used services. A total of 83% of caregivers who used medical services felt they met the needs of their family, whereas only 17% of families that used substance abuse services felt like those services met their needs most or all of the time. A total of 63% of families who used school services felt that their needs were met most or all of the time.

Table 4.25. Frequency Services Met Needs in the Past Six Months

	USED SERVICES	% SERVICE MET NEEDS		
SERVICE SECTOR	N	% Not at all or some of the time	% About half of the time	% Most of the time or always
FAMILY SUPPORT SERVICES	316	42%	8%	50%
SCHOOL SERVICES	563	25%	13%	63%
CHILD CARE SERVICES	375	33%	8%	60%
MEDICAL SERVICES	647	12%	6%	83%
CHILD MENTAL HEALTH SERVICES	409	29%	12%	59%
CAREGIVER MENTAL HEALTH SERVICES	242	38%	10%	53%
POST PERMANENCY SERVICES	276	38%	11%	51%
SUBSTANCE ABUSE SERVICES	78	76%	8%	17%
DCF CHILD WELFARE SERVICES	157	40%	14%	46%

Qualitative Findings

Lastly, caregivers were asked to write in: (1) three services that they found to be the most important, (2) three services they found to be the most needed but hard to get or not available, and (3) three barriers to accessing services and supports.

We used an inductive approach to qualitative content analysis to code participant's responses to what services were most important, what services were most needed, and what barriers got in the way. Participant responses were organized into initial categories for each question based on themes that emerged from the data using an open coding approach in Cycle 2. As we encountered data that did not fit an existing code, we added new codes to represent that data. Upon reviewing the initial open-codes, we grouped similar codes into categories. Categories were reorganized into broader, higher order categories and a codebook was developed and applied in subsequent cycles (3 through 5). Data from Cycle 2 was then retroactively re-coded using the conceptual codebook. Categories were reviewed and refined to ensure each category was mutually exclusive. In some cases, we had to establish decision criteria for responses that fell under more than one category but represented one idea. For example, participants sometimes would name a provider as an important service, others named the specific service, and some participants named both: "Lund" vs. "Case Management" vs. "Lund Case Management." In cases where both were provided, the service identified took precedence over the service provider. Due to the similarity in responses to the questions regarding the most important services and the most needed services, the same codebook was applied to the data gathered from those two questions.

We identified 12 main categories with 27 subcategories that represented participant responses (see Table 4.26). For barriers, we identified eight main categories with 16 subcategories (see Table 4.27). For each question, responses were coded by at least two trained coders. Discrepancies in coding were resolved through discussion, referral to the codebook definitions, and by soliciting input from an additional coder.

Most Important Services

The top services mentioned by participants were post permanency services, mental health services, and financial support (primarily the adoption and guardianship subsidy). Within post permanency services, caregivers most often did not specify a service or they reported a specific provider rather than a service. Of the services mentioned, trainings, support groups, and respite came up most frequently. Counseling and therapy (specifically child, family and adoption/trauma-informed therapy) were the most common mental health services mentioned by caregivers.

Most Needed Services That Are Hard to Get or Not Available

The most needed services mentioned by participants were post permanency services, mental health services, and childcare services. Respite was the most commonly mentioned post permanency service followed by support groups and then trainings. Counseling and therapy, particularly adoption and trauma-informed therapy, were the most needed mental health services.

Table 4.26. Most Important & Most Needed Services: Category Descriptions

CATEGORY DESCRIPTIONS	
ADOPTION, PERMANENCY & FAMILY SUPPORT SERVICES	Support services offered to foster, adoptive, or kinship families at any point prior, during, or after adoption/permanency, including but not limited to, case management, trainings or classes, support groups, respite and/or the name of a specific provider.
MENTAL HEALTH & DISABILITY SERVICES	Mental health and disability services including adoption or trauma-informed mental health, counseling or therapy, wrap services or the name of a specific provider.
MEDICAL SERVICES	Medical services or doctor's appointments, including but not limited to, psychiatric care, medication management, OT, PT, SLP, or personal care assistance.
SCHOOL-BASED SERVICES	Supports provided by the school or within the school environment, including but not limited to, special education services, mentoring, liaison or advocacy services, competency of staff, and connection to an alternative school.
CHILDCARE SERVICES	Childcare or daycare, including but not limited to, before or after school services, summer camps, and general references to child/youth activities. Respite is not included in this category but is captured in the adoption, permanency and family support services.
FINANCIAL SUPPORTS & SERVICES	Financial supports, including but not limited to, medical insurance, employment support, job training, college assistance, or subsidy.
CRISIS SERVICES	Specific mention of supports provided during crises or emergencies, including emergency beds (or e-beds).
LEGAL SERVICES	Supports and services referencing the legal system, including but not limited to, support navigating the legal system or workers within the legal system (i.e. judges, lawyers, guardian ad litems).
STAFF COMPETENCY	Knowledge, competency, and training of general staff not specific to any one service sector. If competency of a provider within one sector (mental health, adoption/perm, school, etc.) is mentioned, the item was coded within that sector.
INCREASED AWARENESS	Responses that describe the importance of or need for increased knowledge or level of understanding of services.
INFORMAL SUPPORT NETWORKS	Informal networks of support (i.e. other families, church, etc.).
OTHER SUPPORTS	Other supports or services that cannot be coded into one of the more specific categories above.

Top Barriers to Services and Supports

The top barriers to services and supports mentioned by participants fell into the following categories: access barriers, provider barriers, financial barriers, and system barriers. In terms of access, participants mentioned issues related to the location of services (rural area, not local, too far to drive, etc.), services not existing, and transportation. The most common provider barrier mentioned was the quality of the providers. Caregivers reported that providers didn't have the expertise needed to meet their child's needs. About half of the caregivers who commented on quality mentioned that providers were not adoption competent nor trauma-informed. The number of times system barriers and financial barriers came up was similar. System barriers included things like staffing, service fragmentation, navigating the system, and policy or regulation barriers. Insurance was the largest financial barrier.

Table 4.27. Barriers to Services: Codebook Definitions

CATEGORY DESCRIPTIONS	
ACCESS/ AVAILABILITY	Responses that describe barriers related to limited or lack of accessibility/availability of services, resources, and providers, including but not limited to, issues related to location, transportation, waitlists, and inconvenient appointment times.
PROVIDER BARRIERS	Responses that relate to service providers, including but not limited to, mention of a specific service provider without additional detail, issues related to provider communication, quality, or lack of adoption and trauma competency.
FINANCIAL/ PAYER BARRIERS	Responses that reference general financial issues from the provider or the payer, including but not limited to insurance coverage.
SYSTEM BARRIERS	Responses that describe general issues with systematic barriers or the organizational structure of services, including but not limited to, staffing, service fragmentation, paperwork, navigation, and policy or regulation barriers.
CAREGIVER CHARACTERISTICS	Responses that attribute the lack of service acquisition to caregiver's personal lack of knowledge, perceptions of services, or lack of interest in seeking out services.
CHILD-LEVEL BARRIERS	Responses that attribute the lack of service acquisition to the child/youth, such as behavior has been a barrier to getting services.
STIGMA/LACK OF GENERAL KNOWLEDGE FROM COMMUNITY	Responses that express concern with the level of understanding or compassion from individuals or community at large.
OTHER BARRIERS	Responses that represent other barriers that cannot be coded into a more specific category.

Outcome 3 & 4. Improved Ability to Share Information & Deliver Data-Driven, Relevant and Timely Services

The Vermont Site team used the survey as one way to identify families who may need services in a timelier manner. Caregivers were asked at the end of the electronic survey if they would like someone to contact them about post permanency services. There were 77 out of 419 caregivers (19%) who took the electronic version of the survey and indicated they would like to talk to someone about post permanency services. Caregivers who received a paper copy of the survey were provided with contact information for post permanency services and could call or email for services if desired.

We analyzed data at the Agency of Human Services (AHS) district level[2] for the state of Vermont, in order to provide targeted findings regarding regional differences in service usage and service needs. Both the statewide data set and the more specific district-level findings, are being used by the state to drive future improvements to the systems of care for post permanency families. The Vermont Site team has presented the data to each district and across the system of care. They also held a summit at the end of the project to share findings with both families and providers.

Lastly, the Vermont Site team developed a post permanency guide, *The Continuing Journey of Children and Families: An Informal Guide for Those Parenting by Adoption or Guardianship*, to provide an additional opportunity to connect with families and highlight themes common to families formed through adoption or guardianship with a particular focus on the impact of trauma and developmental stages. While parenting always has its ups and downs, families who are formed through adoption and guardianship face unique experiences, both rewarding and challenging. Additionally, the guide highlights the unique dynamics of kinship families and families identifying as transracial/transcultural at the end of the study, we mailed a hard copy of this guide to all families formed through adoption and guardianship in Vermont (including private domestic or intercountry adoptive families known to the state).

[2] The state of Vermont has 12 AHS districts, which roughly correspond to the size of a county in the state.

Limitations

There are several limitations to this study. First, based on AFCARS data, we found no instances of post permanency discontinuity over the time-frame this survey was implemented. In order to identify predictors of discontinuity, survey responses would need to be linked to families who have and have not experienced discontinuity. If this survey data is linked to families at a future time point, it will likely be possible to use the survey to identify predictors.

In this study, we were only able to identify risk and protective factors using variables we know play a role in understanding post permanency discontinuity. When we look at these factors, it is difficult to determine how they are related. For example, we don't know whether a child having more behavior challenges leads to more negative parent-child interactions or if more negative parent-child interactions lead to a child having more behavior challenges. We only know there is a relationship between these factors.

Lastly, we found significant differences between caregivers who responded to the survey and those who did not in the number of times their child moved while in foster care and whether their child had a disability. There may be additional differences that we were not able to capture in our analysis. Therefore, care should be used in interpreting the results for those families who responded to the survey—for example, they may have more (or less) needs and/or challenges than other adoptive families.

Cost Evaluation

The Vermont QIC-AG project implemented a survey of adoptive parents to understand the needs of adoptive families and to understand the best ways to reach families. There were 1,470 surveys sent to families formed through adoption and 809 caregivers completed the survey.

Cost Evaluation Approach

Cost evaluations for each site were designed to understand the cost-effectiveness of the intervention selected by the site. 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). With Vermont, a cost-effectiveness analysis was conducted using the desired outcome as the number of caregivers who completed the survey.

Assumptions, Constraints, and Conditions

The first step in this analysis was to identify issues which might impact the validity of our cost analysis findings. CER analyses typically rely on researchers making subjective decisions based on their judgments and perceptions of the available information. Thus, it is important to record assumptions, constraints, and conditions relevant to Vermont 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 with Vermont is that the state was able to access a complete list of families who had adopted from the public child welfare system. An additional assumption is that the resource allocation captured in costs paid to sites is accurate. It is likely that staff time may be over or under-budgeted depending on the time constraints.

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 Vermont, constraints included legal changes at the state agency that delayed data sharing.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. During the planning process in Vermont, the site decided on a process to roll out the survey in phases based on the state's districts. Within that process, families formed by private and/or intercountry adoption were also included in a phase of the survey.

Cost Estimation

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

KEY POINTS IN COST ESTIMATION

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

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. The project was managed by Lund which is a well-established non-profit with existing office space. The sites also received substantial technical support from consultants and evaluators during implementation. Although the consultation was crucial to moving sites into implementation, the costs associated with the consultation will only be noted in the conclusion as additional costs for future programs to consider. Evaluation costs are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates.

Perspective refers to the person or group that incurred the costs. The perspective is essentially a filter that helps determine what costs are included. In this cost evaluation, the costs are determined from the perspective of the Vermont QICAG site. In other words, if funds were spent by the program, they are considered costs.

A cost estimation should include the passage of time in order to account for inflation. Given that Vermont implemented this intervention for a two year period, costs did not change dramatically. The major cost that would be impacted in this short time frame is staff salary and this change is accounted for in the direct expenses that Vermont incurred each year.

Both variable and fixed costs should be captured in a cost estimation. For Vermont, fixed costs include salaries, fringe and facility/office space. Variable costs were charged to the project as needed for items necessary to implement the survey such as gift cards and postage.

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

COST ESTIMATION STEPS

The steps involved in the cost estimation of this analysis are described below. All QIC-AG sites used a standardized budget form and cost reimbursement form. Costs for Vermont were taken from monthly budget forms and summarized into Table 4.28.

Table 4.28. Costs for Vermont

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL EXPENSES				
SITE IMPLEMENTATION MGR SALARY	$33,300	$28,118	$36,927	$98,345
SITE IMPLEMENTATION MGR FRINGE	$9,600	$8,435	$11,078	$29,113
IN-KIND SALARIES	$14,905.58	$56,365	$39,077	$110,347
NON-PERSONNEL DIRECT EXPENSES				
CONTRACTED SERVICES: LUND	$22,325	$54,782	$49,449	$126,556
CONTRACTED SERVICES: UNIV OF VT	$499	$27,811	$1,504	$29,814
CONTRACTED SERVICES: PHONE SURVEY SUPPORT	$659	$0	$0	$659
CONTRACTED SERVICES: LEXISNEXIS	$0	$3,503	$3,415	$6,918
CONTRACTED SERVICES: ANTICIPATORY GUIDANCE-JAYNE SCHOOLER	$71	$0	$0	$71
CONTRACTED SERVICES: DANIEL ZIEGLER		$0	$5,000	$5,000
CONTRACTED SERVICES: BETSY SMALLEY		$360	$473	$833
CONTRACTED SERVICES; JON BABBAGE			$455	$455
PROGRAM SUPPLIES			$1,182	$1,182
GIFT CARD INCENTIVES		$1,405	$5,899	$7,304
POSTAGE		$10,851	$6,649	$17,501
PRINTING/DUPLICATION			$0	$0
INDIRECT COSTS		$298	$681	$979
TOTAL	**$81,359**	**$244,291**	**$164,646**	**$490,295**

*FY 2019 through 3/31/19 only
**FY 2017 started 3/1/29

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 4.28.

Collect Data on Resource Allocation

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

Estimation of Direct Costs

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

Personnel

Personnel costs totaled $98,344 for the SIM's time allocated to the project during the implementation phase. The SIM was located at LUND. Given that the scope of this project was a survey, other staff time needed for the project was contracted out to other agencies.

In addition to these personnel costs, there were multiple individuals who provided time to the project as an in-kind donation. Four individuals were employed by the Department of Children & Families. These individuals contributed time throughout the project as implementation team members. Another individual provided administrative support to the SIM. A private agency provider participated in small group work to provide survey feedback. Finally, several non-profits assisted the project in sending out survey invitations to caregivers. In total, 714 hours were donated to the project. The site consultant kept track of hours and made calculations based on known salaries. In some cases, salaries include benefits. A conservative estimate of the cost of this in-kind donation of time in total is $110,347.

Fringe

Overall fringe for the SIM totaled $29,113. Fringe was calculated based on policies of LUND.

Contractual Expenses

Vermont contracted for services from the following entities.

- LUND was paid $126,555 over the course of the project. These funds were in addition to the salary and expenses related to the SIM who was housed at LUND. Funds were used to pay for time for an administrative assistant to support the project, particularly in monitoring participation and providing anticipatory guidance for participants.
- The University of Vermont was paid $29,813 for assistance in analyzing and presenting data from the survey.
- LexisNexis was paid $7,895 for address verification of participants.
- Jayne Schooler was paid $5,000 for assistance in developing the anticipatory guidance document.
- Daniel Ziegler was paid $833 for assistance with the graphic design and formatting of the anticipatory guidance document.
- Betsy Smalley was paid $455 for editing the anticipatory guidance booklet.
- Jon Babbage was paid $1,182 for assistance with developing REDCap for use in Vermont's child welfare system.

Gift Cards

Gift cards were provided to parents who participated in the project. A total of $17,500 was spent on gift card incentives. Parents who participated in focus groups were paid $100 honorarium and parents who completed the survey were provided a $20 gift card.

Materials and Supplies

Over the implementation period, $5,665 was spent on program supplies to administer the survey.

Travel

Over implementation, $14,275 was paid for travel. A large portion of these funds were used to pay for travel costs for the SIM to attend grantee and other required meetings for the QIC-AG.

Facilities/Office Space

No funds were expended for facilities and office space for the survey.

Other Direct Charges

Other direct charges include all non-personnel direct costs that do not fit into the categories listed above such as postage ($978) and printing ($40,944).

Estimation of Indirect Costs

In terms of general indirect costs, $13,524 were charged to the project by LUND. Indirect costs often include facility costs and infrastructure not captured in the above categories. Since this cost evaluation is designed to help other state child welfare policymakers understand the total costs associated with each site program, indirect costs are important to document. Because the state agency was the project lead, the Vermont site had a substantial infrastructure. Because the evaluation team assumed that other interested child welfare agencies would also have the infrastructure in place to run programs, we did not attempt to portion out the infrastructure costs that another agency would likely need. Likewise, we assumed that indirect costs will vary greatly by state due to the 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 Vermont were **$490,296** over the course of the three years.

Cost Calculations

Based on the total costs of $490,296 and 1,470 participants, the cost per survey was $334.

For this evaluation, an effective outcome is a completed survey. There were 809 caregivers that completed a survey. Thus, the cost per positive outcome or cost-efficiency ratio is

$$\text{COST EFFECTIVENESS RATIO} = \frac{\text{Cost of mailing surveys}}{\text{Number of completed surveys}}$$

which results in a cost of $606 per completed survey.

Sensitivity Analysis

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

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

For this sensitivity analysis, costs that are most likely not needed by other agencies have been removed from the cost calculation. Inclusion or exclusion of costs 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. Because this intervention was a survey, the gift card line was left in the sensitivity analysis. Although the monetary amount of gift cards may vary, they are fairly standard practice with surveys.

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 would not be necessary to implement a survey. This position served as a liaison with external entities and managed internal processes. Internal management could be provided by the agency staff.

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

3. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings. Travel is not necessary for a survey conducted online or by mail.

4. Contracted services by Lund were removed because these costs could be absorbed by the agency.

5. All contracting fees and printing related to anticipatory guidance were removed.

6. 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 4.29 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $172,862 which amounted to $117 per survey and $214 for each completed survey.

Table 4.29. Sensitivity Analysis: Adjusted Costs for Vermont

	IMPLEMENTATION			TOTAL
	FY 2019	FY 2018	FY 2017	
PERSONNEL EXPENSES				
IN-KIND SALARIES	$14,905.58	$56,365	$39,077	$110,347
NON-PERSONNEL DIRECT EXPENSES				
CONTRACTED SERVICES: UNIV OF VT	$499	$27,811	$1,504	$29,814
PROGRAM SUPPLIES			$1,182	$1,182
GIFT CARD INCENTIVES		$1,405	$5,899	$7,304
POSTAGE		$10,851	$6,649	$17,501
TOTAL	**$15,404**	**$100,233**	**$57,225**	**$172,862**

*FY 2019 through 3/31/19 only
**FY 2017 started 3/1/29

The Vermont QIC-AG site focused on families formed by public, private and intercountry adoption. The intention was to provide universal outreach to these families. Of the 1,470 families identified, 809 caregivers completed the survey resulting in a cost of $334 per survey. However, the cost per completed survey was $606. In order to achieve a 55% response rate, the site spent $606 per survey. However, cutting substantial costs could result in $118 per survey or $214 per completed survey.

Discussion

By surveying a high percentage of families, Vermont was able to understand the needs, risks, and strengths of families post permanency in order to provide timely and relevant services and supports. The system of care was able to identify regional gaps in service, identify the types of services and supports that are most important and most needed for families, and identify potential barriers to those services. The system of care, however, was not able to identify direct predictors of discontinuity. To predict discontinuity, survey responses would need to be linked to families who have and have not experienced discontinuity, and we had no cases of discontinuity. If this survey data is linked to families at a future time point, it will likely be possible to use the survey to identify predictors.

Findings of this study are consistent with previous post adoption literature which indicates that most children and families adjust well after adoption from foster care, while a small proportion of families (i.e., about 5-20%) report unmet needs, child behavior problems, placement instability, and other issues (Rolock, 2015; Rolock & White, 2016; Rolock & White, 2017; White, 2016). These families may benefit from additional outreach and timely, relevant services. The Vermont Permanency Survey itself served as a form of outreach and provided families the opportunity to request a follow-up from post permanency services. Almost 20% of families who completed the survey electronically requested to be contacted by a post permanency provider.

The most needed services and supports in Vermont included post permanency services, mental health services, and childcare services. Respite was the most commonly mentioned post permanency service followed by support groups and trainings. Counseling and therapy, particularly adoption and trauma-informed therapy, were the most needed mental health services. The top two barriers to services and supports were lack of access and provider quality. In terms of access, caregivers mentioned issues related to the location of services (rural area, not local, too far to drive, etc.), services not existing, and transportation. In terms of provider quality, caregivers reported that providers were not adoption competent or trauma-informed across the system of care.

Survey findings also indicated that parents and caregivers were not talking to their children about adoption and guardianship or working to keep their child connected to their birth family. Caregivers may need additional training and support around talking to children about adoption, guardianship and birth families with their child. Providers may want to help families understand why birth families matter and how to help their child maintain connections to their birth family.

Lastly, reliable and valid measures are needed in post permanency research. By looking at the relationship between variables we know are connected to post permanency discontinuity and other wellbeing measures, we were able to identify potential measures that begin to help us understand characteristics of families who may be at risk for discontinuity. The Behavior Problem Index, Belonging and Emotional Security Tool (particularly the Emotional Security subscale), the Caregiver Strain Questionnaire for Foster and Adoptive Families, and the Protective Factors Survey (Nurturing and Attachment and Family Functioning subscales) may be useful to include in future studies on post permanency.

References

Behnke, M., Smith, V. C., Abuse, C. on S., & Newborn, C. on F. A. (2013). Prenatal Substance Abuse: Short- and Long-term Effects on the Exposed Fetus. Pediatrics, 131(3), e1009–e1024. https://doi.org/10.1542/peds.2012-3931

Brannan, A. M., Heflinger, C. A., & Bickman, L. (1997). The Caregiver Strain Questionnaire: Measuring the Impact on the Family of Living with a Child with Serious Emotional Disturbance. Journal of Emotional and Behavioral Disorders, 5(4), 212–222.

Calculating the Costs of Child Welfare Services Workgroup. (2013). *Cost analysis in program evaluation: A guide for child welfare researchers and service providers*. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: a self-report measure of protective factors against child maltreatment. Child Abuse & Neglect, 34(10), 762–772. https://doi.org/10.1016/j.chiabu.2010.03.003

Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration. (1993). *Feasibility, Alternatives, And Cost/Benefit Analysis Guide*. Washington DC. Retrieved from http://archive.acf.hhs.gov/programs/cb/systems/sacwis/cbaguide/c1intro.htm

DeVellis, R. F. (2003). Scale development: theory and applications (2nd ed. Vol. 26). Thousand Oaks, CA: Sage Publications.

Dillman, D.A., Smyth, J.D., & Christian, L.M. (2014) Reducing people's reluctance to respond to surveys. In Internet, phone, mail and mixed-mode surveys: The tailored design methods (4th edition; pp 19-55). Hoboken, New Jersey: John Wiley & Sons, Inc.

Fan, W., & Yan, Z. (2010). Factors affecting response rates of the web survey: A systematic review. Computers in Human Behavior, 26(2), 132–139. https://doi.org/10.1016/j.chb.2009.10.015

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Framework Workgroup. *A framework to design, test, spread, and sustain effective practice in child welfare*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Frey, L., Cushing, G., Freundlich, M., & Brenner, E. (2008). Achieving permanency for youth in foster care: assessing and strengthening emotional security. Child & Family Social Work, 13(2), 218–226. https://doi.org/10.1111/j.1365-2206.2007.00539.x

Liao, M., & Testa, M. (2016). Postadoption and Guardianship: An Evaluation of the Adoption Preservation, Assessment, and Linkage Program. Research on Social Work Practice, 26(6), 675–685. https://doi.org/10.1177/1049731514564600

Liao, M., & White, K. R. (2014). Post-permanency service needs, service utilization, and placement discontinuity for kinship versus non-kinship families. Children and Youth Services Review, 44, 370–378. https://doi.org/10.1016/j.childyouth.2014.07.007

Meunnig, P. (2002). *Designing and conducting cost-effectiveness analyses in medicine and health care*. San Francisco: Jossey-Bass.

Peterson, J. L., & Zill, N. (1986). Marital Disruption, Parent-Child Relationships, and Behavior Problems in Children. Journal of Marriage and Family, 48(2), 295–307. https://doi.org/10.2307/352397

Rolock, N. (2015). Post-permanency continuity: What happens after adoption and guardianship from foster care? Journal of Public Child Welfare, 9:2, 153-173, doi:10.1080/15548732.2015.1021986

Rolock, N. & White, K. R. (2016). Post-permanency discontinuity: A longitudinal examination of outcomes for foster youth after adoption or guardianship. Children and Youth Services Review, 70, 419-427. doi:10.1016/j.childyouth.2016.10.025

Rolock, N. & White, K. R. (2017). Continuity for children after guardianship versus adoption with kin: Approximating the right counterfactual. Child Abuse and Neglect, 72, 32-44.

Sandoval-Hernandez, A. (n.d.). Factors and conditions that promote academic resilience: A cross-country perspective. Retrieved from https://www.academia.edu/1707789/Factors_and_conditions_that_promote_academic_resilience_A_cross-country_perspective

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. International Journal of Behavioral Medicine, 15(3), 194–200. https://doi.org/10.1080/10705500802222972

Springer, J. F., & Phillips, J. (2006). The IOM Model: A Tool for prevention planning and implementation. Prevention Tactic 8:13. Sacramento, California: Department of Alcohol and Drug Programs.

Testa, M. F., Snyder, S. M., Wu, Q., Rolock, N., & Liao, M. (2015). Adoption and guardianship: A moderated mediation analysis of predictors of post-permanency continuity. The American Journal of Orthopsychiatry, 85(2), 107–118. https://doi.org/10.1037/ort0000019

White, K.R. (2016). Placement discontinuity for older children and adolescents who exit foster care through adoption or guardianship: A systematic review. Child and Adolescent Social Work Journal, 33(4), 377-394. doi:10.1007/s10560-015-0425-1

Appendix

VERMONT CYCLE 3A DATA REPORT: PRIVATE DOMESTIC AND INTERCOUNTRY/INTERNATIONAL ADOPTIONS

July 2018

Learning from Families Formed Through Adoption and Guardianship

Vermont Cycle 3A Data Report: Private Domestic and Intercountry/International Adoptions

Data Collected July-December 2017

National Quality Improvement Center QIC•AG Adoption & Guardianship Support and Preservation
VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES FAMILY SERVICES DIVISION
LUND HOPE•OPPORTUNITY•FAMILY
Spaulding for Children
The University of Texas at Austin Texas Institute for Child & Family Wellbeing Steve Hicks School of Social Work
The UNIVERSITY of VERMONT

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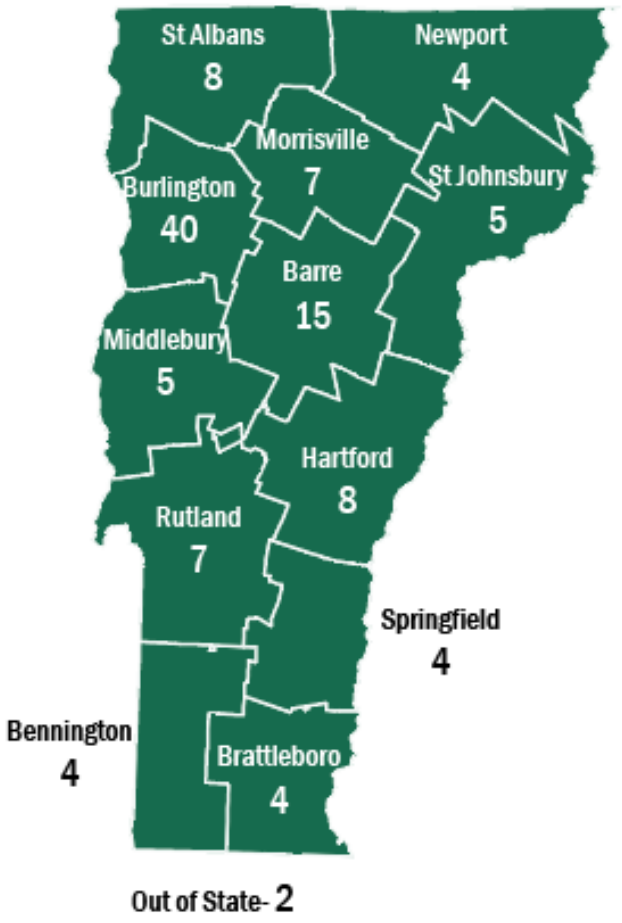
Vermont Private Domestic & International Adoptions Overview

The Vermont Department for Children and Families, Family Services Division has partnered with Lund, Spaulding for Children, the University of Texas at Austin, and the University of Vermont to learn from families formed through adoption and guardianship. For Cycle 3A, the survey was emailed electronically and/or mailed to 129 families throughout the state of Vermont who **opted into** the survey. This report summarizes findings from the 117 participating families (91%). The figure below illustrates the number of families who responded by district. Most of families who responded are from the Burlington district (34%).

Participation by FSD District



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Family Household Composition

The 117 caregivers who completed the survey represent 117 unique family households. Most households (80.3%) had two adult caregivers living at home. Additionally, 20 households were single parent homes (17.1%) and three households had more than two adult caregivers (2.6%).

Adult Caregivers

How many adult caregivers, including yourself, live in your household?

		Frequency	Percent	Valid %	Cumulative %
Valid	1	20	17.1	17.1	17.1
	2	94	80.3	80.3	97.4
	3+	3	2.6	2.6	100.0
	Total	117	100.0	100.0	

Children <21 Years Old

A total of 184 children under the age of 21 years old were represented by the 117 family households. Most of these children under 21 years old were living at home (170, 92.4%). Caregivers reported having between zero and five children under 21 who were currently living at home.

How many of your children under the age of 21 live in your household?

		Frequency	Percent	Valid %	Cumulative %
Valid	0	21	17.9	17.9	17.9
	1	43	36.8	36.8	54.7
	2	38	32.5	32.5	87.2
	3	10	8.5	8.5	95.7
	4	4	3.4	3.4	99.1
	5	1	0.9	0.9	100.0
	Total	117	100.0	100.0	

How many children under 21 years old do you have? How many of these children live in your household?

		How many of your children under 21 live in your household?							
		0	1	2	3	4	5	6	Total
How Many Children Under the Age of 21 Do You Currently Have?	0	17	0	0	0	0	0	0	17
	1	2	40	0	0	0	0	0	42
	2	2	2	35	1	0	0	0	40
	3	0	1	2	9	0	0	0	12
	4	0	0	1	0	4	0	0	5
	5	0	0	0	0	0	0	0	0
	6	0	0	0	0	0	0	1	1

Children <21 Years Old who were Adopted or are in Legal Guardianship

The following tables represent the number of children within each family that are adopted through a private domestic agency, a private agency that facilitated an intercountry/international adoption, and through a child welfare agency/foster care.

Number of children who were adopted through a private domestic agency

		Frequency	Percent	Valid %	Cumulative %
Valid	0	69	56.4	57.9	57.9
	1	35	29.9	30.7	88.6
	2	13	11.1	11.4	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Number of children who were adopted through a private agency that facilitated an intercountry/international adoption

		Frequency	Percent	Valid %	Cumulative %
Valid	0	73	62.4	63.5	63.5
	1	28	23.9	24.3	87.8
	2	13	11.1	11.3	99.1
	3	0	0.0	0.0	99.1
	4	1	0.9	0.9	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

Number of children who were adopted from a child welfare agency/foster care in Vermont

		Frequency	Percent	Valid %	Cumulative %
Valid	0	98	83.8	86.7	86.7
	1	10	8.5	8.8	95.6
	2	4	3.4	3.5	99.1
	3	1	0.9	0.9	100.0
	Total	113	96.6	100.0	
Missing	No Response	4	3.4		
Total		117	100.0		

Number of children who were adopted from another state's child welfare agency/foster care

		Frequency	Percent	Valid %	Cumulative %
Valid	0	106	90.6	93.0	93.0
	1	7	6.0	6.1	99.1
	2	0	0.0	0.0	99.1
	3	0	0.0	0.0	99.1
	4	1	0.9	0.9	100.0
	Total	113	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

The number of children whose caregivers assumed legal guardianship in each household ranged from zero to three. Most caregivers did not assume legal guardianship of a child (85%).

Number of children who are in legal guardianship

		Frequency	Percent	Valid %	Cumulative %
Valid	0	96	82.1	85.0	85.0
	1	9	7.7	8.0	92.9
	2	6	5.1	5.3	98.2
	3	2	1.7	1.8	100.0
	Total	113	96.6	100.0	
Missing	No Response	4	3.4		
Total		117	100.0		

Relationship to the Identified Child

For families that had adopted or were guardians to more than one child in their home, the caregivers were asked to select one child as the "Identified Child" for the purposes of the survey. Caregivers were asked to think about their "Identified Child" as they answered the survey. This section provides a summary of responses from questions that asked caregivers about their relationship to their child. Please note that in this cycle, several caregivers answered questions about their adult children (over the age of 21).

Are you biologically related to your child, or are you not biologically related to your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Biologically Related	5	4.3	4.3	4.3
	Not Biologically Related	112	95.7	95.7	100.0
	Total	117	100.0	100.0	

*While 5 caregivers reported being biologically related to their child, the biological relationship to another caregiver in the household was not asked. Therefore, there may be additional families who have a biological relationship to their child.

Biologically Related Caregivers

The following two questions were asked to the 48 caregivers who reported being biologically related to their child:

What is your biological relationship to your child?

Are you biologically related to your child through (his/her) birth mother or birth father?

The next two tables summarize caregiver's responses below.

What is your biological relationship to this child? (N=5)

		Frequency	Percent	Valid %	Cumulative %
Valid	Grandparent	1	20.0	25.0	25.0
	Aunt/Uncle	2	40.0	50.0	75.0
	Other Relative	1	20.0	25.0	100.0
	Total	4	80.0	100.0	
Missing	No Response	1	20.0		
Total		5	100.0		

Are you biologically related to your child through (his/her) birth mother or birth father? (N=5)

		Frequency	Percent	Valid %	Cumulative %
Valid	Through Birth Mother	1	20.0	25.0	25.0
	Through Birth Father	3	60.0	75.0	100.0
	Total	4	80.0	100.0	
Missing	No Response	1	20.0		
Total		5	100.0		

Child's Adoption and Guardianship History

Did you have a relationship with your child prior to when he/she was removed from his/her birth parents home?

		Frequency	Percent	Valid %	Cumulative %
Valid	Had Prior Relationship	3	2.6	2.6	2.6
	Did Not Have Prior Relationship	111	94.9	97.4	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Has your child previously been adopted or in legal guardianship?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	5	4.3	4.3	4.3
	No	109	93.2	94.8	99.1
	Don't know	1	0.9	0.9	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

Did you or do you have an agreement to maintain contact with the birth family of your adopted child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	51	43.6	44.0	44.0
	No	64	54.7	55.2	99.1
	Don't Know	1	0.9	0.9	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Child Wellbeing

This section provides an overview about the Identified Child selected within each household. Each caregiver was asked to respond to questions as they relate to this child.

About the Identified Child

What is your child's gender?

		Frequency	Percent	Valid %	Cumulative %
Valid	Male	56	47.9	47.9	47.9
	Female	61	52.1	52.1	100.0
	Total	117	100.0	100.0	

Is your child of Hispanic/Latino origin, or is this child not of Hispanic/Latino origin?

		Frequency	Percent	Valid %	Cumulative %
Valid	Hispanic/Latino Origin	16	13.7	13.8	13.8
	Not of Hispanic/Latino Origin	100	85.5	86.2	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

What is your child's race?

		Frequency	Percent	Valid %	Cumulative %
Valid	Asian	26	22.2	23.0	23.0
	Black/African American	31	26.5	27.4	50.4
	White/Caucasian	42	35.9	37.2	87.6
	Multi-Racial	14	12.0	12.4	100.0
	Total	113	96.6	100.0	
Missing	No Response	4	3.4		
Total		117	100.0		

Does your child consider him or herself to be?

		Frequency	Percent	Valid %	Cumulative %
Valid	Heterosexual or Straight	77	65.8	67.0	67.0
	Gay or Lesbian	2	1.7	1.7	68.7
	Bisexual	1	0.9	0.9	69.6
	I Am Unsure	35	29.9	30.4	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

What is your child's age?

	N	Minimum	Maximum	Mean	Std. Deviation
Age In Years	117	0	34	13.27	7.89

Child's age in years (grouped)

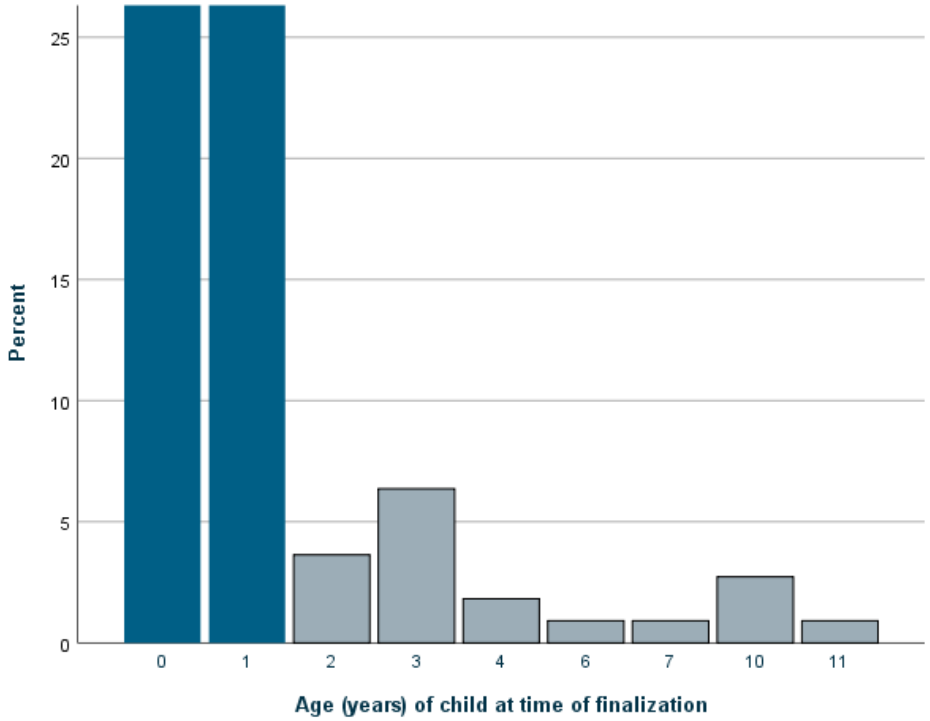
		Frequency	Percent	Valid %	Cumulative %
Valid	0 - 3 Years Old	10	8.5	8.5	8.5
	4 - 7 Years Old	15	12.8	12.8	21.4
	8 - 12 Years Old	29	24.8	24.8	46.2
	13 - 17 Years Old	26	22.2	22.2	68.4
	18 or Older	37	31.6	31.6	100.0
	Total	117	100.0	100.0	

Age at Finalization

How old was your child when you finalized the adoption or guardianship? (Years)

		Frequency	Percent	Valid %	Cumulative %
Valid	0	60	51.3	54.5	54.5
	1	31	26.5	28.2	82.7
	2	4	3.4	3.6	86.4
	3	7	6.0	6.4	92.7
	4	2	1.7	1.8	94.5
	5	0	0.0	0.0	94.5
	6	1	0.9	0.9	95.4
	7	1	0.9	0.9	96.4
	8	0	0.0	0.0	96.4
	9	0	0.0	0.0	96.4
	10	3	2.6	2.7	99.1
	11	1	0.9	0.9	100.0
	Total	100	94.0	100.0	
Missing	No Response	7	6.0		
Total		117	100.0		

Age in years at time of finalization



Child's age in years (grouped) by length of time since finalization

		<2 Years	2-4 Years	5-9 Years	10+ Years	Total
Valid	0 - 3 Years Old	2	7	0	0	9
	4 - 7 Years Old	0	7	7	0	14
	8 - 12 Years Old	0	0	15	12	27
	13 - 17 Years Old	0	1	2	21	24
	18 or Older	0	0	0	36	36
	Total	2	15	24	69	110*

*Seven caregivers did not provide information on the date of their adoption finalization.

Educational Wellbeing

What grade is your child currently in?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Not Started School	13	11.1	11.6	11.6
	Preschool to Pre-K	6	5.1	5.4	17.0
	Kindergarten	3	2.6	2.7	19.6
	Elementary School) (1-5)	28	23.9	25.0	44.6
	Middle School (6-8)	13	11.1	11.6	56.3
	High School (9-12)	22	18.8	19.6	75.9
	In School, No Assigned Grade	0	0.0	0.0	75.9
	Graduated	25	21.4	22.3	98.2
	Dropped Out	0	0.0	0.0	98.2
	Not In School for Other Reason	2	1.7	1.8	100.0
	Total	112	95.7	100.0	
Missing	No Response	5	4.3		
Total		117	100.0		

This section seeks to better understand the educational experiences of the child. A little over half of the children (66, 58.9%) are in school (kindergarten through 12th grade). The following tables summarize the educational wellbeing of these 66 children.

Does your child currently have a 504 plan, or does this child not have a 504 plan? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Has a 504 Plan	10	15.2	15.2	15.2
	Does Not Have a 504 Plan	56	84.8	84.8	100.0
	Total	66	100.0	100.0	

Does your child currently have an Individualized Education Program (IEP)? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Has an IEP	13	19.7	19.7	19.7
	Does Not Have an IEP	53	80.3	80.3	100.0
	Total	66	100.0	100.0	

Does your child have a least one teacher at school who really understands his or her needs? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	49	74.2	75.4	75.4
	No	4	6.1	6.2	81.5
	Don't Know	12	18.2	18.5	100.0
	Total	65	98.5	100.0	
Missing	No Response	1	1.5		
Total		66	100.0		

How would you describe your child's school performance in reading and language arts? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Excellent	29	43.9	43.9	43.9
	Good	20	30.3	30.3	74.2
	Fair	11	16.7	16.7	90.9
	Poor	5	7.6	7.6	98.5
	Very Poor	1	1.5	1.5	100.0
	Total	66	100.0	100.0	

How would you describe your child's school performance in math? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Excellent	20	30.3	30.3	30.3
	Good	29	43.9	43.9	74.2
	Fair	11	16.7	16.7	90.9
	Poor	4	6.1	6.1	97.0
	Very Poor	2	3.0	3.0	100.0
	Total	66	100.0	100.0	

Since starting kindergarten, has your child repeated any grades? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes, Has Repeated Grade	2	3.0	3.1	3.1
	No, Has Not Repeated a Grade	63	95.5	96.9	100.0
	Total	65	98.5	100.0	
Missing	No Response/Has Not Started	1	1.5		
Total		66	100.0		

Child participated in the following activities after school or on weekends in the past 6 months

	N	Frequency	Valid %
Academic Tutoring/Support	64	18	28.1
Sports or Athletic Activities	65	55	84.6
Martial Arts	64	7	10.9
Art, Dance, or Music Class	66	44	66.7
Clubs or Organizations	66	36	54.5
Religious Youth Group	66	14	21.2
Religious Instruction/Sunday School	66	26	39.4
Volunteer Work	66	28	42.4
Part-Time Job	65	14	21.5
Unpaid Internship	63	2	3.2

During the past 6 months, the child has:

	N	Frequency	Valid %
Changed Schools for Reasons Other than Grade Promotion	65	6	9.2
Skipped School or Cut Classes Without Your Permission	65	2	3.1
Received an In-School Suspension	65	2	3.1
Received an Out-Of-School Suspension	65	1	1.5
Been Expelled From School	65	0	0.0
Received Any Awards, Certificates, or Made Honor Roll	65	29	44.6
Held a Leadership Position In Any Club or Organization	65	15	23.1

Social and Emotional Wellbeing

Caregivers were asked the following questions ask about their Identified Child's social and emotional wellbeing. Tables summarizing caregiver's responses are presented below.

In general, how easy or hard is it for your child to make friends?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	48	41.0	42.1	42.1
	Somewhat Easy	34	29.1	29.8	71.9
	Somewhat Hard	26	22.2	22.8	94.7
	Very Hard	6	5.1	5.3	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

How much is your child liked by other children?

		Frequency	Percent	Valid %	Cumulative %
Valid	A Great Deal	44	37.6	38.3	38.3
	A Lot	43	36.8	37.4	75.7
	A Moderate Amount	24	20.5	20.9	96.5
	A Little	3	2.6	2.6	99.1
	Not at All	1	0.9	0.9	100.0
	Total	115	98.3	100.0	
Missing	Don't Know/Does Not Apply	2	1.7		
Total		117	100.0		

How much does your child get along with other adults in his/her life?

		Frequency	Percent	Valid %	Cumulative %
Valid	A Great Deal	62	53.0	53.0	53.0
	A Lot	38	32.5	32.5	85.5
	A Moderate Amount	15	12.8	12.8	98.3
	A Little	1	0.9	0.9	99.1
	Not at All	1	0.9	0.9	100.0
	Total	117	100.0	100.0	

Does your child have others outside of your family that are positive influences in his/her life?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	114	97.4	98.3	98.3
	No	2	1.7	1.7	100.0
	Total	116	99.1	100.0	
Missing	Don't Know/No Response	1	0.9		
Total		117	100.0		

Has anyone consistently been in your child's life since birth?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	86	73.5	74.1	74.1
	No	30	25.6	25.9	100.0
	Total	116	99.1	100.0	
Missing	Don't Know/No Response	1	0.9		
Total		117	100.0		

How easy or hard is it for your child to bounce back quickly when things don't go his or her way?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	28	23.9	23.9	23.9
	Somewhat Easy	53	45.3	45.3	69.2
	Somewhat Hard	29	24.8	24.8	94.0
	Very Hard	7	6.0	6.0	100.0
	Total	117	100.0	100.0	

How easy or hard is it for your child to find things he/she likes about himself/herself?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	48	41.0	43.2	43.2
	Somewhat Easy	47	40.2	42.3	85.6
	Somewhat Hard	12	10.3	10.8	96.4
	Very Hard	4	3.4	3.6	100.0
	Total	111	94.9	100.0	
Missing	Don't Know/Does Not Apply	6	5.1		
Total		117	100.0		

How easy or hard is it for your child to stay calm when faced with a challenge?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	14	12.0	12.0	12.0
	Somewhat Easy	41	35.0	35.0	47.0
	Somewhat Hard	50	42.7	42.7	89.7
	Very Hard	12	10.3	10.3	100.0
	Total	117	100.0	100.0	

How easy or hard is it for your child to ask for help?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	38	32.5	32.8	32.8
	Somewhat Easy	43	36.8	37.1	69.8
	Somewhat Hard	25	21.4	21.6	91.4
	Very Hard	10	8.5	8.6	100.0
	Total	116	99.1	100.0	
Missing	Don't Know/Does Not Apply	1	0.9		
Total		117	100.0		

How optimistic is your child about his or her future?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely	24	20.5	25.0	25.0
	Very Optimistic	42	35.9	43.8	68.8
	Moderately Optimistic	20	17.1	20.8	89.6
	Slightly Optimistic	7	6.0	7.3	96.9
	Not at All Optimistic	3	2.6	3.1	100.0
	Total	96	82.1	100.0	
Missing	Don’t Know/No Response	21	17.9		
Total		117	100.0		

How often does your child help others?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	21	17.9	18.4	18.4
	Most of the Time	53	45.3	46.5	64.9
	About Half of the Time	25	21.4	21.9	86.8
	Some of the Time	11	9.4	9.6	96.5
	Never	4	3.4	3.5	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

During the past 6 months, how often did your child show interest and curiosity in learning new things?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	43	36.8	37.1	37.1
	Most of the Time	42	35.9	36.2	73.3
	About Half of the Time	20	17.1	17.2	90.5
	Some of the Time	10	8.5	8.6	99.1
	Never	1	0.9	0.9	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Child Behavior

The Behavior Problem Index (BPI) consists of 28 statements regarding specific behaviors children that ages four or older might exhibit. For each statement, caregivers were asked to rate whether the statement was "not true," "sometimes true," or "often true" for the Identified Child over the past 6 months. An additional item, "has taken things that do not belong to him or her" was included in Vermont. Scores for each item ranged from 0 "not true" to 2 "often true". The items with the means at or above a score of one ("sometimes true") include: "has had difficulty concentrating", "has been impulsive or has acted without thinking" and "has sudden changes in mood or feelings". The table below summarizes the number of participants who answered the question, the minimum and maximum scores reported, the mean score, and the standard deviation for each item (how spread out the score is from the mean). Overall scores are reported on the next page.

Response choices: 0=Not True | 1=Sometimes True | 2=Often True

Descriptive Statistics for Behavior Problem Index Items

In the past 6 months, your child…	N	Min	Max	Mean	Std. Dev
Has had difficulty concentrating	106	0	2	0.89	0.67
Has been impulsive or has acted without thinking	106	0	2	0.85	0.73
Has cheated or told lies	106	0	2	0.52	0.69
Has argued too much	106	0	2	0.77	0.71
Has demanded a lot of attention	106	0	2	0.82	0.75
Has sudden changes in mood or feelings	106	0	2	0.76	0.71
Has been restless or overly active and/or has not been able to sit still	106	0	2	0.55	0.71
Has been stubborn, sullen, or irritable	106	0	2	0.75	0.70
Has had a very strong temper and lost it easily	106	0	2	0.57	0.72
Has been rather high strung, tense, or nervous	106	0	2	0.42	0.69
Has not seemed to feel sorry after (he/she) has misbehaved	106	0	2	0.40	0.64
Has been disobedient at home	106	0	2	0.58	0.62
Has had difficulty getting mind off certain thoughts or had obsessions	106	0	2	0.54	0.69
Has been disobedient at school	106	0	2	0.24	0.49
Has been easily confused or seemed to be in a fog	106	0	2	0.17	0.45
Has been too fearful or anxious	106	0	2	0.40	0.63
Has had trouble getting along with other children	106	0	2	0.26	0.52
Has bullied or has been cruel or mean to others	106	0	2	0.13	0.39
Has been too dependent on others	106	0	2	0.31	0.54
Has had trouble getting along with teachers	106	0	2	0.11	0.35
Has felt worthless or inferior	106	0	2	0.38	0.59
Has been unhappy, sad, or depressed	106	0	2	0.50	0.64
Has been clinging to adults	106	0	2	0.17	0.45
Has broken things on purpose or deliberately destroyed things	106	0	2	0.23	0.46
Is not liked by other children	106	0	2	0.17	0.40
Has felt or complained that no one loves (him/her)	106	0	2	0.25	0.51
Has cried too much	106	0	2	0.12	0.38
Has been withdrawn or has not gotten involved with others	106	0	2	0.25	0.51
Has taken things that do not belong to him or her	106	0	2	0.15	0.41

*All items were scored for children ages four and older only

The total BPI Index score can be calculated by summing each item to produce an overall score. Higher scores indicate that a child may be exhibiting more behavior problems. For children ages four and older, the total score may range from 0 to 56. With the addition item added, scores may range from 0 to 58.

Additionally, the total BPI index score can be further broken down into two subscales: the BPI Internalizing Subscale (11 items, BPI: IS) and the BPI Externalizing Subscale (19 items, BPI: ES; note that three items are included in both subscales and one items is not included in either subscale). Descriptive statistics are reported below for the total BPI index score and two subscales for children ages four and older.

BPI Scores of Children Ages Four and Older

Total BPI score and subscale scores for children ages four and older

	N	Min	Max	Mean	Std. Dev
BPI Total Index Score	106	0	51	12.08	9.77
BPI Total Index Score + 1 Item	106	0	53	12.23	9.99
BPI Internalizing Behavior Subscale Score	106	0	22	4.25	4.01
BPI Externalizing Behavior Subscale Score	106	0	33	8.50	6.93

Another way to look at the data to gain a better understanding of the relationship between BPI total scores and subscales is to compare the mean scores rather than the total scores. The mean scores will all range from 0 ("not true") to 2 ("often true"). The table below reports the minimum mean score, maximum mean score, and average mean score for the BPI scales and subscales.

Mean BPI scores and subscale scores for children ages four and older

	N	Min	Max	Mean	Std. Dev
Mean BPI Index Score	106	0.00	1.82	0.43	0.35
Mean BPI Index Score + 1 Item	106	0.00	1.83	0.42	0.34
Mean BPI Internalizing Behavior Subscale Score	106	0.00	2.00	0.39	0.36
Mean BPI Externalizing Behavior Subscale Score	106	0.00	1.74	0.45	0.36

Additional Behavior Challenges

In the past 6 months, has your child been in trouble with the law or juvenile justice system?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	5	4.3	4.3	4.3
	No	112	95.7	95.7	100.0
	Total	117	100.0	100.0	

In the past 6 months, has your child been involved in a gang?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	2	1.7	1.7	1.7
	No	114	97.4	98.3	100.0
	Total	116	99.1	100.0	
Missing	Don't Know/No Response	1	0.9		
Total		117	100.0		

In the past 6 months, has your child run away for a period of more than seven days?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	2	1.7	1.8	1.8
	No	112	95.7	98.2	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Job Impact

Please think about this child's physical and mental health, behavioral issues, and child care. In the past 6 months, did you or did anyone in your family have to quit a job, refuse a job offer, or change jobs because of any of these issues with this child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes, Had Job Impact	4	3.4	3.4	3.4
	No, Did Not Have Job Impact	113	96.6	96.6	100.0
	Total	117	100.0	100.0	

General Wellbeing

Physical Health

Does this child have a physical health issue that impacts their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has a Physical Health Issue	13	11.1	11.2	11.2
	Has No Physical Health Issue	103	88.0	88.8	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	.9		
Total		117	100.0		

Mental Health

Does this child have a mental health issue that impacts their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has a Mental Health Issue	27	23.1	23.3	23.3
	Has No Mental Health Issue	89	76.1	76.7	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Sibling Conflicts

Does your child have sibling conflicts that impact their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Sibling Conflicts	12	10.3	15.8	15.8
	Has No Sibling Conflicts	64	54.7	84.2	100.0
	Total	76	65.0	100.0	
Missing	No Response	1	0.9		
	No Siblings	40	34.2		
Total		117	100.0		

Challenges with Food

Does your child have food or eating issues that impact their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Food or Eating Issues	16	13.7	13.8	13.8
	Has No Food or Eating Issues	100	85.5	86.2	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Physical Disability

Does your child have a physical disability that impacts their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Physical Disability Issues	5	4.3	4.3	4.3
	Has No Physical Disability Issues	112	95.7	95.7	100.0
	Total	117	100.0	100.0	

Language

Does your child have language issues that impact their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Language Issues	6	5.1	5.3	5.3
	Has No Language Issues	108	92.3	94.7	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Substance Use

Was your child exposed prenatally to alcohol or substance use?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	24	20.5	35.8	35.8
	No	43	36.8	64.2	100.0
	Total	67	57.3	100.0	
Missing	No Response/Don't Know	50	42.7		
Total		117	100.0		

Does your child have alcohol or substance use problems that impact their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Alcohol/Substance Use Issues	3	2.6	2.6	2.6
	No Alcohol/Substance Use Issues	113	96.6	97.4	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Intellectual Disability

Does your child have an intellectual disability that impacts their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has an Intellectual Disability	14	12.0	12.0	12.0
	Has No Intellectual Disability	103	88.0	88.0	100.0
	Total	117	100.0	100.0	

Living Arrangements of the Identified Child

Out of Home Care

Since the adoption or guardianship was finalized, has your child ever lived outside of your home for two weeks or longer because he or she was…?

	N	Frequency	Valid %
Living With a Relative or Family Friend?	116	5	4.3
Receiving Treatment In a Residential Treatment Setting?	116	2	1.7
Receiving Treatment In a Psychiatric Hospital Setting?	115	1	0.9
At Summer Camp or On Extended Vacation?	116	20	17.2
In a Juvenile Justice Setting?	116	1	0.9
At a Boarding School or In College?	117	17	14.5
Homeless or Ran Away From Home?	114	3	2.6
In an Emergency Assessment Bed?	116	2	1.7

Current Living Arrangement

Where is your child currently living?

		Frequency	Percent	Valid %	Cumulative %
Valid	With Me	93	79.5	79.5	79.5
	Boarding School or College	8	6.8	6.8	86.3
	Homeless or Ran Away From Home	1	0.9	0.9	87.2
	Other	15	12.8	12.8	100.0
	Total	117	100.0	100.0	

Caregiver Wellbeing

Caregiver Demographics

The tables below provide an overview of the demographics information of the participating caregivers. Most caregivers were female (92.2%), White (98.2%), and had some college education or higher (98.3%) and married 79.8%). The average age of participating caregivers was 53.1 years old.

What is your gender?

		Frequency	Percent	Valid %	Cumulative %
Valid	Male	8	6.8	7.0	7.0
	Female	106	90.6	92.2	99.1
	Other	1	0.9	0.9	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

Are you of Hispanic/Latino origin, or are you not of Hispanic/Latino origin?

		Frequency	Percent	Valid %	Cumulative %
Valid	Hispanic/Latino Origin	1	0.9	0.9	0.9
	Not of Hispanic/Latino Origin	114	97.4	99.1	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

What is your race?

		Frequency	Percent	Valid %	Cumulative %
Valid	American Indian/Alaska Native	0	0.0	0.0	0.0
	Asian	0	0.0	0.0	0.0
	Black/African American	0	0.0	0.0	0.0
	Native Hawaiian/Pacific Islander	0	0.0	0.0	0.0
	White/Caucasian	112	95.7	98.2	98.2
	Multi-Racial	2	1.7	1.8	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Caregiver's age in years

	N	Minimum	Maximum	Mean	Std. Deviation
Age In Years	114	27	73	53.05	9.85

Caregiver's age in years (grouped)

		Frequency	Percent	Valid %	Cumulative %
Valid	25-34	4	3.4	3.6	3.6
	35-44	17	14.5	15.3	18.9
	45-54	39	33.3	35.1	54.1
	55-64	33	28.2	29.7	83.8
	65+	18	15.4	16.2	100.0
	Total	111	94.9	100.0	
Missing	No Response	6	5.1		
Total		117	100.0		

Caregiver's age (grouped) by child's age

		0-3 Yrs.	4-7 Yrs.	8-12 Yrs.	13-17 Yrs.	18+ Yrs.	Total
*Valid	25 - 34 Years Old	2	1	1	0	0	4
	35 - 44 Years Old	7	5	5	0	0	17
	45 - 54 Years Old	0	8	17	9	5	39
	55 - 64 Years Old	0	0	4	12	17	33
	65+ Years Old	0	0	1	4	13	18
	Total	9	14	28	25	35	111*

*Six cases did not include sufficient information to be included in this analysis.

What is the highest level of education you have completed?

		Frequency	Percent	Valid %	Cumulative %
Valid	Some High School	0	0.0	0.0	0.0
	High School Diploma	2	1.7	1.7	1.7
	GED	0	0.0	0.0	1.7
	Some College	12	10.3	10.4	12.2
	2 or 4-Year College Degree	48	41.0	41.7	53.9
	Master's Degree	40	34.2	34.8	88.7
	Advanced Graduate Work or Ph.D.	13	11.1	11.3	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

What is your current relationship status?

		Frequency	Percent	Valid %	Cumulative %
Valid	Single, Never Married	8	6.8	7.0	7.0
	Living With a Partner	4	3.4	3.5	10.5
	Married	91	77.8	79.8	90.4
	Separated	1	0.9	0.9	91.2
	Divorced	6	5.1	5.3	96.5
	Widowed	4	3.4	3.5	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Do you consider yourself to be?

		Frequency	Percent	Valid %	Cumulative %
Valid	Heterosexual or Straight	104	88.9	92.9	92.9
	Gay or Lesbian	6	5.1	5.4	98.2
	Bisexual	2	1.7	1.8	100.0
	Total	112	95.7	100.0	
Missing	No Response	5	4.3		
Total		117	100.0		

What is your best estimate of your household income for this past year?

		Frequency	Percent	Valid %	Cumulative %
Valid	Under $15,000	5	3.0	3.2	3.2
	$15,001 to $30,000	3	2.6	2.7	2.7
	$30,001 to $45,000	6	5.1	5.4	8.0
	$45,001 to $60,000	24	20.5	21.4	29.5
	$60,001 to $75,000	8	6.8	7.1	36.6
	$75,001 to $90,000	9	7.7	8.0	44.6
	$90,001 to $105,00	16	13.7	14.3	58.9
	$105,001 to $120,00	23	19.7	20.5	79.5
	Over $120,000	23	19.7	20.5	100.0
	Total	112	95.7	100.0	
Missing	No Response	5	4.3		
Total		117	100.0		

Caregiver Resilience

The Brief Resilience Scale (BRS) consists of 6 items, measured on a scale of 1 through 5, where 1 = strongly disagree and 5 = strongly agree. The scale is designed to measure how easily caregivers cope and respond to stressful events in their lives. The first table displays the min score, max score, average score, and standard deviation for each item. The second table display the mean scale score for this measure. To get the mean scale score, items two, four and six were reverse scored and summed with scores from items one, three and five. The sum score was then divided by six. For the mean scale score, higher responses indicate higher levels of resilience.

Descriptive Statistics for the Brief Resilience Scale items

	N	Min	Max	Mean	Std Dev
I tend to bounce back quickly after hard times.	116	1	5	4.01	0.92
I have a hard time making it through stressful events.*	116	1	5	2.26	0.97
It does not take me long to recover from a stressful event.	116	1	5	3.66	0.94
It is hard for me to snap back when something bad happens.*	115	1	5	2.15	0.96
I usually come through difficult times with little trouble.	116	2	5	3.69	0.91
I tend to take a long time to get over setbacks in my life.*	115	1	5	2.10	0.94

*These items are reverse scored when calculating the mean scale score

Brief Resilience Questionnaire Mean Score

	N	Minimum	Maximum	Mean	Std. Dev
Brief Resilience Questionnaire Mean Score	116	1.67	5.00	3.81	0.69

Caregiver Strain

The Caregiver Strain Questionnaire- Foster Care/Adoption Adaptation (CGSQ-FA) consists of 22 items designed to measure how much objective and subjective strain caregivers are experiencing as a result of parenting a child in foster care, who has been adopted, or is in legal guardianship. Caregivers rated each statement on a scale of 1 through 5, with 1 = not at all and 5 = a great deal. The first ten items measure objective strain and ask, "During the past 6 months, as a result of parenting your child who was adopted or in legal guardianship, how much was each of the following a problem for you (caregiver)?" The remaining items measure a caregiver's subjective strain and asked caregivers to think how they have felt over the past 6 months as a result of parenting their child. Three items highlighted in gray are reverse coded prior to calculating the overall scale scores.

Descriptive statistics for the CGSQ-FA Objective Strain items

	N	Min	Max	Mean	Std Dev
Interruption of personal time?	116	1	5	2.23	1.15
Missing obligations related to your job or similar responsibilities?	116	1	4	1.53	0.73
Disruption of family routines?	116	1	4	1.54	0.76
Financial strain for your family?	116	1	5	1.62	0.94
Less attention paid to other family members?	115	1	5	1.74	0.93
Disruption or upset relationships within in the family?	115	1	5	1.56	0.86
Disruption of your family's social activities?	116	1	5	1.43	0.77
Disruption of friendships or significant relationships within the community?	116	1	4	1.34	0.70
Poor self-care?	116	1	5	1.43	0.87
Increase in your alcohol consumption or substance use?	116	1	4	1.16	0.55

Descriptive statistics for the CGSQ-FA Subjective Strain items

	N	Min	Max	Mean	Std Dev
How isolated have you felt?	116	1	5	1.58	0.92
How sad or unhappy have you felt?	116	1	5	1.61	0.89
How angry or frustrated have you felt?	115	1	5	1.78	0.89
How worried have you felt about your child's future?	116	1	5	2.39	1.18
How worried have you felt about your family's future?	116	1	5	1.61	0.91
How resentful have you felt?	115	1	5	1.29	0.72
How overwhelmed have you felt?	116	1	5	1.85	0.95
How hopeful have you felt?*	116	1	5	3.82	1.07
How proud have you felt?*	116	1	5	4.19	1.06
How supported have you felt?*	116	1	5	3.57	1.16
How misunderstood have you felt?	116	1	5	1.69	0.94
How judged or criticized have you felt?	116	1	5	1.74	0.96

*These items are reverse scored when calculating the mean scale score

CGSQ-FA mean scale and subscale scores

	N	Min	Max	Mean	Std Dev
Mean Caregiver Strain Score	116	1	3.77	1.94	0.45
Mean Objective Caregiver Strain Score	116	1	3.70	1.56	0.58
Mean Subjective Caregiver Strain Score	116	1	4.17	2.26	0.43

Caregiver Adverse Childhood Experiences

The Adverse Childhood Experiences instrument used in Vermont contains 11 statements, where each item represents an adverse childhood experience that the caregiver may or may not have endured. for a caregiver's total ACE score, each item was dichotomized to a "yes/no" response, and each caregiver's "yes" responses were added together to get their individual ACE score. The average was then calculated for the sample. The items, total ACE scores and grouped scores are shown below.

ACE Items

Before the age of 18...	N	Frequency	Valid %
Did you live with anyone who was depressed, mentally ill, or suicidal?	114	28	24.6
Did you live with anyone who was a problem drinker or alcoholic, used illegal street drugs or who abused prescription medications?	112	31	27.7
Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	116	1	0.9
Were your parents separated or divorced?	116	17	14.7
Did you live with a parent or guardian who died?	116	5	4.3
Did anyone at least 5 years older than you or an adult ever touch you sexually or try to make you touch them sexually?	114	22	19.3
Did anyone at least 5 years older than you force you to have sex?	115	3	2.6
How often did your parents, guardians or adults in your home ever slap, hit, kick, punch, or beat each other up? (more than once)	114	13	11.4
How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? (more than once)	113	35	31.0
How often did a parent or adult in your home ever swear at you, insult you, or put you down? (more than once)	115	39	33.9
How often were your basic needs unmet (food, shelter, clothing)? (more than once)	115	7	6.1

Total ACE score

	N	Minimum	Maximum	Mean	Std. Dev
Total ACE Score	115	0	7	1.75	1.84

Total ACE score grouped

		Frequency	Percent	Valid %	Cumulative %
Valid	0	38	32.5	33.0	33.0
	1	25	21.4	21.7	54.8
	2	20	17.1	17.4	72.2
	3	12	10.3	10.4	82.6
	4+	20	17.1	17.4	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

Caregiver Support

In the past 6 months, how often have you felt you could turn to a friend or family member for support?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	61	52.1	53.0	53.0
	Most of the Time	35	29.9	30.4	83.5
	About Half the Time	3	2.6	2.6	86.1
	Sometimes	12	10.3	10.4	96.5
	Never	4	3.4	3.5	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

In the past 6 months, has the support you received from others increased, stayed about the same, or decreased?

		Frequency	Percent	Valid %	Cumulative %
Valid	Support Increased	10	8.5	8.6	8.6
	Support Stayed the Same	100	85.5	86.2	94.8
	Support Decreased	6	5.1	5.2	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

In the past 6 months, how easy or hard has it been to get child care when needed?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	28	23.9	39.4	39.4
	Somewhat Easy	23	19.7	32.4	71.8
	Somewhat Hard	16	13.7	22.5	94.4
	Very Hard	4	3.4	5.6	100.0
	Total	71	60.7	100.0	
Missing	Have Not Needed	44	37.6		
	No Response	2	1.7		
Total		117	100.0		

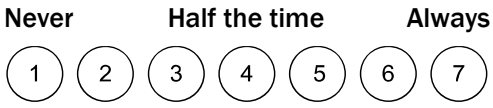
In the past 6 months, how easy or hard has it been to get respite when needed?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	12	10.3	23.5	23.5
	Somewhat Easy	17	14.5	33.3	56.9
	Somewhat Hard	16	13.7	31.4	88.2
	Very Hard	6	5.1	11.8	100.0
	Total	51	43.6	100.0	
Missing	Have Not Needed	64	54.7		
	No Response	2	1.7		
Total		117	100.0		

Family Wellbeing

Protective Factors Survey

This Protective Factor Survey (PFS) is traditionally used with caregivers receiving child abuse prevention and family support services such as parent education and home visiting. It can be used once to obtain a snap-shot of how families are doing but is often used as a pre-post survey to measure changes in protective factors that may occur because of a family participating in an intervention. There are five protective factors: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. The Family Functioning/Resiliency Subscale and the Nurturing and Attachment Subscale were included along with individual items used to measure knowledge on parenting and child development. For the two subscales, caregivers were asked to indicate on a scale of 1 to 7 how often a statement was true for their family (1=never to 7 = always). Higher scores on the Family Functioning/Resilience Subscale indicate more open communication within the family and a greater ability to persevere or manage problems in times of crisis. On the Nurturing and Attachment Subscale, higher scores indicate a higher level of emotional bonding and positive interaction between the parent and child. The mean scale scores of these two subscales are reported below.



Protective Factors Survey Results: Family Functioning + Nurturing and Attachment Subscales

	Valid N	Min	Max	Std. Dev	Mean Score
Mean Family Functioning Score	116	4.0	7.0	0.80	5.88★
Mean Nurturing Attachment Score	117	2.0	7.0	0.88	5.93★

There are five items in the PFS that ask about the caregiver's knowledge of parenting and child development. Three of these items ask caregivers to indicate how much they agree with each statement on a scale from 1 to 7 (1=strongly disagree to 7=strongly agree). The means of these items are listed in the table below.

PFS: Knowledge of Parenting and Child Development Items (1=Strongly Disagree to 7=Strongly Agree)

	Valid N	Min	Max	Mean	Std. Dev
There are many times when I don't know what to do as a parent.	117	1	7	3.15	1.65
This child misbehaves just to upset me.	116	1	7	2.46	1.65
I know how to help this child learn.	117	1	7	6.05	1.01

PFS: Knowledge of Parenting and Child Development Items (1=Never true to 7=Always true)

	Valid N	Min	Max	Mean	Std. Dev
I praise this child when he/she behaves well.	116	4	7	6.17	0.75
When I discipline this child, I lose control.	117	1	5	2.10	0.87

Belonging and Emotional Support Tool (BEST)

The BEST was originally designed for youth who are unable to reunify with their family of origin and do not yet have a legal family relationship; however, in this study it is used to measure a sense of emotional security within the family and the level of belonging, or commitment of the caregiver post permanency. Examples of statements include: *My child belongs to our family. (1=Strongly Disagree…to 5=Strongly Agree). The* BEST has 20 items. In Vermont, an additional item was added.

Descriptive Statistics for BEST items

	Valid N	Min	Max	Mean	Std. Dev
My child belongs to our family.	117	2	5	4.92	0.42
When something important happens to my child, I want to talk with him/her about it.	117	4	5	4.94	0.24
I care deeply about what happens to my child.	117	4	5	4.97	0.16
It makes me feel happy when we spend time together.	117	2	5	4.79	0.48
I let my child know he/she is wanted.	117	3	5	4.88	0.35
I expect to exchange holiday cards or gifts with my child just like	117	3	5	4.95	0.29
I feel close to my child.	117	2	5	4.83	0.48
I love my child.	117	4	5	4.99	0.09
I trust my child.	117	1	5	4.56	0.86
I would give my child money if he/she ever needed it.	117	3	5	4.68	0.60
I include my child in family photos and portraits.	117	1	5	4.96	0.38
I pay attention to my child when she/he asks for help.	117	4	5	4.94	0.24
My child cares deeply about what happens to me.	117	1	5	4.74	0.70
I include my child in family vacations.	117	1	5	4.89	0.55
My child loves me.	117	1	5	4.85	0.55
I let my child know he/she will be in our family for life.	117	3	5	4.97	0.23
I let my child know he/she will always be able to count on my help.	117	1	5	4.91	0.49
I will do everything to keep my relationship going when my child is no longer living at home.	117	2	5	4.91	0.41
I find a way to stand behind my child even when he/she is wrong.	117	1	5	4.54	0.76
I have done everything I can to make my child feel he/she belongs to our family.	117	3	5	4.92	0.30
I am committed to my child for life, no matter what*	117	2	5	4.93	0.39

*Item was added to original scale

Additional Commitment Item:

I am committed to my child for life, no matter what.

		Frequency	Percent	Valid %	Cumulative %
Valid	Strongly Disagree	0	0.0	0.0	0.0
	Disagree	1	0.9	0.9	0.9
	Neutral	2	1.7	1.7	2.6
	Agree	1	0.9	0.9	3.4
	Strongly Agree	113	96.6	96.6	100.0
	Total	117	100.0	100.0	

The BEST includes two subscales, the Emotional Security Subscale (13 items) and the Commitment Subscale (7 items). Emotional security, or the shared sense of family belonging plays an important role in legal permanence. This cumulative scoring of this subscale ranges from 13 to 65. The commitment subscale looks at the degree to which the caregiver is claiming the child either emotionally or legally. This cumulative scoring on this subscale ranges from 7 to 35. Cumulative scoring for the BEST ranges from a low of 20 to a high of 100 (21 to 105 with additional item). A higher cumulative score is protective and indicates a higher level of commitment and emotional security. Total scores for the overall instrument and two subscales are displayed in the table below.

BEST scale and subscale scores

	Valid N	Min	Max	Mean	Std. Dev
Total BEST Score	117	63	100	97.01	5.90
Total BEST Score + 1 Item	117	67	105	101.94	6.15
Total BEST Emotional Security Subscale	117	38	65	62.72	4.47
Total BEST Commitment Subscale Score	117	25	35	34.29	1.66

Additional Parent Child Relationship Items

Three additional items were asked to better understand relationship between the Caregiver and the Identified Child. A summary of responses from each item are reported below.

During the past month, how often have you felt that you just did not understand this child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Everyday	1	0.9	0.9	0.9
	A Few Times a Week	11	9.4	9.6	10.4
	Once a Week	20	17.1	17.4	27.8
	Less than Once a Week	53	45.3	46.1	73.9
	Never	30	25.6	26.1	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

How confident are you that you can meet your child's needs?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Confident	50	42.7	42.7	42.7
	Very Confident	42	35.9	35.9	78.6
	Somewhat Confident	21	17.9	17.9	96.6
	Slightly Confident	2	1.7	1.7	98.3
	Not at All Confident	2	1.7	1.7	100.0
	Total	117	100.0	100.0	

How would you describe your relationship to this child over the past 6 months?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Gotten Better	58	49.6	49.6	49.6
	About the Same	59	50.4	50.4	100.0
	Has Gotten Worse	0	0.0	0.0	100.0
	Total	117	100.0	100.0	

Adoption and Guardianship

Impact

Caregivers were also asked to consider the impact of parenting the Identified Child on their family. A summary of responses from each item are reported below.

Overall, how would you rate the impact of your child's adoption/guardianship on your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Positive	91	77.8	78.4	78.4
	Moderately Positive	17	14.5	14.7	93.1
	Slightly Positive	5	4.3	4.3	97.4
	Neither Positive nor Negative	1	0.9	0.9	98.3
	Slightly Negative	1	0.9	0.9	99.1
	Moderately Negative	1	0.9	0.9	100.0
	Extremely Negative	0	0.0	0.0	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Overall, how do you think your spouse, partner, or other adult caring for your child would rate the impact of your child's adoption/guardianship on your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Positive	77	65.8	72.0	72.0
	Moderately Positive	18	15.4	16.8	88.8
	Slightly Positive	5	4.3	4.7	93.5
	Neither Positive nor Negative	2	1.7	1.9	95.3
	Slightly Negative	2	1.7	1.9	97.2
	Moderately Negative	3	2.6	2.8	100.0
	Extremely Negative	0	0.0	0.0	100.0
	Total	107	91.5	100.0	
Missing	No Response	1	0.9		
	Not Applicable	9	7.7		
Total		117	100.0		

Overall, would you say the impact of your child's adoption/guardianship on your relationship with your partner, spouse, or other adult caring for this child has been…?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Positive	58	49.6	55.8	55.8
	Moderately Positive	19	16.2	18.3	74.0
	Slightly Positive	3	2.6	2.9	76.9
	Neither Positive nor Negative	14	12.0	13.5	90.4
	Slightly Negative	7	6.0	6.7	97.1
	Moderately Negative	2	1.7	1.9	99.0
	Extremely Negative	1	0.9	1.0	100.0
	Total	104	88.9	100.0	
Missing	No Response	2	1.7		
	Not Applicable	11	9.4		
Total		117	100.0		

Overall, would you say the impact of your child's adoption/guardianship on your other children has been…?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Positive	37	31.6	48.7	48.7
	Moderately Positive	21	17.9	27.6	76.3
	Slightly Positive	9	7.7	11.8	88.2
	Neither Positive nor Negative	2	1.7	2.6	90.8
	Slightly Negative	4	3.4	5.3	96.1
	Moderately Negative	3	2.6	3.9	100.0
	Extremely Negative	0	0.0	0.0	100.0
	Total	76	65.0	100.0	100.0
Missing	No Response	1	0.9		
	Not Applicable	40	34.2		
Total		117	100.0		

Conversations about Adoption and Guardianship

In the past 6 months, how often did you bring up adoption or guardianship with your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	3	2.6	2.6	2.6
	Weekly	13	11.1	11.2	13.8
	Monthly	36	30.8	31.0	44.8
	Less than Monthly	50	42.7	43.1	87.9
	Never	11	9.4	9.5	97.4
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

In the past 6 months, how often did your child bring up adoption or guardianship in conversation?

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	0	0.0	0.0	0.0
	Weekly	14	12.0	13.5	13.5
	Monthly	15	12.8	14.4	27.9
	Less than Monthly	52	44.4	50.0	77.9
	Never	23	19.7	22.1	100.0
	Total	104	88.9	100.0	
Missing	No Response/Not Applicable	13	10.1		
Total		117	100.0		

Relationship between Caregiver and Child's Frequency of Discussion of Adoption or Guardianship

		Caregiver's Frequency of Discussion of Adoption or Guardianship					
		Daily	Weekly	Monthly	< Monthly	Never	Total
Child's Frequency of Discussion of Adoption or Guardianship	Daily	0	0	0	0	0	0
	Weekly	1	7	4	1	0	13
	Monthly	0	1	12	2	0	15
	Less than Monthly	0	0	9	40	3	52
	Never	0	3	7	5	8	23
	Total	1	11	32	48	11	103*

*Fourteen cases did not include sufficient information to be included in this analysis.

Level of comfort answering child's questions about his/her birth parents' history?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Comfortable	83	70.9	74.1	74.1
	Somewhat Comfortable	24	20.5	21.4	95.5
	Somewhat Uncomfortable	4	3.4	3.6	99.1
	Very Uncomfortable	1	0.9	0.9	100.0
	Total	112	95.7	100.0	
Missing	No Response/Not Applicable	5	4.3		
Total		117	100.0		

Birth Family Contact

Several items were asked to better understand the relationship a child may or may not have with his or birth parents and birth siblings.

Contact with Birth Mother

Is contact with your child's birth mother possible?

		Frequency	Percent	Valid %	Cumulative %
Valid	Contact Is Possible	72	61.5	62.0	62.0
	Contact Is Not Possible	44	37.6	37.9	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.00		

In general, how important is it to you that your child has contact with his or her birth mother? (N=72)

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Important	12	10.3	16.7	16.7
	Very Important	18	15.4	25.0	41.7
	Moderately Important	6	5.1	8.3	50.0
	Slightly Important	17	14.5	23.6	73.6
	Not at All Important	19	16.2	26.4	100.0
	Total	72	61.5	100.0	

In the past 6 months, how often has your child had contact with his or her birth mother? (N=72)

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	2	2.8	3.0	3.0
	Weekly	2	2.8	3.0	6.0
	Monthly	3	4.2	4.5	10.5
	Less than Monthly	13	18.1	19.7	30.2
	Never	46	63.9	69.8	100.0
	Total	66	91.7	100.0	
Missing	No Response	6	8.3		
Total		72	100.0		

In the past 6 months, what type of contact has your Identified Child had with his/her birth mother?

	Valid N	Frequency	Percent
In Person/Visitation	20	9	45.0
Phone/Skype/FaceTime	20	5	25.0
Mail/Email	20	8	40.0
Social Media	20	6	30.0
Other Contact	20	1	5.0

In the past 6 months, how has your child's contact with his/her birth mother impacted your family (N=20)

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Positive Impact	8	40.0	42.1	42.1
	Slightly Positive Impact	3	15.0	15.8	57.9
	Neither Positive nor Negative	6	30.0	31.6	89.5
	Slightly Negative Impact	0	0.0	0.0	89.5
	Very Negative Impact	2	10.0	10.5	100.0
	Total	19	95.0	100.0	
Missing	No Response	1	5.0		
Total		20	100.0		

Contact with Birth Father

Is contact with your child's birth father possible?

		Frequency	Percent	Valid %	Cumulative %
Valid	Contact Is Possible	51	43.5	43.9	43.9
	Contact Is Not Possible	65	55.6	56.0	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.00		

In general, how important is it to you that your child has contact with his or her birth father? (N=51)

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Important	5	9.8	9.8	9.8
	Very Important	11	21.6	21.6	31.4
	Moderately Important	6	11.8	11.8	43.1
	Slightly Important	8	15.7	15.7	58.8
	Not at All Important	21	41.2	41.2	100.0
	Total	51	100.0	100.0	

In the past 6 months, how often has your child had contact with his or her birth father? (N=51)

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	0	0.0	0.0	0.0
	Weekly	2	3.9	4.7	4.7
	Monthly	3	5.9	7.0	11.6
	Less than Monthly	4	7.8	9.3	20.9
	Never	34	66.7	79.1	100.0
	Total	43	84.3	100.0	
Missing	No Response/Not Applicable	8	15.7		
Total		51	100.0		

In the past 6 months, what type of contact has your child had with his/her birth father? (N=9)

	Valid N	Frequency	Percent
In Person/Visitation	9	6	66.7
Phone/Skype/FaceTime	9	4	44.4
Mail/Email	9	5	55.6
Social Media	9	0	0.0
Other Contact	9	1	11.1

In the past 6 months, how has your child's contact with his/her birth father impacted your family (N=9)

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Positive Impact	4	44.4	44.4	44.4
	Slightly Positive Impact	3	33.3	33.3	77.8
	Neither Positive nor Negative	1	11.1	11.1	88.9
	Slightly Negative Impact	1	11.1	11.1	100.0
	Very Negative Impact	0	0.0	0.0	100.0
	Total	9	100.0	100.0	

Contact with Birth Siblings

Caregivers indicated that their child had anywhere from 0 to 10 birth siblings. On average, a child had two birth siblings (Mean= 1.95; SD=2.10).

Does your child have any birth siblings? (N=117)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	61	52.1	52.1	52.1
	No	27	23.1	23.1	75.2
	Unknown	29	24.8	24.8	100.0
	Total	117	100.0	100.0	

*A total of 137 out of 166 caregivers (83.0%) indicated that their child had at least one birth sibling living outside of their home.

Do any of your child's birth siblings live outside of your home? (N=61)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	57	93.4	96.6	96.6
	No	2	3.3	3.4	100.0
	Total	59	96.7	100.0	
Missing	No Response	2	3.3		
Total		61	100.0		

In general, how important is it to you that your child has contact with his or her birth siblings living outside of your home? (N=57)

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Important	13	22.8	26.0	26.0
	Very Important	13	22.8	26.0	52.0
	Moderately Important	7	12.3	14.0	66.0
	Slightly Important	13	22.8	26.0	92.0
	Not at All Important	4	7.0	8.0	100.0
	Total	50	87.7	100.0	
Missing	No Response	7	12.3		
Total		57	100.0		

In the past 6 months, how often has your child had contact with his or her birth sibling living outside of your home? Please refer to the birth sibling living outside of your home with has the most contact with the identified child. (N=57)

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	1	1.8	2.1	2.1
	Weekly	7	12.3	14.9	17.0
	Monthly	6	10.5	12.8	29.8
	Less than Monthly	6	10.5	12.8	42.6
	Never	27	47.4	57.4	100.0
	Total	47	82.5	100.0	
Missing	No Response	10	17.5		
Total		57	100.0		

In the past 6 months, what type of contact has your child had with his/her birth siblings? Please refer to the birth sibling living outside of your home with has the most contact with your child. (N=20)

	Valid N	Frequency	Percent
In Person/Visitation	20	11	55.5
Phone/Skype/FaceTime	20	7	35.0
Mail/Email	20	4	20.0
Social Media	20	8	40.0
Other Contact	20	1	5.0

In the past 6 months, how has your child's contact with his/her birth siblings impacted your family (N=20)

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Positive Impact	10	50.0	50.0	50.0
	Slightly Positive Impact	3	15.0	15.0	65.0
	Neither Positive nor Negative	5	25.0	25.0	90.0
	Slightly Negative Impact	1	5.0	5.0	95.0
	Very Negative Impact	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

Adoption and Guardianship Experiences

How often do you think of ending the adoption or guardianship? Would you say…?

		Frequency	Percent	Valid %	Cumulative %
Valid	Never	111	94.9	95.7	95.7
	Rarely	5	4.3	4.3	100.0
	Sometimes	0	0.0	0.0	100.0
	Usually	0	0.0	0.0	100.0
	Always	0	0.0	0.0	100.0
	Total	116	98.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Have you or your spouse/partner ever taken any of the following actions to end this adoption or guardianship?

	Valid N	Frequency 'Yes'	Percent
Spoke With a Caseworker, Adoption Agency Worker or Social Service Agency Worker About It	5	0	0.0
Spoke With an Attorney About It	5	0	0.0
Spoke With a Close Friend or Family Member About It	5	1	20.0
Spoke With Clergy or Religious Leader About It	5	0	0.0
Reached Out Online or Via Social Media	5	0	0.0
Spoke With Others	5	0	0.0

If you knew then what you know now, do you think you still would have adopted/assumed guardianship of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Definitely Would Have	108	92.3	93.1	93.1
	Probably Would Have	0	0.0	0.0	93.1
	Might or Might Not Have	5	4.3	4.3	97.4
	Probably Would Not Have	2	1.7	1.7	99.1
	Definitely Would Not Have	1	0.9	0.9	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Overall, how would you describe your adoption or guardianship experience?

		Frequency	Percent	Valid %	Cumulative %
Valid	Easier than I Anticipated	35	29.9	30.7	30.7
	What I Anticipated	42	35.9	36.8	67.5
	Harder than I Anticipated	37	31.6	32.5	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Given your experience of adoption or guardianship with this child, how likely would you be to recommend adoption or guardianship to others?

		Frequency	Percent	Valid %	Cumulative %
Valid	Definitely Would Have	93	79.5	80.2	80.2
	Probably Would Have	11	9.4	9.5	89.7
	Might or Might Not Have	8	6.8	6.9	96.6
	Probably Would Not Have	2	1.7	1.7	98.3
	Definitely Would Not Have	2	1.7	1.7	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Service Use

Pre-Permanency Services

Caregivers were asked about their family's participation in eight different pre-permanency services. If a family had participated in service, the caregiver was asked to rate how helpful each service was from 1=Not helpful to 3=Very helpful.

Did your family use the following pre-permanency services?

	Don't know about		No		Yes	
	N	Valid %	N	Valid %	N	Valid %
Pre-Placement Social Work Services	19	16.4	28	24.1	69	59.5
Post-Placement Supervision Services	16	32.5	38	33.3	60	52.6
Pre-Placement Training	22	19.6	42	37.5	48	42.9
Vermont Adoption Consortium Training/Conference	30	26.1	46	40.0	39	33.9
Adoption Learning Partnership Online Training	41	36.0	61	53.5	12	10.5
VFAFA Training/Conferences	33	28.9	57	50.0	24	21.1
Vermont Kin As Parents	35	30.7	77	67.5	2	1.8
Transracial Cross-Cultural Training	24	20.7	53	45.7	39	33.6

How helpful is this service?

	Not helpful		Somewhat		Very helpful	
	N	Valid	N	Valid %	N	Valid %
Pre-Placement Social Work Services	3	4.3	25	36.2	41	59.4
Post-Placement Supervision Services	7	11.7	22	36.7	31	51.7
Pre-Placement Training	2	4.2	25	52.1	21	43.8
Vermont Adoption Consortium Training/Conference	0	0.0	13	33.3	26	66.7
Adoption Learning Partnership Online Training	1	8.3	7	58.3	4	33.3
VFAFA Training/Conferences	3	12.5	9	37.5	12	50.0
Vermont Kin As Parents	0	0.0	0	0.0	2	100.0
Transracial Cross-Cultural Training	4	10.3	14	35.9	21	53.8

Overall, how prepared did you feel to meet the needs of your child at the time of finalization?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Prepared	61	36.7	38.1	38.1
	Very Prepared	52	31.3	32.5	70.6
	Somewhat Prepared	36	21.7	22.5	93.1
	A Little Prepared	6	3.6	3.8	96.9
	Not at All Prepared	5	3.0	3.1	100.0
	Total	160	96.3	100.0	
Missing	No Response	6	3.6		
Total		166	100.0		

Overall, how would you rate the Vermont Department for Children and Families (DCF) in preparing you to meet the needs of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Good	52	31.3	31.3	31.3
	Good	48	28.9	28.9	60.2
	Fair	42	25.3	25.3	85.5
	Poor	15	9.0	9.0	94.6
	Very Poor	9	5.4	5.4	100.0
	Total	166	100.0	100.0	

Post Permanency Services

Service use is reported for families over the past six months in the tables below. Services highlighted in gray represent services where at least 20% of families indicated they had used on the past 6 months.

Family support services used in past 6 months

	N	Frequency	Valid %
Family Counseling through Community Mental Health	117	4	3.4
Intensive Family Based Services	117	1	0.9
Case Management Service Coordination	117	7	6.0
DCF Social Work Services	117	1	0.9
Family Safety Planning	117	2	1.7
Agency Support Services	117	5	4.3
LGBTQ Support Services	117	1	0.9
Online Support/Blogs	117	11	9.4
Family Counseling through a Private Provider	117	12	10.3

School/Child care services for child used in past 6 months

	N	Frequency	Valid %
Regular Child Care Services	117	10	8.5
Afterschool Program	117	19	16.2
Mentoring	117	2	1.7
Behavior Support Services	117	7	6.0
School-Based Clinician	117	13	11.1
Alternative School	117	5	4.3

Medical services for child used in past 6 months

	Valid N	Frequency	Percent
Routing Medical Care	117	94	80.3
Medication Management	117	14	12.0
Services for Children Who Are Blind or Visually Impaired	117	0	0.0
Services for Children Who Are Deaf or Hard of Hearing	117	1	0.9
Speech or Occupational Therapy	117	8	6.8
Developmental Disability Case Management Services	117	7	6.0
Physical Disability Services	117	1	0.9
Other Developmental Disabilities Services (Including Personal Care	117	4	3.4

Mental health services for child used in past 6 months

	N	Frequency	Valid %
Psychological Assessment	117	7	6.0
Individual Counseling or Therapy through Community Mental Health	117	23	19.7
Group Counseling	117	1	0.9
Psychiatric Medication	117	9	7.7
Coordinated Service Plan/ACT 264	117	1	0.9
Care Coordination/Case Management	117	5	4.3
Individual Counseling through a Private Provider	117	12	10.3
Substance Abuse Treatment	117	0	0.0

Mental health services for caregiver used in past 6 months

	N	Frequency	Valid %
Individual Counseling or Therapy through Community Mental Health	117	7	6.0
Group Counseling	117	0	0.0
Psychiatric Medication	117	1	0.9
Substance Abuse Treatment	117	0	0.0
Individual Counseling or Therapy through Private Provider	117	10	8.5

Post permanency services used in past 6 months

	N	Frequency	Valid %
Post Permanency Services	117	7	6.0
Vermont Adoption Consortium (VAC) Resource Library	117	1	0.9
Vermont Adoption Registry	117	3	2.6
Post Permanency Newsletter	117	3	2.6
Parent Support Group	117	5	4.3
Post Permanency Trainings for Adoptive Parents & Guardians	117	3	2.6
Trauma Assessment	117	0	0.0
Conference for Families Formed through Adoption & Guardianship	117	2	1.7
LGBTQ Services / Trainings	117	0	0.0
Adoption/Guardianship Assistance Agreement (Subsidy)	117	4	3.4

How often do services meet the needs of your family?

In the past 6 months how often have family support services (family counseling/family-based services) in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	3	2.6	13.0	13.0
	Most of the Time	6	5.1	26.1	39.1
	About Half of the Time	1	0.9	4.3	43.5
	Some of the Time	5	4.3	21.7	65.2
	Never	8	6.8	34.8	100.0
	Total	23	19.7	100.0	
Missing	No Response	7	6.0		
	Have Not Used	87	74.4		
Total		117	100.0		

In the past 6 months how often have school services in your community met the needs of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	21	17.9	31.8	31.8
	Most of the Time	24	20.5	36.4	68.2
	About Half of the Time	2	1.7	3.0	71.2
	Some of the Time	13	11.1	19.7	90.9
	Never	6	5.1	9.1	100.0
	Total	66	56.4	100.0	
Missing	No Response	4	3.4		
	Have Not Used	47	40.2		
Total		117	100.0		

In the past 6 months how often have child care services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	13	11.1	32.5	32.5
	Most of the Time	15	12.8	37.5	70.0
	About Half of the Time	2	1.7	5.0	75.0
	Some of the Time	2	1.7	5.0	80.0
	Never	8	6.8	20.0	100.0
	Total	40	34.2	100.0	
Missing	No Response	7	6.0		
	Have Not Used	70	59.8		
Total		117	100.0		

In the past 6 months how often have medical services in your community met the needs of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	48	41.0	60.8	60.8
	Most of the Time	21	17.9	26.6	87.3
	About Half of the Time	3	2.6	3.8	91.1
	Some of the Time	4	3.4	5.1	96.2
	Never	3	2.6	3.8	100.0
	Total	79	67.5	100.0	
Missing	No Response	7	6.0		
	Have Not Used	31	26.5		
Total		117	100.0		

In the past 6 months how often have mental health services in your community met the needs of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	7	6.0	23.3	23.3
	Most of the Time	11	9.4	36.7	60.0
	About Half of the Time	1	0.9	3.3	63.3
	Some of the Time	4	3.4	13.3	76.7
	Never	7	6.0	23.3	100.0
	Total	30	25.6	100.0	
Missing	No Response	7	6.0		
	Have Not Used	80	68.4		
Total		117	100.0		

In the past 6 months how often have mental health services in your community met your needs as a caregiver?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	7	6.0	30.4	30.4
	Most of the Time	5	4.3	21.7	52.2
	About Half of the Time	3	2.6	13.0	65.2
	Some of the Time	1	0.9	4.3	69.6
	Never	7	6.0	30.4	100.0
	Total	23	19.7	100.0	
Missing	No Response	7	6.0		
	Have Not Used	87	74.4		
Total		117	100.0		

In the past 6 months how often have post permanency services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	7	6.0	35.0	35.0
	Most of the Time	2	1.7	10.0	45.0
	About Half of the Time	1	0.9	5.0	50.0
	Some of the Time	2	1.7	10.0	60.0
	Never	8	6.8	40.0	100.0
	Total	20	17.1	100.0	
Missing	No Response	6	5.1		
	Have Not Used	91	77.8		
Total		117	100.0		

In the past 6 months how often have substance abuse services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	0	0.0	0.0	0.0
	Most of the Time	1	0.9	10.0	10.0
	About Half of the Time	0	0.0	0.0	10.0
	Some of the Time	0	0.0	0.0	10.0
	Never	9	7.7	90.0	100.0
	Total	10	8.5	100.0	
Missing	No Response	8	6.8		
	Have Not Used	99	84.6		
Total		117	100.0		

In the past 6 months how often have DCF child welfare services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	0	0.0	0.0	0.0
	Most of the Time	0	0.0	0.0	0.0
	About Half of the Time	1	0.9	11.1	11.1
	Some of the Time	0	0.0	0.0	11.1
	Never	8	6.8	88.9	100.0
	Total	9	7.7	100.0	
Missing	No Response	7	6.0		
	Have Not Used	101	86.3		
Total		117	100.0		

In the past 6 months how often have physical disability services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	1	0.9	12.5	12.5
	Most of the Time	0	0.0	0.0	12.5
	About Half of the Time	0	0.0	0.0	12.5
	Some of the Time	0	0.0	0.0	12.5
	Never	7	6.0	87.5	100.0
	Total	8	6.8	100.0	
Missing	No Response	8	6.8		
	Have Not Used	101	86.3		
Total		117	100.0		

Psychiatric Medication Service by Age of Child

Due to concerns about the overmedication of children that have been involved in the child welfare system, psychiatric medication usage was examined in more detail. Specifically, in conjunction with the age groups of the children who are receiving these medications. A total of 34 children out of 166 (20.5%) in the cycle were currently prescribed prescription medication, according to their caregiver's self-report.

Psychiatric Medication Use by Child's Age (grouped)

		Yes	No	Total
Child's age in years	0 - 3 years old	0	0	0
	4 - 7 years old	3	23	26
	8 - 12 years old	11	44	55
	13+ years old	20	65	85
	Total	34	132	166

Transracial/Transcultural Adoption Experiences

Does your family see itself as a transracial family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	77	65.8	71.3	71.3
	No	31	26.5	28.7	100.0
	Total	108	92.3	100.0	
Missing	No Response	9	7.7		
Total		117	100.0		

Has your family talked about being a transracial family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	70	90.9	92.1	92.1
	No	6	7.8	7.9	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Has your family chosen childcare providers, teachers, or other role models similar to your child's race and ethnicity? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	38	49.4	51.4	51.4
	No	36	46.8	48.6	100.0
	Total	74	96.1	100.0	
Missing	No Response	3	3.9		
Total		77	100.0		

Does your family have friends that share the same racial or ethnic background of your child? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	62	80.5	81.6	81.6
	No	14	18.2	18.4	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Has your family prepared foods associated with your child's racial or ethnic background? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	53	68.8	69.7	69.7
	No	23	29.9	30.3	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Has your family lived in or moved to a racially or culturally diverse neighborhood? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	11	14.3	14.5	14.5
	No	65	84.4	85.5	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Do you feel confident that your family can meet your child's needs based on his or her transracial ethnic identity? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	55	71.4	73.3	73.3
	No	20	26.0	26.7	100.0
	Total	75	97.4	100.0	
Missing	No Response	2	2.6		
Total		77	100.0		

Is your child comfortable being in a transracial family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	72	93.5	96.0	96.0
	No	3	3.9	4.0	100.0
	Total	75	97.4	100.0	
Missing	No Response	2	2.6		
Total		77	100.0		

Has your family discussed your child's international or private adoption? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	73	94.8	96.1	96.1
	No	3	3.9	3.9	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Did you have a travel support group when you adopted internationally? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	15	19.5	24.2	24.2
	No	47	61.0	75.8	100.0
	Total	62	80.5	100.0	
Missing	No Response	15	19.5		
Total		77	100.0		

Do you keep in touch with that travel support group? (N=15)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	10	66.7	66.7	66.7
	No	5	33.3	33.3	100.0
	Total	15	100.0	100.0	

Has there been any impact of your child's transracial adoption on your immediate family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	30	39.0	40.5	40.5
	No	44	57.1	59.5	100.0
	Total	74	96.1	100.0	
Missing	No Response	3	3.9		
Total		77	100.0		

Has there been any impact of your child's transracial adoption on your extended family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	25	32.5	34.2	34.2
	No	48	62.3	65.8	100.0
	Total	73	94.8	100.0	
Missing	No Response	4	5.2		
Total		77	100.0		

Has your family been involved in religious, social, or recreational groups or activities that reflect your child's race, ethnicity, or culture? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	45	58.4	60.8	60.8
	No	29	37.7	39.2	100.0
	Total	74	96.1	100.0	
Missing	No Response	3	3.9		
Total		77	100.0		

Does your child have problems being in a transracial/transcultural family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	7	9.1	9.6	9.6
	No	66	85.7	90.4	100.0
	Total	73	94.8	100.0	
Missing	No Response	4	5.2		
Total		77	100.0		

Does your child have sources of support in your transracial/transcultural family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	47	61.0	62.7	62.7
	No	28	36.4	37.3	100.0
	Total	75	97.4	100.0	
Missing	No Response	2	2.6		
Total		77	100.0		

Does your child have problems with racial discrimination? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	28	36.4	37.8	37.8
	No	46	59.7	62.2	100.0
	Total	74	96.1	100.0	
Missing	No Response	3	3.9		
Total		77	100.0		

Do you feel you know how to help your child when he or she is being teased, bullied, or discriminated against because of race? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	51	66.2	72.9	72.9
	No	19	24.7	27.1	100.0
	Total	70	90.9	100.0	
Missing	No Response	7	9.1		
Total		77	100.0		

Has your child's wellbeing been impacted by the transracial/transcultural adoption? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	25	32.5	34.2	34.2
	No	48	62.3	65.8	100.0
	Total	73	94.8	100.0	
Missing	No Response	4	5.2		
Total		77	100.0		

Has the transracial adoption had an impact on your marriage or significant other relationship? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	13	16.9	17.3	17.3
	No	62	80.5	82.7	100.0
	Total	75	97.4	100.0	
Missing	No Response	2	2.6		
Total		77	100.0		

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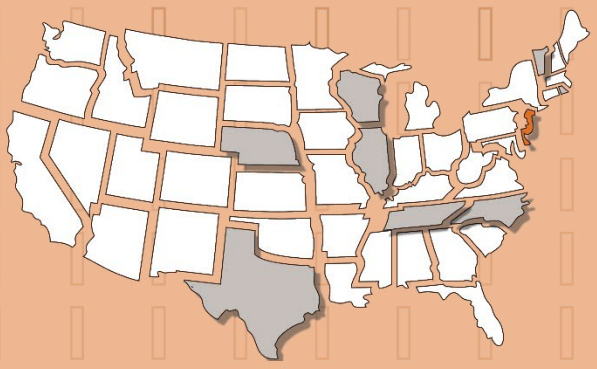
Evaluation Results from

New Jersey



Final Evaluation Report

September 2019

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

This report was designed by staff at the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work. We thank them for their partnership and dedication to the work of translational research.

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

Report Authors

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

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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

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

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

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

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

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

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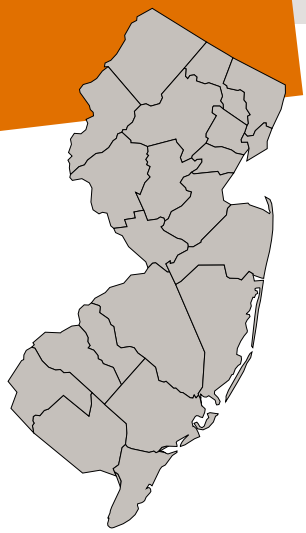
We also thank the many stakeholders on the QIC-AG site specific Project Management Team (PMT), Stakeholder Advisory Team (SAT) and Implementation Team (IT) who were invaluable in providing the support and direction needed to implement the study. The participants on these three teams included community 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 Office of Adoption Operations within the State of New Jersey, Department of Children and Families, Division of Child Protection and Permanency. The site team leaders and Site Implementation Manager (SIM) who guided this work, in addition to their other roles within the agencies they work. Your partnership made this project a success.

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

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

Evaluation Results from New Jersey



PROJECT PARTNERS

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

CONTINUUM PHASE

Selective

INTERVENTION

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

STUDY DESIGN

Experimental: Randomized Controlled Trial

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

RESEARCH QUESTION

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

Findings

443 FAMILIES ASSIGNED TO THE COMPARISON GROUP

187 COMPARISON GROUP CAREGIVERS COMPLETED THE OUTCOME SURVEY

769 FAMILIES ASSIGNED TO THE INTERVENTION GROUP

442 (57%) SUCCESSFULLY CONTACTED

62 TINT CAREGIVERS COMPLETED 4+ SESSIONS AND THE OUTCOME SURVEY

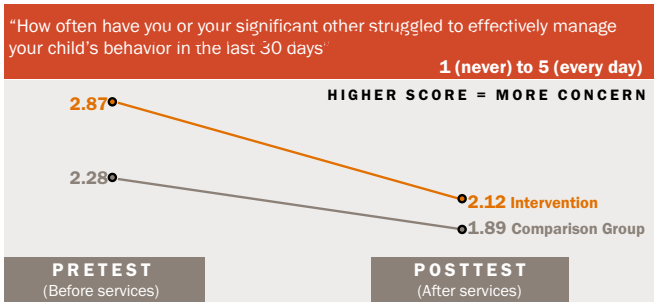
RECRUITMENT & PARTICIPATION

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

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

OUTCOMES

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



WHAT CAREGIVERS HAD TO SAY...

Adoption and guardianship was a positive experience!

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

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

It was also a challenging experience.

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

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

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Jack, Joseph and Morton Mandel School of Applied Social Sciences Case Western Reserve University

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

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

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

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

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Executive Summary

Overview

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

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

Intervention

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

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

Primary Research Question

The primary research question for this study was:

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

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

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

Key Findings and Discussion

RECRUITMENT & FIDELITY

Key findings related to recruitment and fidelity are summarized below.

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

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

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

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

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

INTERVENTION-SPECIFIC OUTCOMES

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

PRIMARY OUTCOMES

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

- No statistically significant differences were found between the TINT intervention participants who had outcome data (n = 62) and the overall comparison group who had outcome data (n = 187). Similarly, no statistically significant difference was found between the TINT participants (n = 31) and a matched sample of the comparison group (n = 31) on the key short-term measures of child and family wellbeing that are related to longer-term discontinuity. However, promising trends suggest that with additional time, statistically significant differences may emerge.

- Results found improvement in parents' self-reproted ability to better manage their child's behavior, approaching a statistically significant difference. Therefore, while the primary outcomes measured did not detect statistically significant improvements for the TINT participants, compared to either comparison group, parents and guardians who participated in the intervention tended to feel better able to manage their child's behavior. This is an important finding as child behavioral issues are a key factor related to post permanency stability and family wellbeing.

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

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

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

Caregivers Struggled to Manage Child Behavior: Pre and Post Tests

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

Cross-Site Summary

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

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

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

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

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

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

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

Chapter 5

NEW JERSEY: TUNING IN TO TEENS (TINT)

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List of Figures and Tables

Site Background

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

The Office of Adoption Operations identifies two types of adoptions:

1. **Kinship adoption,** where a child is adopted by a relative.

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

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

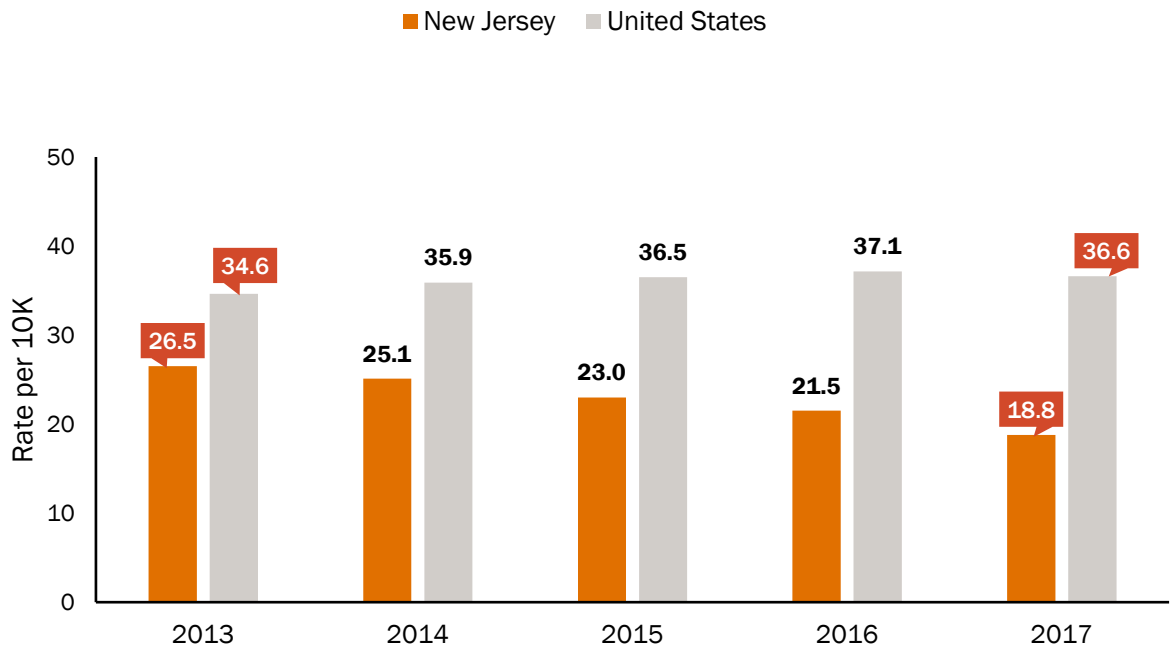
CP&P has engaged in a number of efforts to enhance adoption skills of staff and improve adoption services. In 2007, the DCF Office of Training and Professional Development (OTPD) partnered with the Institute of Families at the Rutgers School of Social Work to offer an adoption certificate program to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

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

National Data: Putting New Jersey in Context

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

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

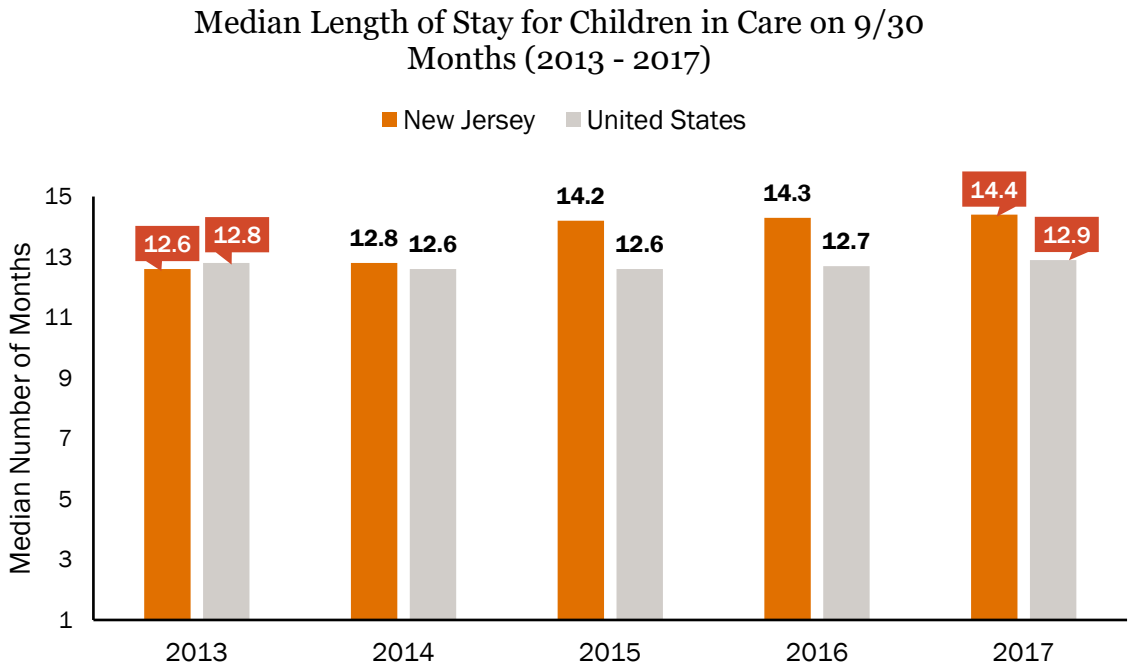


DATA SOURCE: UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION FOR CHILDREN AND FAMILIES, ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES BUREAU, HTTPS://CWOUTCOMES.ACF.HHS.GOV/CWODATASITE/

As displayed in Figure 5.1, between Fiscal Years 2013 and 2017, the rate[1] of children entering foster care in New Jersey decreased as the rate of children entering foster care in the U.S. increased. Between 2013 and 2017, the state's foster care entry rate decreased from 26.5 per 10K (5,361 children) to 18.8 per 10K (3,726 children). This per capita rate is lower than the per capita rates for the U.S. The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. Thus, fewer children, per capita, entered foster care in New Jersey over each of the five years than in the U.S.

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

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

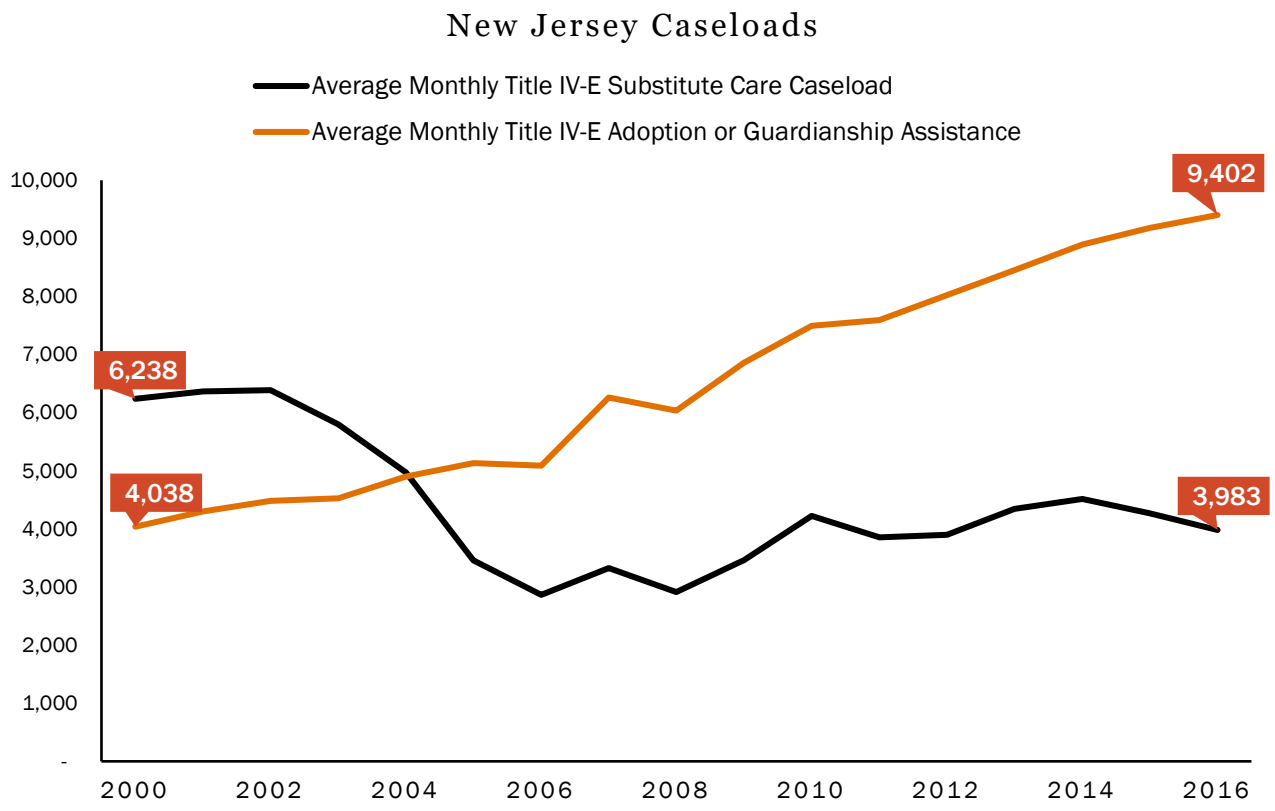


DATA SOURCE: UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION FOR CHILDREN AND FAMILIES, ADMINISTRATION ON CHILDREN, YOUTH AND FAMILIES BUREAU, HTTPS://CWOUTCOMES.ACF.HHS.GOV/CWODATASITE/

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

Nationally, we have seen a shift in the number and proportion of children living in IV-E supported foster care and IV-E funded adoptive or guardianship homes. As shown in Figure 5.3, the number of children in New Jersey in IV-E funded foster care and the number of children in IV-E funded adoptive homes in 2000 was 6,238 and 4,038 respectively. In 2016 these numbers were 3,983 children in IV-E funded substitute care and 9,402 children in IV-E funded adoptive homes.

Figure 5.3. New Jersey Caseloads, 2000-2016



DATA SOURCES: TITLE IV-E NUMBERS: U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / ADMINISTRATION FOR CHILDREN AND FAMILIES, COMPILED DATA FROM STATES' TITLE IV-E PROGRAMS QUARTERLY FINANCIAL REPORTS, FORMS IV-E-1 (FOR YEARS PRIOR TO 2011) AND CB-496 (FOR 2011 AND LATER).

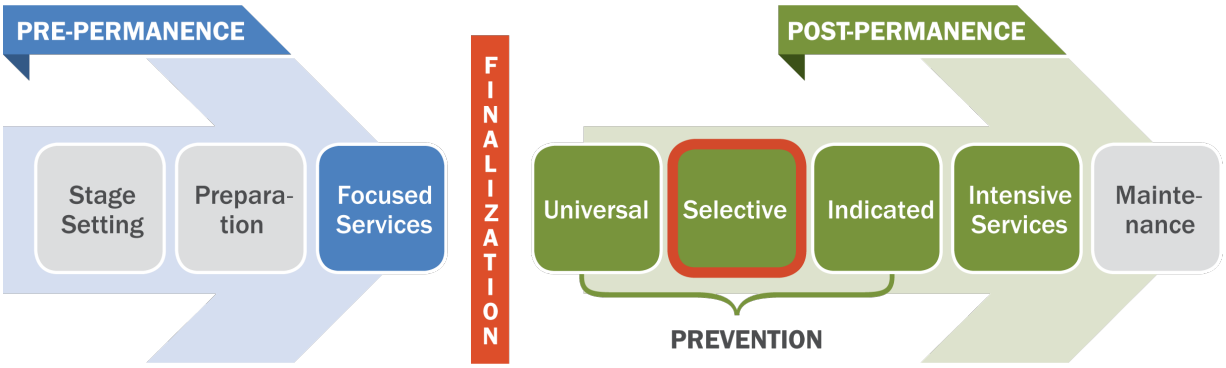
QIC-AG Permanency Continuum Interval

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

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

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

Figure 5.4. New Jersey QIC-AG Permanency Continuum



Primary Research Question

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

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

Each component of the PICO described below.

Target Population

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

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

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

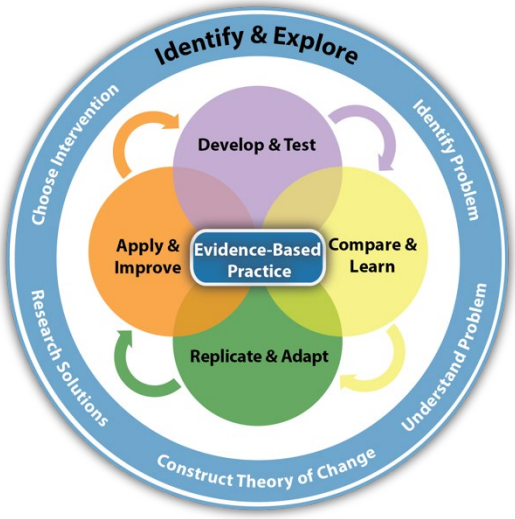
Children and families who met any of the following criteria were excluded from the study:

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

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

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

Intervention



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

This intervention was selected specifically because it addresses the adolescent developmental context identified as a primary risk factor for discontinuity. Adaption would be needed, however, to include the adoption context. According to *A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*, the **Replicate and Adapt** phase should result in "widespread, consistent, and appropriate implementation of the adopted intervention with other populations and in other contexts that continue to achieve the desired outcomes" (Framework Workgroup, p. 4). Therefore, it was determined that adaption should include the purveyor of TINT and additional steps to ensure the appropriateness of the adaptation.

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

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

TUNING IN TO TEENS

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

Structure

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

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

Table 5.1. TINT Sessions and Goals-Six Week Format

TINT SESSION	KEY SESSION GOALS
1) FOUNDATIONS OF EMOTION COACHING TEENS	✓ Engagement ✓ Normalizing parent and adolescent ✓ Psychoeducation (emotional intelligence) ✓ Introduction of emotional coaching ✓ Tuning in to low-intensity emotions ✓ Learn about the importance of having mental maps of teen ✓ Changes in the parent-child relationship; parent's role (from manager to consultant)
2) CONNECTING AND EMOTIONAL ACCEPTANCE	✓ Increase parents' awareness of own emotions ✓ Psychoeducation: Adolescent emotional development ✓ Explore beliefs and feelings about emotions (meta-emotion) and how this affects parenting ✓ Becoming aware of and tuning in to teens emotions ✓ Recognizing opportunities to connect ✓ Learn and practice reflecting and labeling feelings (emotion coaching)
3) BUILDING INTIMACY AND SHOWING EMPATHY	✓ Increase parent's awareness of own emotions ✓ Psychoeducation: Empathy ✓ Build an empathic understanding ✓ Understanding the difference between emotion dismissing and emotion coaching ✓ Recognize feelings behind statements and behaviors ✓ Manage rejection ✓ Sitting with emotions and staying alongside the young person with acceptance ✓ Learn and practice empathic reflective listening skills (emotion coaching)
4) EMOTION COACHING ADOLESCENT WORRY AND SADNESS	✓ Consolidate the skills of emotion coaching for stronger intensity emotions ✓ Psychoeducation: (Self-care; Anxiety) ✓ Emotion regulation and anxiety ✓ Increase awareness of the importance of own emotional awareness/regulation ✓ Increase awareness of the developmental effects of criticism on teens ✓ Practice emotion coaching anxiety and sadness ✓ Problem-solving
5) EMOTION COACHING ANGER	✓ Consolidate the skills of emotion coaching for stronger intensity emotions ✓ Psychoeducation: Anger ✓ Managing own anger and feelings of rejection ✓ Responding to teens anger ✓ Emotion regulation and anger ✓ Recognize emotion coaching opportunity/when not to emotion coach ✓ Practice emotion coaching anger ✓ Managing conflict and sibling fighting
6) EMOTION COACHING NOW AND IN THE FUTURE.	✓ Review main areas of the program and further consolidate emotion coaching ✓ Understanding different parenting styles ✓ Practicing emotion coaching and problem-solving ✓ Where to find support in the local area

Kehoe (2014), p. 56.

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

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

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

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

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

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

ADAPTATIONS

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

- New Jersey TINT target population or children from adoption and guardianship families. The Australian TINT did not have an adoption specific lens.

- Examples of some of the unique issues of adoptive families (both private and public) and kinship guardianship families may experience (e.g., how trauma might be impacting the youth's current behavior; identity issues such as learning and discussing the youth's birth history and birth family; feelings of abandonment and rejection both on the youth's and parents' part; a sense of belonging especially as the youth seeks autonomy during the stage of adolescence, etc.).

- Vignettes and examples reflecting the experiences of adoptive parents and guardians and children.

- Parent handouts so that they were clearly understood.

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

Comparison

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

Outcomes

Short-term outcomes included:

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

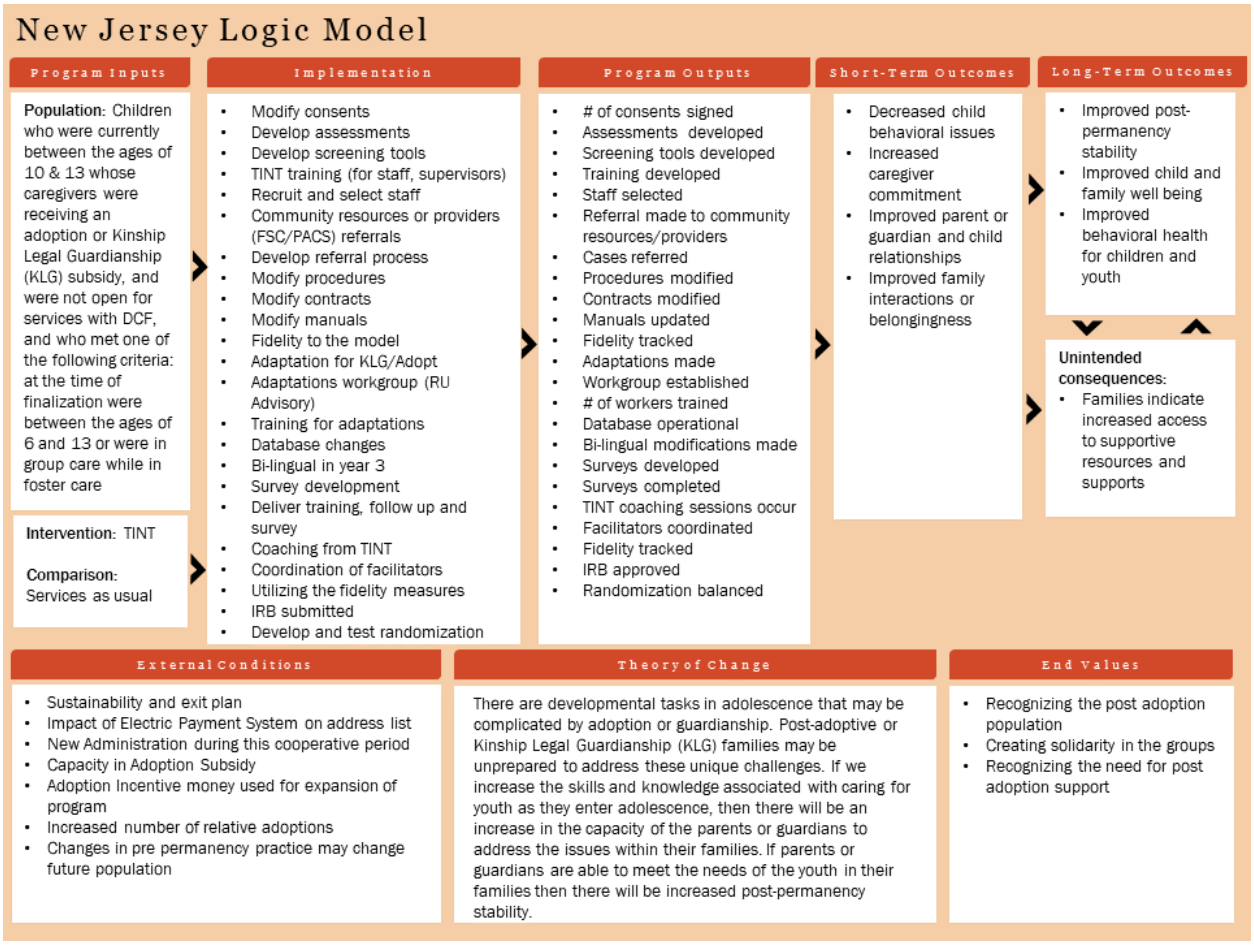
Long term outcomes included:

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

Logic Model

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

Figure 5.5. New Jersey Logic Model



Evaluation Design & Methods

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

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

Procedures

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

USABILITY

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

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

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

RECRUITMENT AND IMPLEMENTATION

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

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

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

FIDELITY AND ADHERENCE

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

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

Fidelity Checklist Revised

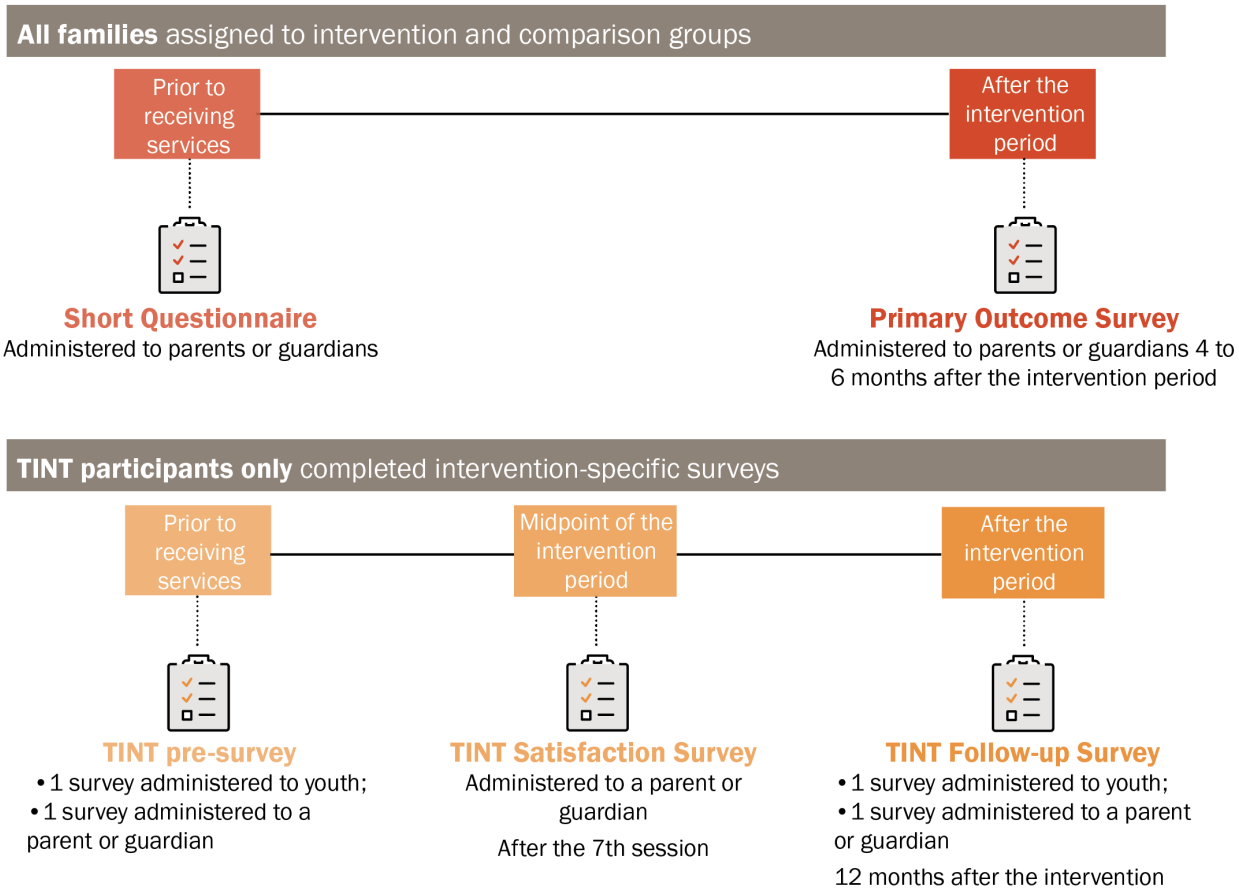
The Fidelity Checklist was revised before Cohort 4 and a number of items that were part of the adoption overlay were removed. It was determined that these items should be covered as needed, rather than be included as expected. A review was conducted on specific items to determine whether certain items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

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

OUTCOMES

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

Figure 5.6. Timeframe Associated with Surveys and Questionnaires



Intervention-Specific Outcomes

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

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

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

Primary Outcomes

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

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

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

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

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

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

Measures

FIDELITY

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

OUTCOMES

Intervention-Specific Outcomes Survey

The Strengths and Difficulties Questionnaire (SDQ)

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

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

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

Difficulties in Emotion Regulation (DERS)

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

Emotions as a Child Scale (EACS)

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

Family Assessment Device (FAD)

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

Family Conflict Scale

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

Known and Unknown Causes for Physical Problems

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

The Spence Children's Anxiety Scale (SCAS)

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

Acceptance and Action Questionnaire (AAQ-II)

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

Primary Outcomes Survey

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

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

Family Protective Factors Survey (PFS)

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

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

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

Illinois Post permanency Commitment Items

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

Behavior Problem Index (BPI)

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

Missing Data

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

Findings

Sample Frame and Participant Profile

DEMOGRAPHICS

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

Table 5.2. New Jersey Sample Characteristics

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

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

PRIVATE DOMESTIC AND INTERCOUNTRY ADOPTIVE FAMILIES

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

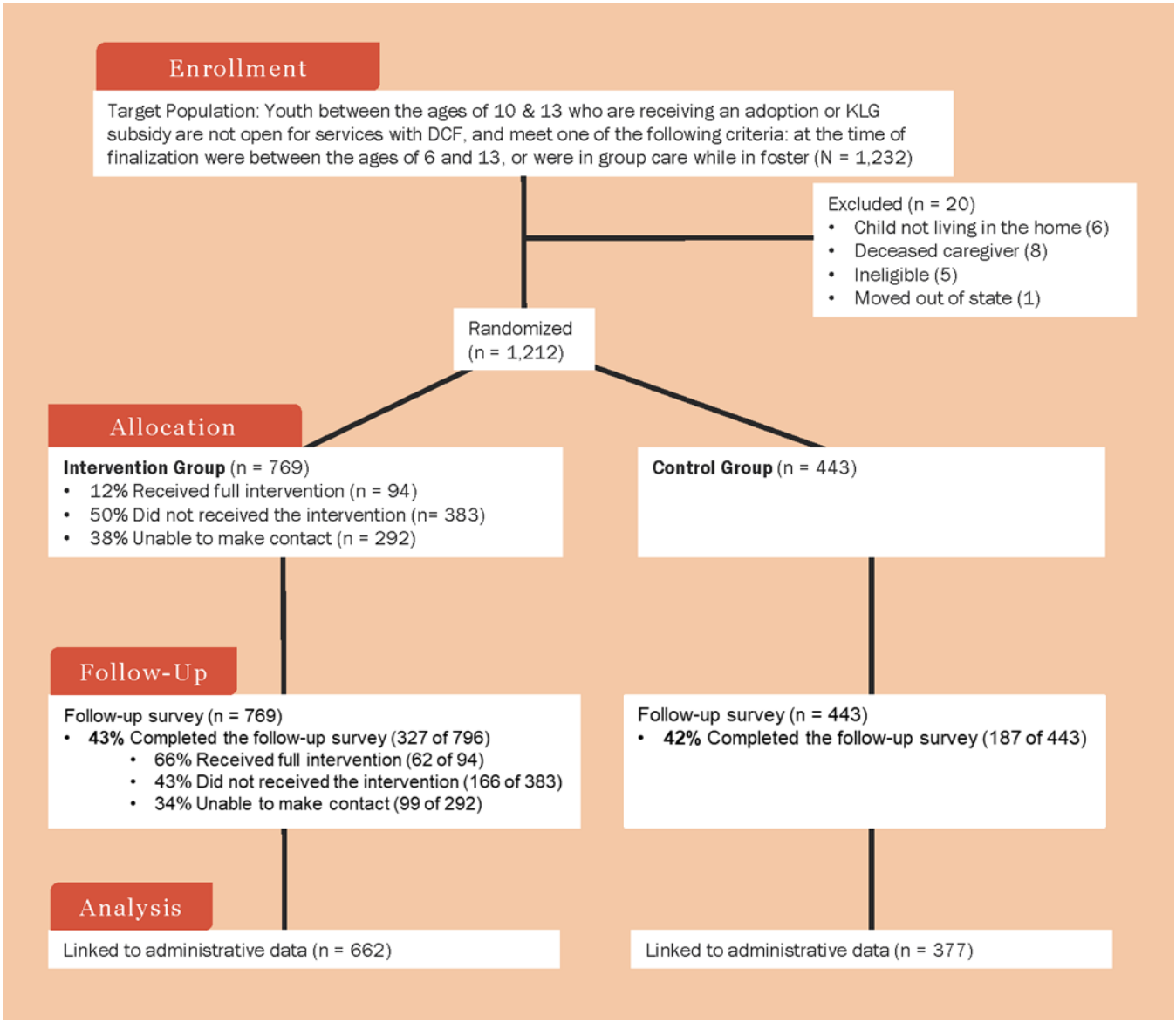
CONSORT DIAGRAM

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

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

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

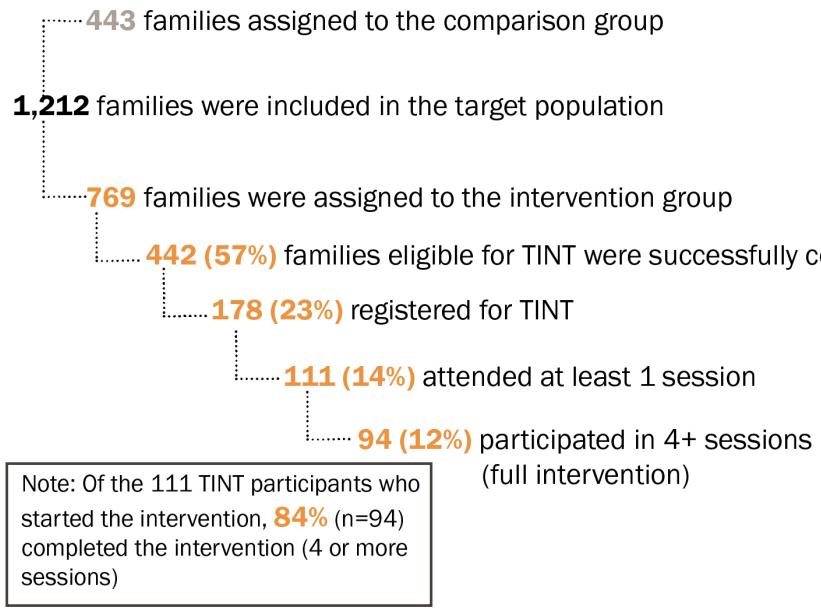
Figure 5.7. New Jersey Consort Diagram



RESPONSE TO INTERVENTION RECRUITMENT

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

Figure 5.8. New Jersey Recruitment Response



SAMPLE CHARACTERISTICS

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

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

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

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

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

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

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

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

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

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

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

Process Evaluation

A process evaluation "determines whether program activities have been implemented as intended and resulted in certain output" (Centers for Disease Control and Prevention, 2015). Initial implementation of TINT began when the first clients received services. At this time, the evaluators began the formative (process) evaluation and tested whether the early phases of the initiative were associated with the expected program outputs of the intervention.

FIDELITY AND ADHERENCE

Two aspects of implementation were assessed:

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

RECRUITMENT AND ENGAGEMENT ADHERENCE

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

Table 5.3. Number of Calls to Reach and Register Families

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

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

Table 5.4. Reason for Not Participating in TINT

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

FIDELITY

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

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

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

Table 5.5. Fidelity to TINT by Cohort

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

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

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

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

SUMMARY

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

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

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

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

Outcome Evaluation

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

INTERVENTION-SPECIFIC OUTCOMES

Baseline Scale Scores

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

Follow-Up Scale Scores

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

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

PRIMARY OUTCOMES

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

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

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

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

Terminology

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

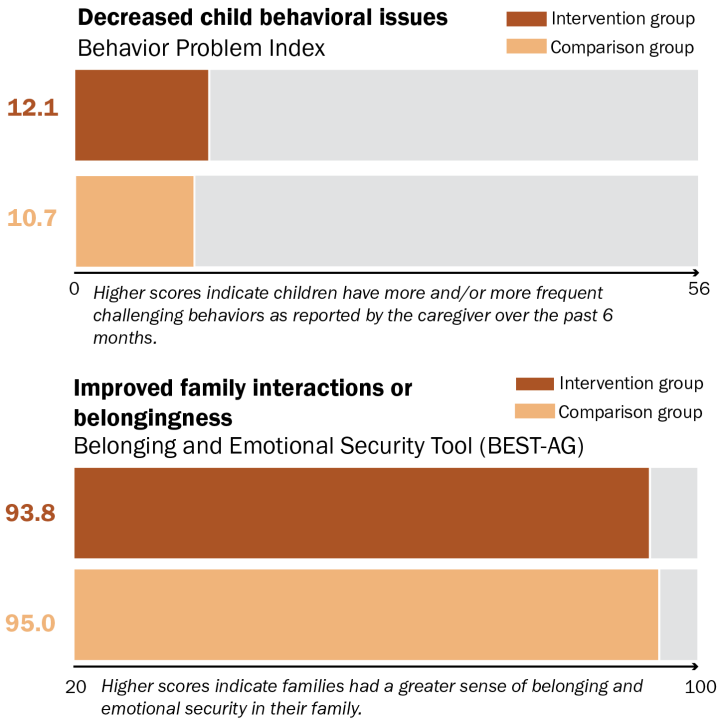
TINT participants (also called treatment participants): Families who participated in the intervention, and received at least 4 TINT sessions.

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

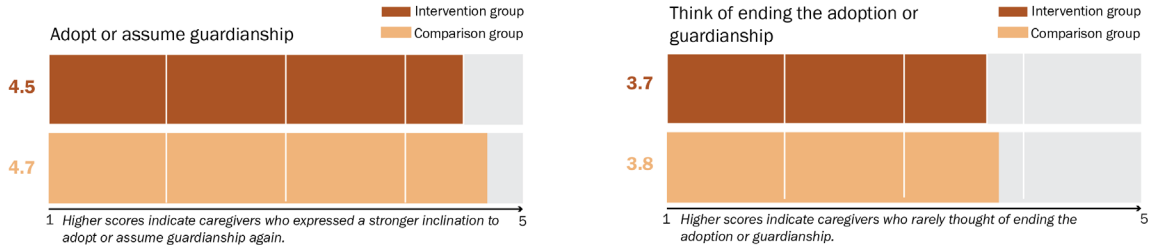
Matched comparison group: Statistically significant differences were observed when comparing TINT participants to the comparison group on baseline measures. Thus, propensity score analysis was conducted using matched groups, to provide a less biased comparison of outcomes. The matched group is referred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

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

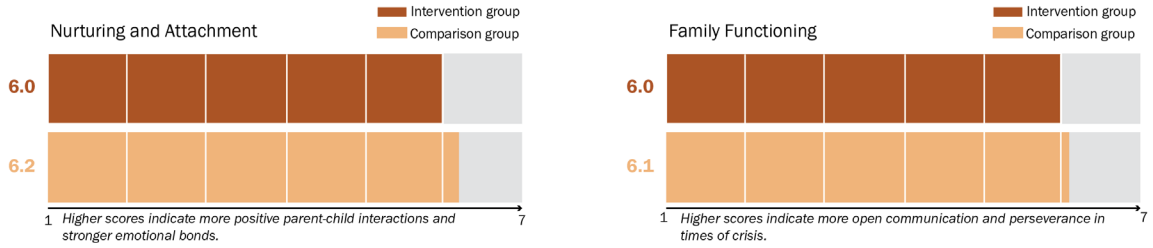
Figure 5.9. Outcomes for Intervention and Comparison Groups



Increased Caregiver Commitment



Improved Parent or Guardian Child Relationships



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

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

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

Notes:

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

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

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

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

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

Limitations

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

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

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

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

Thoughts from Parents and Guardians

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

> **"Adopting our son has been the single best decision we have made in our lives."**
>
> **"Great experience. Would do it again if I had to."**
>
> **"I thank God every day for him being in our lives."**
>
> **"He is my world."**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cost Evaluation

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

Cost Evaluation Approach

The cost-effectiveness research (CER) analysis provides information for policymakers and administrators to help maximize desired outcomes based on the associated cost of achieving them (Meunnig, 2002). CER analysis was applied to the outcomes identified by New Jersey.

Assumptions, Constraints, and Conditions

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

ASSUMPTIONS

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

We also assume multiple positive outcomes are likely impacted by the QIC-AG site programs. For post permanency interventions such as New Jersey, the desired impact of the programs is to prevent re-entry into foster care for the target child. However, improvement of parent knowledge and/or child behaviors are also considered to be positive outcomes. While the New Jersey site measured outcomes for the selected target child, it is likely that the intervention impacted every child in the home. However, those impacts are not able to be measured.

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

CONSTRAINTS

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

CONDITIONS

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

Cost Estimation

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

KEY POINTS IN COST ESTIMATION

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

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

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

Cost estimation should include the passage of time in order to account for inflation. Given that New Jersey implemented this intervention for a three-year period, costs did not change dramatically. The major cost that would be impacted in this short time frame was staff salary and this change was accounted for in the direct expenses that New Jersey incurred each year.

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

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

COST ESTIMATION STEPS

The steps involved in the cost estimation of this analysis are described below. All QIC-AG sites used a standardized budget form and cost reimbursement form. Costs for New Jersey were taken from monthly budget forms and summarized into Table 5.7.

Table 5.7. Costs for New Jersey

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

*FY2019 ended 3/31/19

**FY2017 began 4/1/17

Collect Data on Resource Costs

In order to collect accurate information, monthly expense forms were used to track actual costs. All QIC-AG sites developed an annual budget. The actual costs billed to QIC-AG were provided to the evaluation team via monthly expense reports. These expense reports contained a year to date summary of expenses. Expenses for each fiscal year were then compiled into Table 5.7.

Collect Data on Resource Allocation

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

Estimation of Direct Costs

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

Personnel

Personnel costs totaled $225,577 for the salary of the SIM during the implementation phase. The SIM provided program support by organizing all aspects of groups, including coordinating locations, recruitment, and meals. The SIM also processed documents, managed budgets and/or provided other administrative support. Additionally, personnel time included overtime pay for agency employees to complete trainings and facilitate groups.

Fringe

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

Contractual Expenses

New Jersey contracted for services from six entities.

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

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

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

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

Gift Cards

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

Materials and Supplies

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

Travel

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

Facilities/Office Space

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

Other Direct Charges

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

Estimation of Indirect Costs

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

Indirect costs often include facility costs and infrastructure not captured in the above categories. Since this cost evaluation is designed to help other state child welfare policymakers understand the total costs associated with each site program, indirect costs are important to document. Since the state agency was the project lead, the New Jersey site had a substantial infrastructure. Because the evaluation team assumed that other interested child welfare agencies would also have infrastructure in place to run programs, we did not attempt to portion out the infrastructure

costs that another agency would likely need. Likewise, we assumed that indirect costs will vary greatly by state due to cost of living issues influencing real estate prices and wages and thus, more detailed indirect cost calculations would not be useful to other entities. In order to run a similar program in another area, programs would need building space with heating, air, electricity, and water; some administrative support for contracting and financial management; access to a computer, printer, and phone, as well as supervision of project staff.

Summary of Costs

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

Cost Calculations

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

COST PER PARTICIPANT

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

COST-EFFECTIVENESS ESTIMATION

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

Sensitivity Analysis

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

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

For this sensitivity analysis, costs that are most likely not needed have been removed from the cost calculation. Inclusion or exclusion of costs in a sensitivity analysis such as this one is subjective. A decision was made based on the following question: Is this expense critical to the functioning of the intervention? Another agency would want to adjust costs specific to their program needs. The following exclusions were made for this sensitivity analysis.

1. The salary and fringe for the Site Implementation Manager were removed. At this site, the Site Implementation Manager was not needed to implement the actual intervention. This

position served as a liaison with external entities and managed internal processes. The internal management could, in theory, be provided by one of the other staff positions.

2. Fees for storage and office space were removed, as this was not necessary for the intervention.

3. Gift cards were removed from the cost calculation. Gift cards were provided to offset childcare and transportation costs. Other agencies would want to consider how to best meet these needs, as this may not be with gift cards.

4. Program supplies not related to TINT were excluded.

5. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings.

6. Costs related to computers/IT resources, phones, postage, and printing were removed. It is not clear to what extent these costs are actually needed for the intervention.

7. Costs related to facilitator observations were removed because this was related to the evaluation.

8. Costs related to food were removed. While meals are an important component, other agencies may be able to get in-kind donations or find other ways to cover food costs.

9. Other direct charges that were excluded consist of CPFA registration, recruitment of private families, honorarium, reimbursement for CLEAR. These expenses were not necessary for the implementation of the intervention.

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

Based on these exclusions, Table 5.8 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $366,948, which amounted to $3,904 per participant.

Table 5.8. Sensitivity analysis: Adjusted costs for New Jersey

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

*FY2019 ended 3/31/19

**FY2017 began 4/1/17

Cost Evaluation Summary

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

Discussion

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

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

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

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

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

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

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

References

Allgaier, A-K, Fruhe, B., Pietsch, K., Saravo, B., Baethmann, M. & Schulte-Korne, G. (2012). Is the Children's Depression Inventory Short version a valid screening tool in pediatric care? A comparison to its full-length version. Journal of Psychosomatic Research, 73, 369-374.

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionniare - II: A revised measure of psychological flexibility and experiential avoidance. *Behavior Therapy, 42,* 676-688.

Brannan, A. M., Helfinger, C. A. & Bickman, L. (1997). The caregiver strain questionnaire: Measuring the impact of the family of living with a child with a serious emotional disturbance. *Journal of Emotional and Behavioral Disorders, 5(4),* 212-222.

Calculating the Costs of Child Welfare Services Workgroup. (2013). *Cost analysis in program evaluation: A guide for child welfare researchers and service providers*. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2015). Types of Evaluation. Retrieved from https://www.cdc.gov/std/Program/pupestd/Types%20of%20Evaluation.pdf

Children and Family Research Center (CFRC). (2008). *Illinois Post permanency Surveys (Round 1 - 2005 and Round 2 - 2008)*. CFRC: University of Illinois at Urbana-Champaign.

Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: A self-report measure of protective factors against child maltreatment. *Child Abuse & Neglect, 34*(10), 762-772.

Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration. (1993). *Feasibility, Alternatives, And Cost/Benefit Analysis Guide*. Washington DC. Retrieved from http://archive.acf.hhs.gov/programs/cb/systems/sacwis/cbaguide/c1intro.htm

Epstein, N.B., Baldwin, L.M., & Bishop, D.S. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy*, 9, 171-180

Framework Workgroup. *A framework to design, test, spread, and sustain effective practice in child welfare.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Frey, L., Cushing, G., Freundlich, M., & Brenner, E. (2008). Achieving permanency for youth in foster care:

Assessing and strengthening emotional security. *Child & Family Social Work, 13,* 218-226. doi: 10.1111/j.1365-2206.2007.00539.x

Goodman, R. (1997) The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38, 581-586.

Gratz K. L., Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: development, factor structure, and initial validation of the difficulties in emotion regulation scale. J. PSYCHOPATHOL. BEHAV. ASSESS. 26 41–54. 10.1023/B:JOBA.0000007455.08539.94

Havighurst, S. S., Kehoe, C. E. & Harley, A. E. (2015). Tuning in to teens: Improving parental responses to anger and reducing youth externalizing behavior problems. *Journal of Adolescence*, 42, 148-158. doi: http://dx.doi.org/10.1016/j.adolescence.2015.04.005

Kehoe, E. K. (2014). TUNING IN TO TEENS: Examining the efficacy of an emotion-focused parenting intervention in reducing pre-adolescents' internalizing difficulties. (doctoral dissertation). Melbourne School of Psychological Sciences, The University of Melbourne, Australia.

Magai C, & O'Neal CR (1997). Emotions as a child (child version). Unpublished manuscript, Long Island University, Brooklyn.

Meunnig, P. (2002). *Designing and conducting cost-effectiveness analyses in medicine and health care*. San Francisco: Jossey-Bass.

Netemeyer, R. G., Boles, J. S., & McMurrian, R. (1996). Development and validation of work-family conflict and family-work conflict scales. *Journal of Applied Psychology, 81*(4), 400- 410.

New Jersey Department of Children and Families (DCF). Retrieved from https://www.state.nj.us/dcf/about/

New Jersey Department of Children and Families, Adoption Report 2016. Retrieved from https://www.nj.gov/dcf/childdata/exitplan/AdoptionReport2016.pdf

Peterson, J. L. & Zill, N. (1986). Marital disruption, parent=child relationships, and behavioral problems in children. *Journal of Marriage and the Family,* 48, 295-308.

Richardson, W., Wilson, M. Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, 123(3), A12.

Razali (2008) Known and unknown causes for physical pain

Rutgers School of Social Work. Adoption Certificate Training Program/Child Welfare Professional Development. Retrieved from https://socialwork.rutgers.edu/centers/institute-families/office-child-welfare-initiatives/adoption-certificate-training-programchild-welfare-professional-development

Spence, S. H., Barrett, P. M., & Turner, C. M. (2003). "Psychometric properties of the Spence Children's Anxiety Scale with young adolescents". *Journal of Anxiety Disorders*. 17 (6): 605–25. doi:10.1016/S0887-6185(02)00236-0

United States Census Bureau (2017). Retrieved from https://www.census.gov

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/

Zelen, M. (1979). A new design for randomized clinical trials. *New England Journal of Medicine,* 300, 1242–1245.

Zelen, M. (1990). Randomized consent designs for clinical trials: An update. *Statistics in Medicine*, 9, 645–656.

Appendices

Appendix A. Data Sources and Collection

ADMINISTRATIVE DATA

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

FIDELITY MEASURES

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

TINT SURVEYS

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

The following TINT surveys were administered:

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

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

PRIMARY OUTCOME SURVEY

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

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

Appendix B. Site Teams

The New Jersey QIC-AG site team selected members to participate on the Project Management Team (PMT), the Stakeholder Advisory Team (SAT) and the Implementation Team to help design and implement the project. The PMT included key leaders across DCF's multiple systems that provided direction in creating a sustainable assessment, implementation and evaluation model. The SAT served as an advisory group consisting of key community representatives including consumers and providers of adoption and guardianship services. Both the PMT and SAT teams had representatives from private, domestic, and international adoption; adoptive and KLG families; and representatives from support agencies.

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

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

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

Appendix C. Data Tables

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

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

Table 5.10. Baseline Differences between Comparison and Intervention Participants

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

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

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

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

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

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

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

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

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

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

PARENT AND YOUTH PAIRED SAMPLE RESULTS PRE AND POST INTERVENTION							
	N	T_1 M	(SD)	T_2 M	(SD)	*t*	*p*
PARENT							
EMOTIONS AS A CHILD SCALE	39	89.40	(16.74)	103.57	(17.04)	-4.34	<0.001
ACCEPTANCE & ACTION QUESTIONNAIRE	21	9.05	(4.22)	11.29	(6.46)	-2.38	0.027
YOUTH							
STRENGTHS AND DIFFICULTIES QUESTIONNAIRE	13	15.19	(6.96)	15.54	(6.97)	-0.158	0.877
SDQ: INTERNALIZING BEHAVIORS	13	5.23	(3.83)	5.23	(4.27)	0.00	1.000
SDQ: EXTERNALIZING BEHAVIORS	13	7.69	(4.09)	7.85	(3.53)	-0.15	0.881
SPENCE CHILDREN'S ANXIETY SCALE	12	23.19	(15.94)	21.49	(17.72)	0.42	0.683
CHILDREN'S DEPRESSION INVENTORY	11	2.18	(2.75)	2.73	(3.93)	0.54	0.599
EMOTIONS AS A CHILD SCALE	11	103.97	(22.09)	91.29	(22.18)	2.55	0.029
EACS: ENCOURAGING SUBSCALE	11	19.54	(9.35)	15.81	(5.92)	1.33	0.213
EACS: PUNISHING SUBSCALE	11	16.61	(5.25)	14.27	(4.71)	1.46	0.173
EACS: NEGLECTING SUBSCALE	11	22.63	(4.98)	21.98	(4.67)	0.56	0.585
EACS: MATCHING SUBSCALE	11	21.36	(7.89)	15.27	(5.85)	2.25	0.049
EACS: OVERRIDING SUBSCALE	11	23.82	(6.18)	23.96	(8.25)	-0.05	0.960
FAMILY ASSESSMENT DEVICE	12	20.71	(6.42)	21.09	(6.93)	-0.26	0.802
FAMILY CONFLICT SCALE	11	5.82	(2.18)	5.36	(1.80)	0.86	0.410
DIFFICULTIES WITH EMOTION REGULATION	10	82.96	(25.40)	76.54	(21.94)	1.08	0.340

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

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

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

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

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

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

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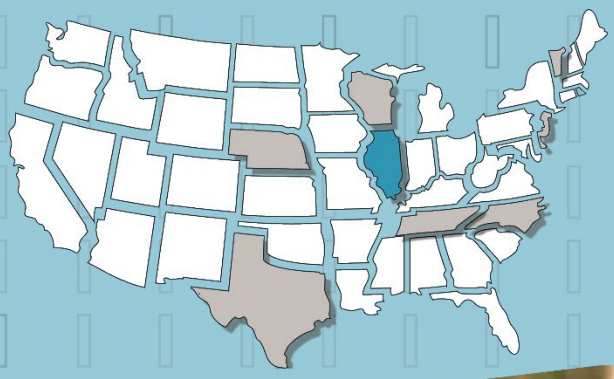
Evaluation Results from

Illinois



Final Evaluation Report

September 2019

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

This report was designed by staff at the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work. We thank them for their partnership and dedication to the work of translational research.

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

Report Authors

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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

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

Lixia Zhang, PhD | Assistant Professor
University of Northern Iowa
Department of Social Work

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

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

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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.

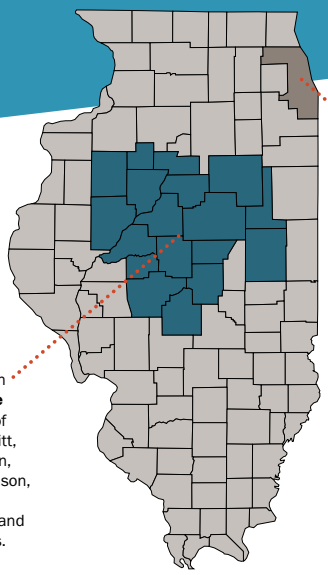
We also thank the many stakeholders on the QIC-AG site specific Project Management Team (PMT), Stakeholder Advisory Team (SAT) and Implementation Team (IT) who were invaluable in providing the support and direction needed to implement the study. The participants on these three teams included community 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 Illinois Department of Children and Family Services, Illinois Adoption Advisory Council, Metropolitan Family Services, Baby Fold, Family Core, Catholic Charities, Jewish Child and Family Services, and Healthy Families Chicago. Our partnerships these groups, their team leaders and the Site Implementation Managers (SIMS) guided this work in addition to their other roles within the agencies they work. These partnerships 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.

A special appreciation goes to Advanced Trauma Solutions, the purveyor of TARGET, who supported the site in adapting their model for this study.

Evaluation Results from Illinois



The target population was **children between the ages of 11 and 16 with a finalized adoption or guardianship.**

Comparison and intervention groups were identified in **Cook County, IL.**

Comparison and intervention groups were identified in **the Central Region** composed of Champaign, Christian, De Witt, Ford, Fulton, Knox, Livingston, Logan, Macon, Marshall, Mason, McLean, Menard, Peoria, Sangamon, Stark, Tazewell, and Woodford Counties in Illinois.

PROJECT PARTNERS

QIC-AG partnered with the **Illinois Department of Children and Family Services (DCFS), Metropolitan Family Services and Baby Fold.**

CONTINUUM PHASE

Selective

INTERVENTION

Illinois DCFS implemented **Trauma Affect Regulation: Guide for Education and Therapy (TARGET)**. TARGET is a strengths-based, psycho-educational intervention for children affected by trauma or exposed to adverse childhood experiences that includes 7 essential core skills.

STUDY DESIGN

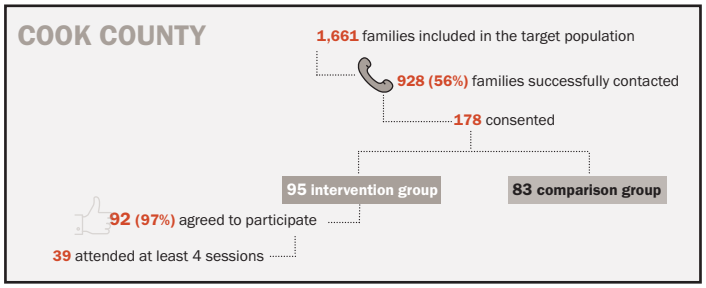
Experimental: **Cook County:** Random Assignment
Central Region: Random Consent Design

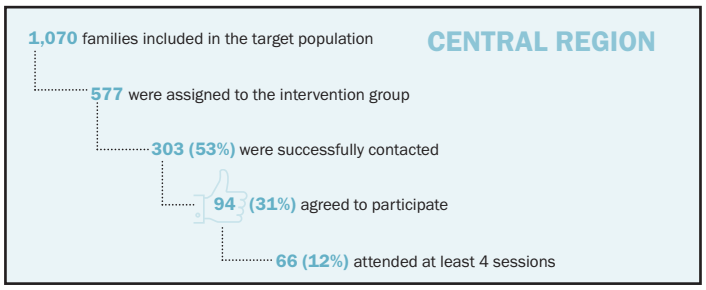
RESEARCH QUESTION

Will children between the ages of 11 and 16 in Cook County or in specific counties within the Central Region with a finalized adoption or guardianship, experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health if they are provided TARGET as compared to similar children who are provided services as usual?

Findings

RECRUITMENT





TO PARTICIPATE OR NOT?

Compared to caregivers who chose not to participate, caregivers who chose to participate were, on average:

- Less confident in meeting their child's needs
- Struggling more to effectively manage their child's behavior
- Less likely to report a warm relationship with their child
- Less likely to view the impact of adoption or guardianship on their family as positive

OUTCOMES

The study's short-term outcomes for Cook County and the Central Region were measured by examining differences between the TARGET participants and the comparison group on:

- Child behavioral issues
- School-based problematic behaviors
- Caregiver commitment
- Caregiver strain

There were no statistically significant intervention effects after six months; however, in both Cook County and Central Region, we did see fewer school-based problematic behaviors in children whose families received TARGET. It is important to keep in mind that TARGET families were experiencing significant needs at baseline that may require a longer observation period to detect change.

WHAT CAREGIVERS HAD TO SAY...

The majority of families reported positive adoption and guardianship experiences.

"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."

Families also provided suggestions for improvements:

"I feel that the social worker should call and check-up. I reached out for help and help was never given."

Promoting the wellbeing of families formed through adoption and guardianship may require an approach where a variety of services are offered that take into account developmental considerations, cultural issues, lifestyle choices, and work or other life stressors faced by adoptive and guardianship families.

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

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Jack, Joseph and Morton Mandel School of Applied Social Sciences Case Western Reserve University

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

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

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

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

Funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1122. The contents of this presentation do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain. Readers are encouraged to copy and share it, but please credit the QIC-AG.

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.

Executive Summary

Overview

The Illinois Department of Children and Family Services (DCFS) support adoptive and guardianship families by providing services that promote child wellbeing, stable homes, and family permanence through adoption support and preservation programs. DCFS has a long history of conducting evidence-based research to ensure barriers to permanency are reduced for children in foster care. The Illinois site of the National Quality Improvement Center for Adoption and Guardianship Support (QIC-AG) selected Trauma Affect Regulation: Guide for Education and Therapy (TARGET) as the evaluable intervention in Illinois. The intervention was located in the **Replicate and Adapt** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. The study's Theory of Change postulated that offering timely services to adoptive parents and guardians at the earliest signs of difficulty would enable them to anticipate issues that may arise and therefore decrease post permanency discontinuity. TARGET was implemented at the Selective Interval of the QIC-AG Permanency Continuum.

Intervention

TARGET, a strength-based, psycho-educational intervention for children affected by trauma or exposed to adverse childhood experiences, includes 7 essential core skills called FREEDOM Steps:

1. **F**OCUS: Reducing anxiety and increasing mental alertness
2. **R**ECOGNIZE. Helping individuals recognize stress triggers
3. **E**MOTIONS. Identify a primary emotion
4. **E**VALUATE. Evaluate a primary thought
5. **D**EFINE. Determine a primary goal
6. **O**PTION. Identify and focus on prior success
7. **M**AKE A CONTRIBUTION. Identify a way to make a difference in others' lives (Advanced Trauma Solutions; ATS)

Primary Research Question

The study's primary research question was:

Will children between the ages of 11 and 16 in Cook County or in specific counties within the Central Region with a finalized adoption or guardianship experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health for children and youth if they are provided TARGET as compared to similar children who are provided services as usual?

An experimental design was employed to test the effectiveness of TARGET with different randomization techniques employed in the two selected geographic regions (Cook County and Illinois' Central Region). In both areas of the state, random assignment was employed to ensure that the comparison and intervention groups were balanced and that each group had a representative mix of children.

The study's short-term outcomes for Cook County and the Central Region were:

- Reduced child behavioral issues
- Reduced school-based problematic behaviors
- Increased caregiver commitment
- Reduced caregiver strain

Key Findings and Discussion

In prior research, most families formed through adoption or guardianship report that they are doing well with the supports and services they are currently receiving and that they do not need additional services. In this study, we found that the majority (64% to 65%) of families who said they were not interested in participating in the study, largely reported that everything was fine and that they did not need services at this time. This study found that, in both Cook County and the Central Region, families who chose to participate in the intervention (TARGET participants) were families who were struggling more than families who did not participate in the intervention. Compared to non-participants, TARGET participants were, on average:

- Less likely to report a warm relationship with their child
- Less confident that they could meet the needs of their child
- More likely to struggle to effectively manage their child's behavior
- Less likely to report that the impact of their child's adoption or guardianship on the family has been positive

These questions were effective in identifying families who reported that they were experiencing difficulty in caring for their children. These questions might be good questions for future research to consider when attempting to identify families at an elevated risk for post permanency discontinuity.

Due to the different evaluation designs used in the two evaluation sites in Illinois (Cook County and specific counties within the Central Region), intervention-related results are presented for each evaluation site separately. In Cook County, 39 families received the intervention, and 32 (82%) returned the primary outcome survey. In the Central Region, 66 families received the intervention and 49 (64%) returned the outcome survey. In addition, primary outcome surveys were administered to families in the comparison group, (46 were received in Cook and 281 in Central).

Based on the analysis of these data, the study did not find a strong intervention effect. In other words, on the outcomes measured (e.g., child behavioral issues and wellbeing measures) families who received TARGET and reported outcome data (n = 81 total for both sites) did not fare better than families who received services-as-usual and reported outcome data (n = 327). While not statistically significant, in both Cook County and Central Region, fewer school-based problematic behaviors were reported for children in the intervention group compared to children in the

comparison group. However, the sample size was small, and the observation period rather limited (6 months).

It is important to keep in mind that pretest findings showed TARGET participants (who received a minimum of four sessions) were also experiencing more family difficulties prior to the study than those in the comparison group who did not participate in TARGET. To account for these differences, TARGET participants were matched to a subset of the comparison group who profiled more similarly to the families who received the intervention. However, this also did not yield an intervention effect. Thus, despite efforts to make TARGET participants and the comparison group as alike as possible, any comparisons between the groups after the intervention may be biased by these pre-existing differences and are a limitation to the study.

It is possible that no intervention effects were observed due to the limited observation window of about 6 months post intervention. Personal and interpersonal change is difficult and takes time, especially given the long history of trauma that many adoptive and guardianship youth have experienced due to maltreatment and previous placement moves (Jones & Schulte, 2019).

The target population in Illinois included a wide variety of families with a wide variety of experiences. This was illustrated by the diverse comments received from adoptive parents and guardians who responded to the surveys. For example, while some families said they were doing well, others were struggling and were reported to be in crisis by program staff. Over 200 caregivers wrote positive responses such as:

> **"Adoption is a gift. I would do it again in a heartbeat."**

> **"Adopting my child is the best thing I have ever done in my life."**

The word "love" or "loved" was mentioned 114 times in these comments. However, some families described their adoption or guardianship experiences in less than positive terms and had more mixed or negative feelings such as:

> **"We don't recommend to anyone that they adopt from foster care. You never get help."**

> **"The kids are angry with us, the people that raise them, 'cause they want their parents."**

In sum, families in the study reported needing additional or different services than what is currently available, and that the services need to be provided by someone who understands issues related to adoption and guardianship. Furthermore, project staff in one of the Illinois sites reported that many (over half) of the TARGET recipients became engaged in services-as-usual after receiving TARGET. This suggests that perhaps a single intervention is not what was needed for some adoptive and guardianship families. They may have needed a wider array, or a different array, of services. Perhaps, similar to other prevention efforts, preventing adoption and guardianship instability and promoting the wellbeing of families formed through adoption and guardianship may require an approach where a variety of services are offered that take into account the diversity of issues families face. These may include providing services that address significant mental health and medical health needs of adopted and guardian children and youth. Future projects should consider how to address the wide array of needs that families who have adopted or assumed guardianship are struggling with.

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 6

ILLINOIS: TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY (TARGET)

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List of Figures and Tables

Site Background

The Illinois Department of Children and Family Services (DCFS) is a state-run child welfare organization that has supported adoptive and guardianship families to gain stability and prevent out of home placement through the Adoption Support and Preservation program since 1991. Services provided to families include comprehensive assessments, case management, crisis intervention, counseling, support groups, and limited cash assistance. These services are contracted through private agencies in each region of the state. The goal of the state's family preservation services is to promote child safety, development, wellbeing, prevent placement disruption and support family permanence (Illinois DCFS website, 2018).

DCFS's earlier efforts in supporting families of children who exited foster care did not ensure stable placements once adoptions were finalized (Smith, Howard, Garnier & Ryan, 2006). A study examining all children in Illinois who exited foster care through adoption or guardianship (N= 51,576) between 1998 and 2010 found that 13% (N= 6,781) of children experienced post permanency discontinuity (Rolock & White, 2016).

The Illinois National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) project in Illinois selected a manualized intervention called Trauma Affect Regulation: Guide for Education and Therapy (TARGET) as their evaluable intervention. TARGET uses a strength-based, psycho-educational approach to education and therapy for youth who have been affected by trauma or exposed to adverse childhood experiences. The intervention has been shown to be effective with juveniles in detention facilities in improving their ability to self-regulate emotions and behaviors (Ford & Hawke, 2012). Also, the intervention has been shown to be effective with delinquent girls diagnosed with either full or partial posttraumatic stress disorder (Ford, Steinberg, Hawke, Levine & Zhang, 2012).

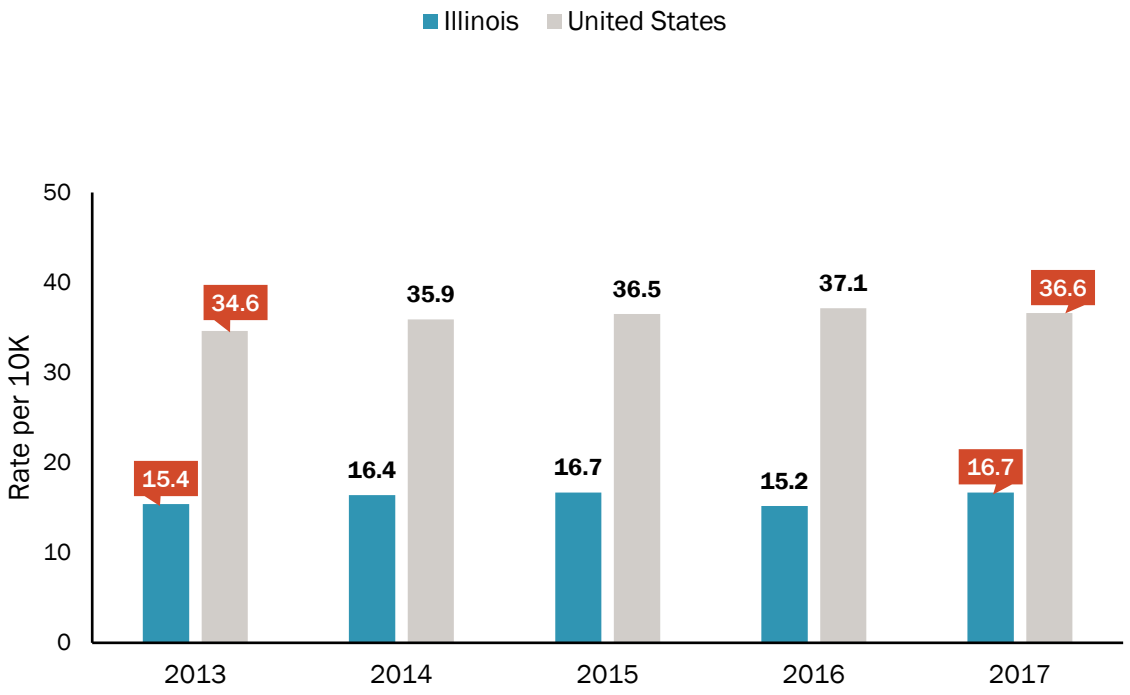
The Theory of Change in the Illinois QIC-AG project postulated that adoptive parents and guardians should be connected to supports and services to help them meet the emerging and future mental health, educational, and other needs of the children in their care. If parents and guardians are offered services at a time when a child's needs do not exceed the capacity of the adoptive parent or guardian, they will be better able to anticipate issues that may arise and have a basic understanding of available resources and services. If parents and guardians are connected to services and supports early, they will be more likely to use these services and supports at the earliest signs of difficulty. If adoptive parents and guardians have the capacity to meet the emerging needs of the children in their care, there will be a decrease in discontinuity including high-end placements and lockouts.

At the onset of the QIC-AG, Illinois was ending a federally-funded project (the Permanency Innovations Initiative [PII] project) that tested TARGET with a foster care population. Given that Illinois has recent experience with, and training on, TARGET, there was an economic advantage to using existing resources for the QIC-AG (TARGET-trained therapists and staff expertise on the intervention). Although the PII project in Illinois ended and the study's results were pending at the start of the QIC-AG project period, TARGET has been successfully implemented in various locations in the U.S., including Connecticut, Ohio, and Maine. Yet, TARGET had not been tested with adoptive and guardianship families.

National Data: Putting Illinois in Context

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

Figure 6.1. Illinois Foster Care Entry Per Capita Rate (2013-2017)

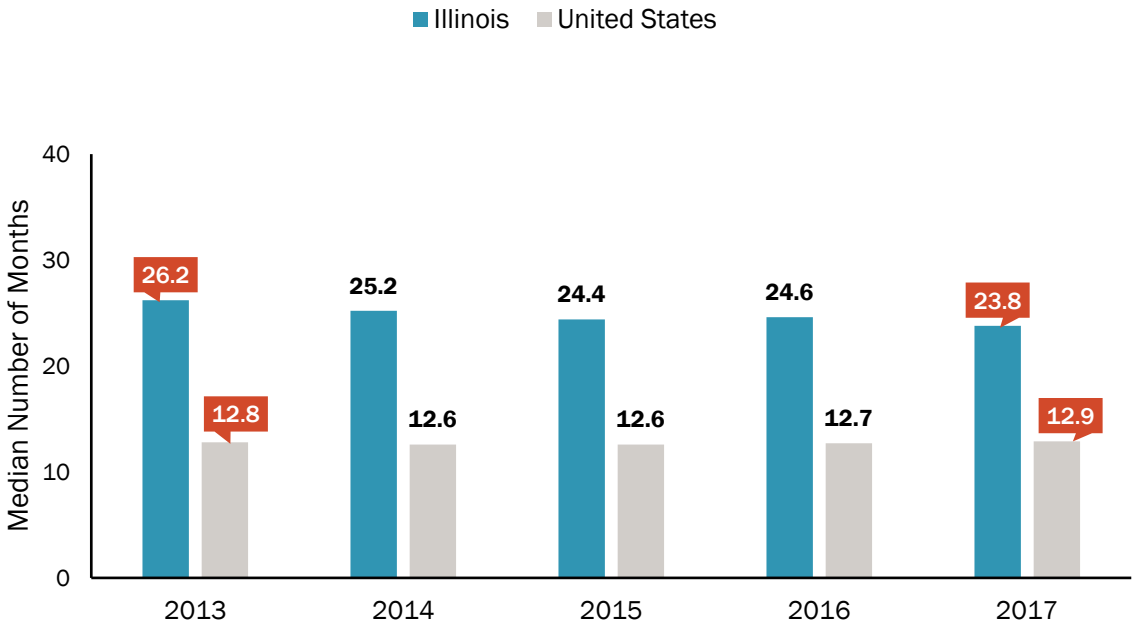


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

As displayed in Figure 6.1, between Fiscal Years 2013 and 2017, the rate[1] of children entering foster care in Illinois and the U.S. increased slightly. Between 2013 and 2017, the state's foster care entry rate decreased from 15.4 per 10K (4,648 children) to 16.7 per 10K (4,843 children). This per capita rate was lower than the per capita rates for the U.S. The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. In other words, fewer children, per capita, entered foster care in Illinois than in the U.S., but increases occurred over the past five years occurred at the state level and at the national level.

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

Figure 6.2. Illinois Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)

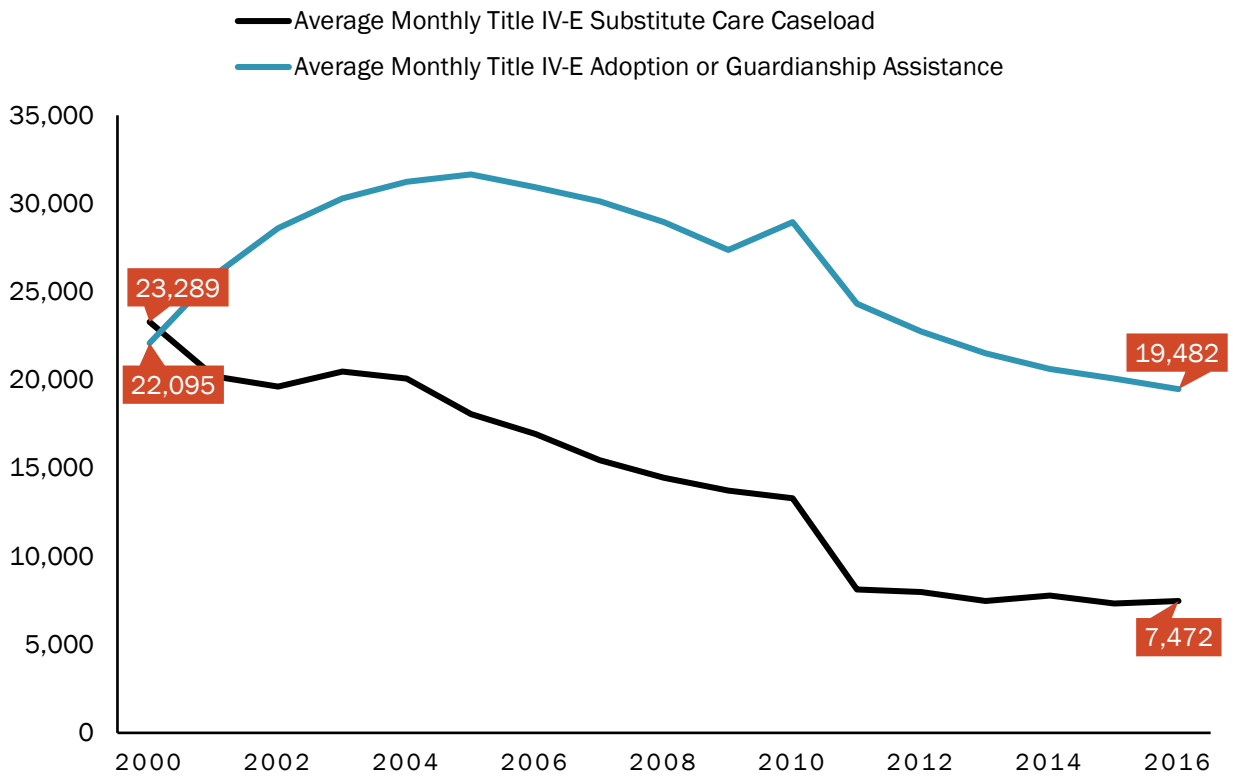


Data Source: United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/ Data current as of Oct. 2017.

Between 2013 and 2017, the median length of stay for children in foster care at the end of each year (shown in Figure 6.2) was relatively flat in Illinois and the U.S., but overall stays in care were markedly higher in the state. The length of stay in Illinois was 26.2 months in 2013 to 23.8 months in 2017, and in the U.S, it was 12.8 months in 2013 and 12.9 months in 2017.

Nationally, we have seen a shift in the number and proportion of children living in IV-E supported foster care and IV-E funded adoptive or guardianship homes. As shown in Figure 6.3, the number of children in Illinois in IV-E funded foster care and the number of children in IV-E funded adoptive and guardianship homes were approximately the same in 2000 (23,289 and 22,095 respectively), yet in 2016 these numbers have diverged. In 2016 there were 7,472 children in IV-E funded substitute care and 19,482 children in IV-E funded adoptive and guardianship homes.

Figure 6.3. Illinois Caseloads (2000 – 2016)



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

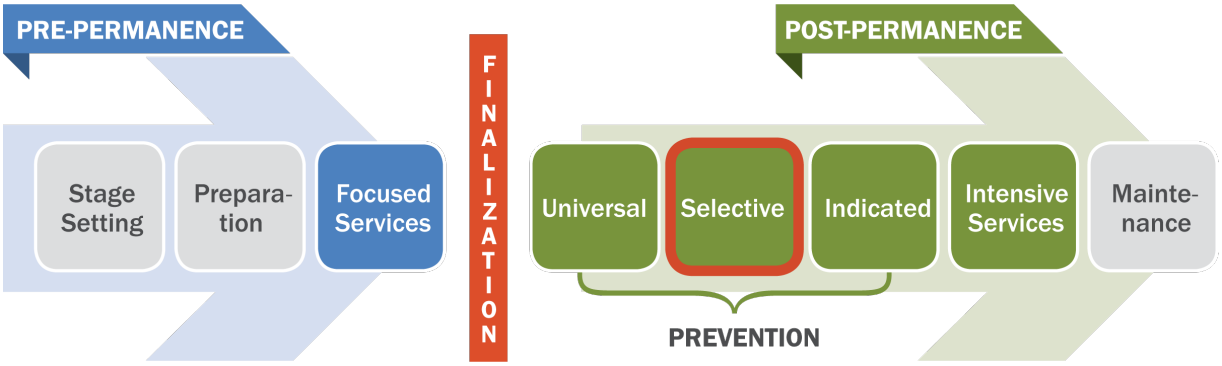
QIC-AG Permanency Continuum Interval

Illinois implemented a trauma-focused intervention in the **Selective Interval** of the QIC- AG Permanency Continuum Framework. In **selective** prevention efforts, services are offered to sub-groups of individuals identified based on their membership in a group that has an elevated risk for a particular outcome (Offord, 2000; Springer and Phillips, 2006). Selective services are preventive and offered proactively, seeking to engage families before a specific need is indicated.

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

Previous research in Illinois and additional analysis conducted by the QIC-AG evaluation team found the risk for post permanency discontinuity for children in adoptive and guardianship homes was most likely to occur when children enter their teen years (i.e., average 13-years old), and that the risk of discontinuity increases as children age (Rolock, 2015; Rolock & White, 2016). Based on this research, the Illinois QIC-AG initiative focused on the child's current age as the primary risk factor in selecting families for the intervention.

Figure 6.4. Illinois 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 children between the ages of 11 and 16 in Cook County or in specific counties within the Central Region with a finalized adoption or guardianship (P), experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health (O) if they are provided TARGET (I) as compared to similar children who are provided services as usual (C)?

Each component of the PICO is described below.

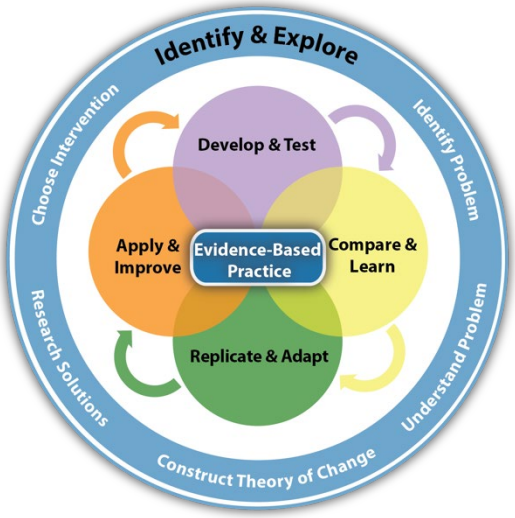
Target Population

The Illinois QIC-AG prevention efforts focused on adopted youth who were currently in, or about to begin, their teenage years, a population of children who may be at risk for discontinuity. Analysis of the available administrative data from Illinois found that children who experienced post permanency discontinuity were, on average, 13 years old when they experienced discontinuity. Given the project's focus on prevention, it was decided that the target population would be children and youth between the ages of 11 and 16. TARGET was also offered to youth older than 10 years old who were adopted either internationally or domestically. The age for intercountry and private adoptions was based on the purveyor's recommendation for the applicable age range for the intervention.

Youth must have met the following criteria were to be offered TARGET. Parents or guardians were asked about these eligibility criteria:

- Currently residing in the home of their adoptive parent or guardian
- An IQ over 70
- The ability to learn new concepts and apply what he/she had learned to new situations
- The ability to understand cause and effect
- Could perform tasks or activities at the same level as his/her peers
- Could generally follow basic instruction
- Did not have developmental disabilities of sufficient severity to prevent comprehension of or participation in TARGET activities
- Did not currently use or misuse substances, or currently in treatment for these issues
- Had not made suicidal threats or plans within the last 24 hours

The initiative was implemented in Cook County, and in several counties within the Central Region including Champaign, Christian, DeWitt, Ford, Fulton, Knox, Livingston, Logan, Macon, Marshall, Mason, McLean, Menard, Peoria, Sangamon, Stark, Tazewell, and Woodford.



Illinois, already implementing TARGET as part of their PII project, had buy-in from leadership at DCFS. DCFS had been training its workforce to understand the difficulties associated with traumatic events, recognize how the children and families they work with were impacted by trauma, and evaluate how trauma impacts the staff working with children and families. TARGET built upon these skills and the current knowledge in the field to enhance trauma-related services. The testing of TARGET with adoptive and guardianship families in Illinois fit into the **Replicate and Adapt** phase of the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare.* The goal of this phase is "widespread, consistent, and appropriate implementation of the adopted intervention with other populations and in other contexts that continue to achieve the desired outcomes" (Framework Workgroup, p. 4).

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY (TARGET)

TARGET is a strengths-based intervention that teaches participants about the impact of trauma on cognitive, emotional, behavioral, and relational processes. It is designed to address difficulties with emotional regulation and relational engagement that occur across a wide range of trauma-related and mental health issues. TARGET teaches a set of skills, called the Freedom Steps, to help participants learn new ways of understanding their stressors and regulating their reactions and responses to stressors. The goal in TARGET is to help people recognize their personal strengths, make good decisions and build healthy relationships.

TARGET is designed to benefit children and families by:

- Providing youth with a set of skills they can employ when a trigger that could cause emotional or behavioral issues is identified. As youth maintain control over their reactions, they will experience a reduction in emotional or behavioral issues, resulting in increased capacity to form and maintain healthy relationships.
- Assisting parents or guardians in addressing issues that children and youth may be struggling with, including struggles with alcohol or other substance abuse issues. Through participation in TARGET, they will also gain knowledge and be able to support their children as they develop their own set of emotional regulation skills through TARGET.
- Providing parents and guardians with training and support in the foundation and skills necessary to assist youth when a trigger occurs, working with the youth to employ the skills that will ultimately result in improved self-regulation for the youth.

TARGET focuses on providing a safe learning environment for the children and their adoptive families that is conducive to understanding the impact of stress and the skills that increase their personal control over feeling stressed. The program includes 12 sessions in a home environment where the child and their adoptive parents or guardians learn 7 essential core skills called the FREEDOM steps. Sessions can be repeated, so some participate in more than 12 sessions. The FREEDOM steps are:

- **F**OCUS: Reducing anxiety and increasing mental alertness
- **R**ECOGNIZE: Helping individuals recognize stress triggers
- **E**MOTIONS: Identify a primary emotion
- **E**VALUATE: Evaluate a primary thought
- **D**EFINE: Determine a primary goal
- **O**PTION: Identify and focus on prior success
- **M**AKE A CONTRIBUTION: Identify a way to make a difference in others' lives (Advanced Trauma Solutions; ATS)

These steps were designed to help participants change their reactions, from stress reactions driven by hypervigilance to proactive emotional regulation.

A TARGET therapist trains adoptive parents or guardians to understand, support and reinforce the FREEDOM steps. The program also builds on and incorporates the child's strengths. A session typically lasts 50-90 minutes and one or two sessions per week were recommended.

Comparison

COOK

Project staff attempted to reach all families in the target population. Random assignment to the intervention (TARGET) or comparison group (services as usual) occurred after families agreed to participate in the research. Families assigned to the comparison group were eligible for services as usual.

CENTRAL

Families assigned to the comparison group were randomly assigned at the start of the study. These families did not receive outreach from the QIC-AG program and were eligible for services as usual.

Outcomes

The short-term and long-term outcomes for the Illinois QIC-AG project were the same for Cook County and Central Region.

Short-term outcomes included:

- Reduced child behavioral issues
- Reduced school-based problematic behaviors
- Increased caregiver commitment
- Reduced caregiver strain

Long term outcomes included:

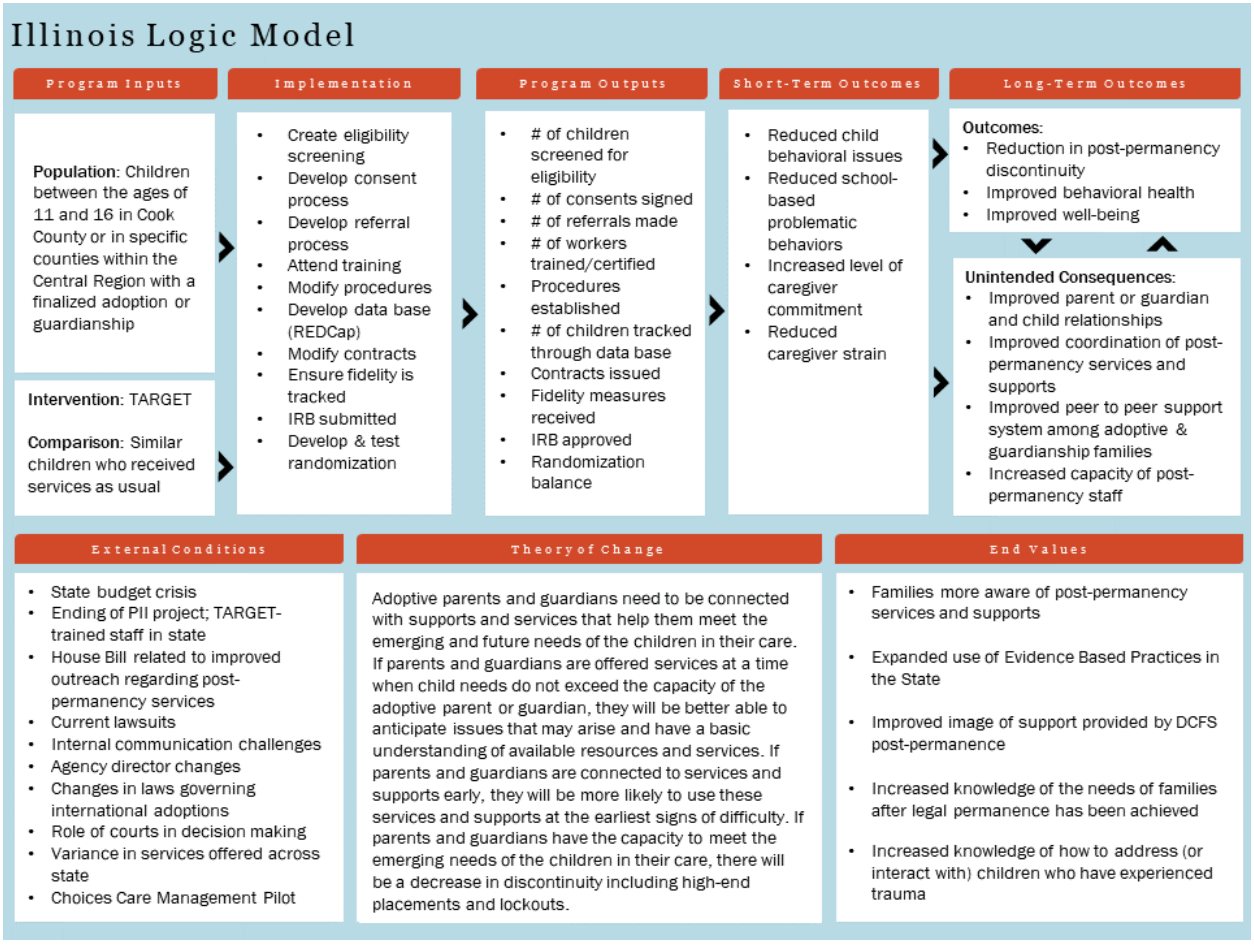
- Improved post permanency stability
- Improved child and family wellbeing
- Improved behavioral health for children and youth

Surveys were sent to families in the intervention and comparison groups to assess outcomes at the end of the project period.

Logic Model

The Logic Model (Figure 6.5) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and core developmentally informed interventions to the intended proximal and distal outcomes. The model 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 6.5. Illinois Logic Model



Evaluation Design & Methods

The QIC-AG evaluation team was committed to using the most rigorous evaluation design possible in each of the eight QIC-AG sites. This meant that experimental designs were used whenever possible. In Illinois, this resulted in different randomization methods in the two Illinois sites: Cook County and Central Region. This decision to use different randomization approaches was based on prior research in Illinois where there was low uptake of the intervention, and the early experiences with the QIC-AG project. However, in the Central Region, there was a waiting list for families seeking post permanency services. The QIC-AG team was concerned that this waiting list could grow if families were being contacted proactively to engage in TARGET. Additional families seeking services from the existing Preservation programs in the Central Region could make it difficult for them to obtain services. These constraints were evaluated when selecting the evaluation design.

As a result, an experimental design was employed to test the effectiveness of TARGET, but different randomization techniques were applied in the two geographic regions (Cook County and Central Region). In both sites, random assignment was employed to ensure that the comparison and intervention groups were balanced and that each group had a "representative mix" of youth. Even though the causal effect of TARGET on any individual family cannot be known with certainty, with random assignment the average differences in outcomes between families assigned to the intervention or comparison group can be attributed to the effects of the intervention rather than to any preexisting differences at baseline (selection), changes that would have occurred in any event (maturation), happenings that unfold over time (history), or differences in how the measurements are made (instrumentation). However, for random assignment of participants in experiments to balance intervention and comparison groups, one assumption is that participants who are eligible for the intervention actually participate in the intervention, without differential participation as a result of other characteristics. In the Illinois QIC-AG site, this did not occur; not all families assigned to the intervention group received TARGET. Important caveats related to this issue are highlighted in the Findings section below.

The selection of participating children was determined using administrative data supplied to the QIC-AG by DCFS. Once eligibility was established, random assignment was used to assign children to intervention and comparison conditions.

CENTRAL REGION

In the Central Region, the evaluation team used a random consent design for assignment to the intervention or comparison group (Zelen, 1979, 1990). In this design, families were randomized into either the intervention or the comparison group by the evaluation team in advance of any outreach. Subsequently, only adoptive parents or guardians assigned to the intervention group received outreach.

This design builds on Zelen's argument that because a client's only legitimate expectation is to receive that best standard treatment, obtaining informed consent from clients who were randomized to receive services as usual, was not ethically necessary (Ellenberg, 1984) and is congruent with work done in other federal projects (e.g., Testa & White, 2014). Therefore, we asked for a waiver of consent to examine the administrative data for those assigned to the intervention but did not participate.

COOK COUNTY

In Cook County, a traditional random assignment protocol was used. Families were notified by mail about the study, and then an outreach worker followed up with a phone call. After describing the study the outreach worker asked families to consent to be part of the study. Once adoptive parents and guardians consented to participate in the study, the outreach worker used an online random assignment calculator to assign families to the intervention or comparison group, and families were informed of their assignment.

The evaluation design and protocol were reviewed by the Institutional Review Board (IRB) at the University of Wisconsin-Milwaukee (UWM), the University of Illinois at Chicago (UIC), and the IRB at the Illinois Department of Children and Family Services.

Procedures

USABILITY TESTING

During usability testing, the program outputs listed in the Logic Model were tracked. The program successfully completed all the output measures. In addition, several different approaches to outreach were examined (e.g., addressing envelopes by hand, changing the wording of the outreach letters) in an effort to increase the level of participation in the study. However, these changes did not result in an increased rate of participation.

In order for program staff to have contact with a regular and deliberate supply of families, the evaluation team randomly assigned participants to one of 19 cohorts. The first two cohorts were usability testing, and the remainder made up the formative evaluation sample.

RECRUITMENT: COOK COUNTY

The QIC-AG evaluation team was provided access to the DCFS administrative data. Using the administrative data, the Principal investigator (PI) of the study identified the target population. Eligibility was determined at the child level's eligibility status, but outreach was conducted at the family level. In each family, one target child was selected, and adoptive parents or guardians were asked to respond to the surveys about that child.

An address-locating service (LexisNexis) was used to obtain current contact information for the parents or guardians. These data were shared with DCFS staff who printed and mailed letters to potential study participants.

The outreach procedures in Cook County involved mailing a letter from DCFS that alerted potential participants that they were selected to participate in a research study, and that someone would call them with additional information, or that they could call the outreach worker to find out more information. This mailing included a copy of the consent form.

Contact information was securely shared by the project PI with the project staff. Project staff contacted families approximately two weeks after the introductory letter was sent to ascertain their interest in the study.

Agency staff tracked program data into a REDCap database hosted at DCFS. REDCap is a secure web application for building and managing data. REDCap allowed multiple users to simultaneously enter data into the system.

RECRUITMENT: CENTRAL REGION

The QIC-AG evaluation team was provided access to the DCFS administrative data. Using the administrative data, the PI identified the target population. Eligibility was determined based on the child's eligibility status, but outreach was conducted at the family level. In each family, one target child was selected, and adoptive parents or guardians were asked to respond to the surveys about that child.

An address-locating service (LexisNexis) was used to obtain current contact information for the parents or guardians. These data were shared with DCFS staff who printed and mailed letters to potential study participants.

The outreach procedures in Central Region involved the mailing of a letter from DCFS that alerted adoptive families that they had been selected to participate in a research study, and that someone would call them with additional information, or that they could call the outreach worker to find out more information.

Contact information was securely shared by the project PI with the project staff. Project staff initiated attempts to contact families approximately two weeks after the introductory letter was sent.

Families assigned to the intervention group were screened in, and, if eligible, offered TARGET services. Project staff contacted the designated agency to inform them that they have been assigned a new family who has agreed to participate. Agency staff tracked program data into a REDCap database hosted at DCFS.

FIDELITY AND ADHERENCE

Adherence and exposure variables for both Cook and Central Region were measured in terms of the degree of practitioners' adherence (fidelity) to the best practice model of service delivery as intended by the developers and the numbers of children families reached.

Advanced Trauma Solutions (ATS; the TARGET purveyor) has trained Fidelity Monitors who reviewed videos of therapists as they conducted TARGET sessions. Videos were uploaded by the therapists into a secure web-based system. ATS Fidelity Monitors reviewed a random sample of videos and reviewed and rated sessions for model fidelity.

OUTCOMES

The primary evaluation in Cook County and Central Region was the comparison between the intervention and comparison groups. The QIC-AG contracted with an outside firm, The Survey Research Lab (SRL) at the University of Illinois at Chicago (UIC) to administer one-page questionnaires and primary outcome surveys to families in both the intervention and comparison groups. All surveys were administered to an adoptive parent or guardian.

- A one-page questionnaire was sent prior to outreach by the program staff. The purpose of the questionnaire was to gather preliminary information about all families. The SRL protocol for survey administration included a $5 non-contingent incentive attached to the request to participate. The questionnaire informed respondents that they should expect a follow-up survey in approximately 6 months and asked the respondent to contact SRL if they moved before receipt of the main survey. These questionnaires began with Cohort 6 and continued through Cohort 19. Cohorts prior to 6 received the primary outcome survey only. This questionnaire asked questions related to the caregivers' views of their relationship with their child, a child who they had assumed guardianship of, or who they adopted.

- The primary outcome survey was administered to all families assigned to both the intervention and comparison groups, in both Cook and Central, for all 19 cohorts. The purpose of the survey was to gather information related to the outcomes. The SRL protocol for survey administration included a $5 non-contingent incentive attached to the request to participate and a $20 incentive for survey completion.

In addition, administrative data, provided by DCFS to the evaluation team, was used to track post permanency discontinuity and to examine foster care experiences of the target population prior to adoption or guardianship.

Measures

OUTCOME EVALUATION MEASURES

The specific outcomes measures used in the Illinois evaluation are described below. The selection of measures for this study were based on findings from extant research. In surveys from Illinois with adoptive parents and guardians, a series of questions were asked that, in later analysis, were predictive of post permanency stability (Testa, Snyder, Wu, Rolock, & Liao, 2015). Specifically, the study found that children and youth with behavioral problems were more likely to experience post permanency instability, which was not surprising. What was surprising was that once caregiver thoughts about ending the relationship were added to the statistical models, children with behavioral problems were no more likely to experience instability than children with no behavioral problems. In other words, thoughts about ending the relationship mediated, or explained away, the effect of child behavioral problems on the risks of post permanency instability, meaning that caregiver thoughts about ending the relationship likely provide a more immediate and reliable signal of post permanency discontinuity than child behavior problems alone (Testa, et al., 2015). The selection of measures used in the QIC-AG study (Illinois Post Permanency Commitment Items, BEST-AG, and BPI) were selected to build upon findings from prior post permanency research. Outcomes for the QIC-AG evaluation in Illinois were measured through the following scales or items.

Illinois Post Permanency Commitment Items

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

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).

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 behavior. The BPI contains two subscales: the BPI Internalizing Subscale (11 items) and the BPI Externalizing Subscale (19 items) which are used to measure a child's tendency to internalize problems or externalize behaviors.

Education Outcomes

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

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.

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 as missing.

Findings

Sample Frame and Participant Profile

Tables 6.1 and 6.2 depict characteristics for the samples in Cook County and Central Region, respectively. The descriptive statistics in the table provide a profile of the families involved with the QIC-AG in both IL sites. In addition, bivariate statistical tests for variables help examine if characteristics differed between intervention and comparison groups. If characteristics were different, this would indicate that perhaps the random assignment procedures did not balance intervention and comparison groups on pre intervention characteristics. However, it is important to note that even with random assignment, it is possible that groups may differ on a few variables on bivariate statistical tests, simply due to chance.

The descriptive results for Cook County in Table 6.1 show that the majority of youth (86%) spent two or more years in foster care, with an average time in foster care for all youth in the sampling frame of over 3 years. Only 9% of the youth overall in Cook County had three or more moves in foster care. Most youth were Black/African-American (84% of the sampling frame), and the average age at permanency was close to 4 years old. Bivariate tests showed no statistically significant differences between intervention and comparison groups on the descriptive characteristics, which provides support that randomization was successful in balancing the characteristics between groups on these observed characteristics. Public Adoptive or Guardianship Families

Table 6.1. Cook County: Characteristics of Public Adoptive and Guardianships Families

ILLINOIS: COOK	SAMPLE FRAME (N = 1,661)	ASSIGNED TO INTERVENTION GROUP (N = 95)	ASSIGNED TO COMPARISON GROUP (N = 83)	BIVARIATE COMPARISON		
	%	%	%	χ^2	*df*	*p*
3+ MOVES IN FOSTER CARE	9%	7%	13%	1.69	1	0.194
CHILD RACE OR ETHNICITY				5.01	3	0.171
WHITE	8%	9%	12%			
BLACK	84%	82%	87%			
OTHER RACE	1%	1%	0%			
HISPANIC	7%	7%	1%			
CHILD IS FEMALE	50%	49%	45%	0.43	1	0.514
AGE AT PERMANENCE				4.96	4	0.291
0-2 YEARS OLD	33%	33%	28%			
3-5 YEARS OLD	48%	45%	55%			
6-8 YEARS OLD	14%	17%	11%			
9-11 YEARS OLD	4%	3%	6%			
12-14 YEARS OLD	1%	2%	0%			
15+ YEARS OLD	0%	0%	0%			
	M (SD)	M (SD)	M (SD)	*t*	*df*	*p*
CHILD AGE AT PERMANENCE	3.82 (2.39)	3.93 (2.39)	3.90 (2.17)	-0.07	176	0.947
MEAN TIME (IN YEARS) IN FOSTER CARE	3.28 (1.88)	3.41 (1.79)	3.36 (1.74)	-0.19	176	0.853

For the Central Region, the results in Table 6.2 show a similar length of time in foster care as the youth in Cook County, with 82% of youth spending two or more years in foster care and an average length of time in foster care of slightly over 3 years. However, in contrast to Cook County, a majority youth in the Central Region were White (53%) and a smaller proportion of youth were Black/African-American (42%, or close to half of the proportion in Cook County). The average age of permanence for youth in the Central Region was about 5 years old. All bivariate tests except one were not statistically significant, providing support that randomization in Central Region was largely successful in balancing groups on these observed pre intervention descriptive characteristics. However, results did show some slight differences in child age between intervention and comparison groups.

Table 6.2. Central Region: Characteristics of Public Adoptive and Guardianships Families

ILLINOIS: CENTRAL	SAMPLE FRAME (N = 1,070)	ASSIGNED TO INTERVENTION GROUP (N = 557)	ASSIGNED TO COMPARISON GROUP (N = 513)	BIVARIATE COMPARISON		
	%	%	%	χ^2	*df*	*p*
3+ MOVES IN FOSTER CARE	14%	14%	14%	0.03	1	0.865
CHILD RACE OR ETHNICITY				6.12	3	0.410
WHITE	53%	52%	54%			
BLACK	42%	42%	42%			
OTHER RACE	2%	2%	2%			
HISPANIC	3%	3%	2%			
CHILD IS FEMALE	49%	50%	48%	0.40	1	0.526
AGE AT PERMANENCE				22.40	5	0.000
0-2 YEARS OLD	26%	28%	23%			
3-5 YEARS OLD	37%	38%	36%			
6-8 YEARS OLD	20%	15%	25%			
9-11 YEARS OLD	13%	13%	12%			
12-14 YEARS OLD	4%	5%	4%			
15+ YEARS OLD	0%	1%	0%			
	M (SD)	M (SD)	M (SD)	*t*	*df*	*p*
CHILD AGE AT PERMANENCE	5.04 (3.23)	4.95 (3.39)	5.13 (3.04)	0.88	1068	0.380
MEAN TIME (IN YEARS) IN FOSTER CARE	3.03 (1.87)	3.03 (1.99)	3.03 (1.73)	-.014	1068	0.989

PRIVATE DOMESTIC AND INTERCOUNTRY ADOPTIVE FAMILIES

In Cook County, 17 Private and Intercountry adoptive families expressed interest in TARGET, and 14 attended at least 4 sessions, demographic characteristics of these 14 children are listed below (see Table 6.3). In the Central Region, 21 Private and Intercountry adoptive families expressed interest in TARGET, of those 21 families, 18 attended at least 4 sessions, demographic characteristics of these 18 children are listed below.

Note: The primary outcome surveys sent to public adoptive and guardianship families were not administered to private or intercountry adoptive families. Hence, the information we have for these participants is limited in this report. Please refer to a report by the University of Nebraska, Lincoln, for additional information on private and intercountry adoptive families.

Table 6.3. Characteristics of Private and Intercountry Adoptive Families

CHARACTERISTIC	COOK (N=14)	CENTRAL (N=18)
BOYS+	7	13
GIRLS+	6	5
MEAN AGE AT ADOPTION+	0.7 years old (SD=2.20)	3.9 years old (SD=4.12)
MEAN AGE AT INTERVENTION	12.3 years old (SD=2.02)	12.6 years old (SD=1.92)
DOMESTIC ADOPTION	5	9
INTERCOUNTRY ADOPTION	9	9

Notes:
+ In Cook we have missing information for one child's gender and one child's date of adoption.

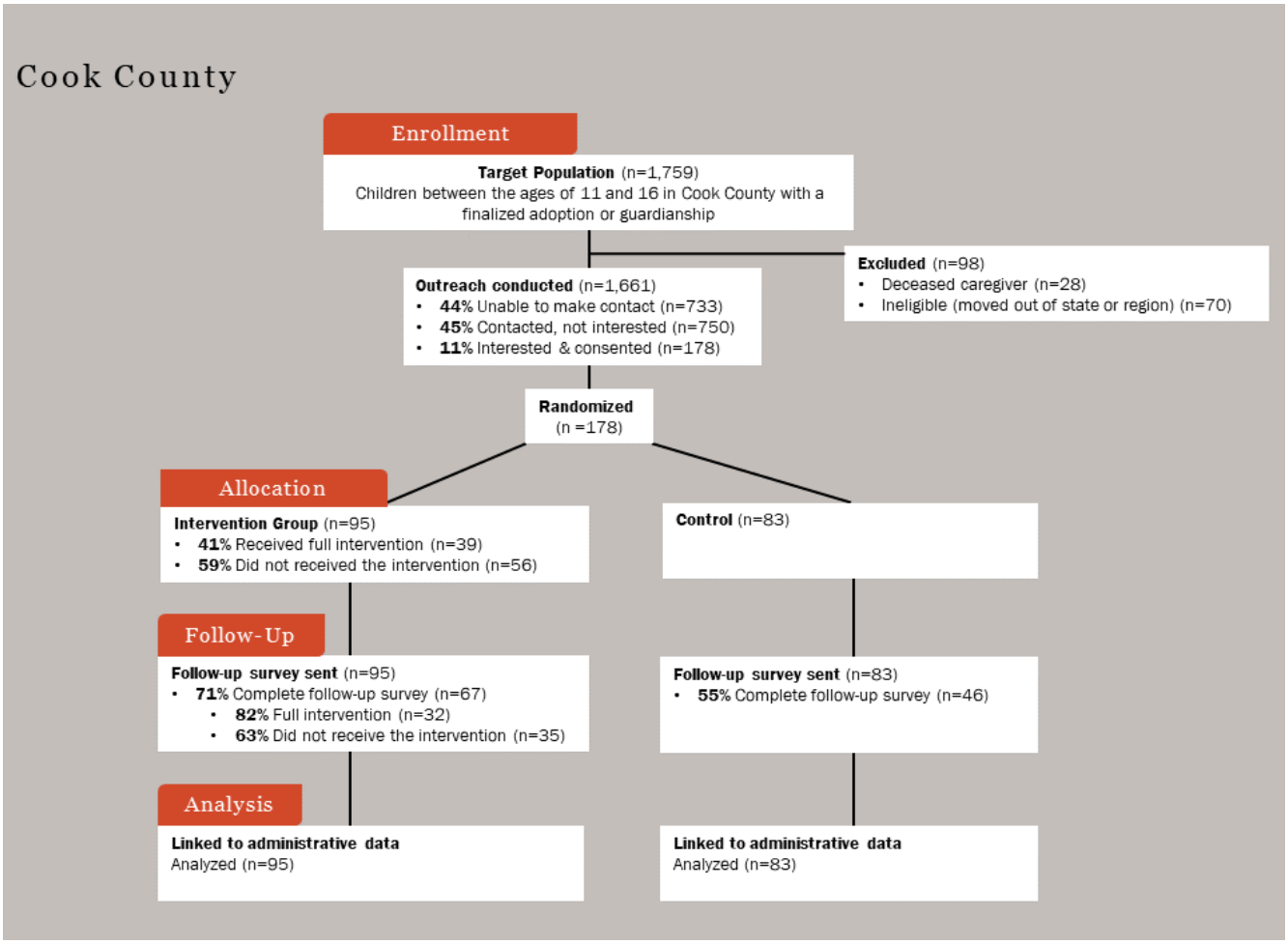
Consort Diagram

The Consort Diagram (Figure 6.6) depicts the randomization procedure and response to outreach for the intervention and surveys. This is different than the uptake chart on subsequent pages (Figures 6.8 and 6.9). The consort diagram reports the number of research subjects with data. The uptake charts report on how many subjects were recruited and participated. In Cook County, 1,661 children were eligible for the intervention. Staff successfully reached 56% of families, and 178 agreed and consented to randomization. Of those families, 95 were randomly assigned to the intervention group and 83 to the comparison group.

Depicted on the left side of Figure 6.6 is the intervention group's response to outreach efforts (i.e. Allocation) and their response to survey procedures (i.e. Follow-up). For example, of those that were allocated to the intervention group, 41% (n=39) received the full intervention and 59% (n=56) agreed to participate in the study but did not follow-through with the intervention. Further, of those in the intervention group, 71% (n=67) completed the follow-up survey and 82% (n=32) of those that participated in the full intervention completed the follow-up survey. We were successfully able to link all 95 of those in the intervention sample to administrative data using their encrypted ID codes.

Depicted on the right side of Figure 6.6 in the comparison group (n=83). The comparison group did not receive any further contact directly after allocation to the group, so no additional information is provided at Allocation. The comparison group did receive a survey around six months after being allocated to the comparison group and 55% (n=46) of them completed the survey. Additionally, all 83 of those in the comparison group were able to be linked to administrative data using their encrypted ID codes.

Figure 6.6. Cook County: Consort Diagram

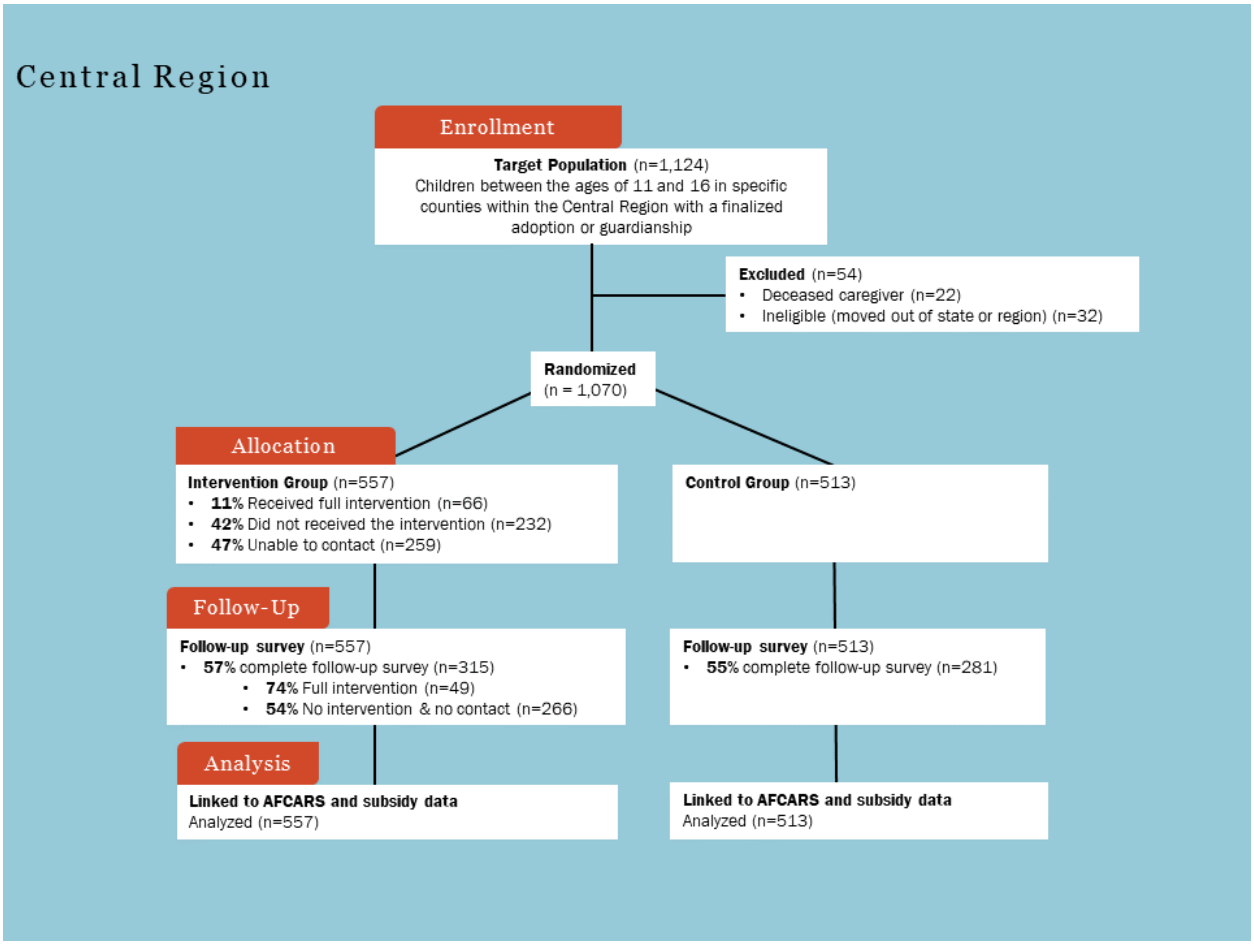


The Consort Diagram for Central Region (Figure 6.7) depicts the randomization procedure and response to outreach for the intervention and surveys. In the Central Region, of the 1,070 families eligible for the intervention, 557 (52%) were assigned to the intervention and 513 (48%) to the comparison group.

Depicted on the left side of Figure 6.7 is the intervention group's response to outreach efforts (i.e. Allocation) and their response to survey procedures (i.e. Follow-up). For example, of those that were allocated to the intervention group, 11% (n=66) received the full intervention, 42% (n=232) were contacted but did not participate in the intervention and 47% (n=259) were not successfully contacted. Further, of those in the intervention group, 57% (n=315) completed the follow-up survey and 74% (n=49) of those that participated in the full intervention completed the follow-up survey. We were successfully able to link all 557 of those in the intervention sample to administrative data using their encrypted ID codes.

Depicted on the right side of Figure 6.7 in the comparison group (n=513). The comparison group did not receive outreach directly after allocation to the group, so no additional information is provided at Allocation. The comparison group did receive a survey around six months after being allocated to the comparison group and 55% (n=281) of them completed the survey. Additionally, all 513 of those in the comparison group were able to be linked to administrative data using their encrypted ID codes.

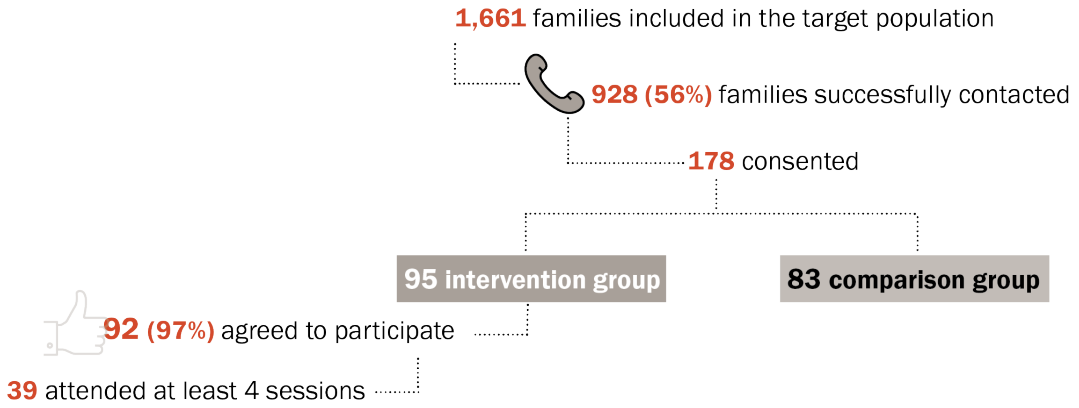
Figure 6.7. Central Region: Consort Diagram



RESPONSE TO INTERVENTION RECRUITMENT: COOK COUNTY

Figures 6.8 and 6.9 provide a more nuanced depiction of the results of outreach to the intervention group than the Consort figure. In Cook County, letters were sent to 1,661 families, and staff subsequently called families to assess their interest in the program. Among these families, 928 families chose to speak with the workers, and 178 families consented to participate. Among the 178 families, 95 families were randomized to the intervention group, and 83 families were randomized to comparison group. Finally, 92 families in the intervention group agreed to participate in TARGET program, yet many of the families who agreed to participate did not end up participating. Ultimately, 39 families attended at least 4 sessions, the minimum number of sessions, according to the purveyor, needed to observe an intervention effect. Of the 39 families who attended at least 4 sessions, 31 (79%) completed all TARGET sessions ("graduated" from the program).

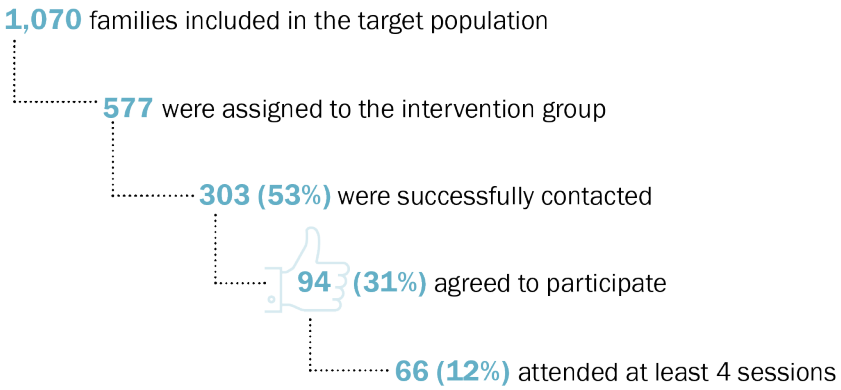
Figure 6.8. Cook County: Uptake



RESPONSE TO INTERVENTION RECRUITMENT: CENTRAL REGION

For Central Region, the target population was 1,070 families, who were randomized to comparison or intervention group. Letter were sent to the 557 families randomly assigned to the intervention program. 303 of those families chose to speak with the workers, and 94 families consented to participate. Among the 94 families, 66 families have attended at least 4 sessions, the minimum number of sessions, according to the purveyor, needed to observe an intervention effect. Of the 66 families who attended at least 4 sessions, 64 (97%) completed all TARGET sessions ("graduated" from the program).

Figure 6.9. Central Region: Uptake



In both of the Illinois sites, a variety of outreach methods were used to make contact with families. For example, at the suggestion of the stakeholders in Illinois, project staff attempted to address envelopes with different colored ink, the outreach letters were redesigned several times, and additional follow-up calls to families who initially said they wanted to participate but later declined were attempted. However, these additional efforts did not yield additional uptake.

SAMPLE CHARACTERISTICS

This section examines whether there were differences between families assigned to the comparison and intervention groups, and between TARGET participants and families who opted not to participate in the intervention. Demographics and key characteristics of families assigned to the intervention or comparison groups in both Illinois sites found that the two groups were largely similar, suggesting randomization was successful in creating balanced groups at assignment on observed characteristics. However, the analysis below goes one step further by asking if there were differences between families who actually participated in TARGET and families who did not participate in TARGET, even though they were assigned to receive the intervention.

COOK COUNTY

Differences were found between families who said that they were interested, and consented to randomization, and families who were not randomized. Of the 113 families who agreed to being randomized in cohorts 6 – 19 (cohorts prior to 6 did not receive the one-pager), 102 (90%) returned the one-page questionnaires; of the 1,345 families who were not randomized, 813 (60%) returned one-pagers. The results found statistically significant differences on all the questions asked (see Table 6.10 in the Appendix). In sum, this analysis found that families who agreed to participate in the study (those who agreed to randomization) were not doing as well as families who did not participate (they did not speak to the outreach worker or they actively declined participation).

On average, families who opted into randomization:

- **Were less:**
    - likely to report a warm relationship with their child
    - confident that they could meet the needs of their child
    - likely to report that the impact of their child's adoption or guardianship on the family has been positive
    - inclined to consider adopting or entering into guardianship again
- **More frequently:**
    - struggled to effectively manage their child's behavior
    - experienced stress as a parent
    - struggled to appropriately respond to their child
    - thought of ending the adoption or guardianship

In other words, those who said that they were interested in participating in the study (agreed to be randomized) were not doing as well as those who did not participate. This means that this evaluation of TARGET involved a higher risk group of adoptive and guardianship families than average. These families likely had significant needs that may require a longer observation period than was available with this study to observe change.

What do families say about why they do not want to participate? Of the 647 families in Cook County who spoke to a worker, declined services, and provided a reason for not wanting to participate, the following reasons were reported:

- **65% (420)** reported that everything is fine and that they don't need services at this time
- **13% (83)** reported that their needs were being met elsewhere
- **9% (59)** reported that they were not interested
- **13% (85)** reported other reasons, primarily ineligible (e.g., parents divorced, not living at home; moving out of state)

Differences between families assigned to the intervention and comparison groups. Of the 38 families assigned to the intervention group in cohorts 6 - 19, 37 (97%) returned the questionnaires; of the 75 assigned to the comparison group, 65 (87%) retuned questionnaires.

Responses to these questions were examined to understand if, at baseline there were statistically significant differences between children assigned to the intervention group and those assigned to the comparison group. There were no statistically significant differences between these two groups, on any of the questions, suggesting that randomization was successful in creating intervention and comparison groups that were balanced on these characteristics at baseline (see Table 6.11 in the Appendix).

CENTRAL REGION

Differences between families assigned to the intervention and comparison groups. Of the 424 families assigned to the intervention group in cohorts 6 – 19 (cohorts prior to 6 did not receive the one-pager), 249 (59%) returned the one-page questionnaire; of the 385 assigned to the comparison group, 213 (55%) returned questionnaires. There were no statistically significant differences between these two groups, on any of the questions, suggesting that randomization was successful in creating intervention and comparison groups that were balanced on these observed characteristics (see Table 6.12 in the Appendix).

Differences between TARGET participants and families assigned to the comparison group. Given the relatively low rate of participation among the intervention group, additional tests were run. The next test examines differences between the comparison group and families who *participated* in the intervention. These results found statistically significant differences between these two groups (see Table 6.13 in the Appendix). On average, compared to the comparison group, families who opted to receive the TARGET intervention reported that they were:

- Less likely to have a warm relationship with their child
- More likely to struggle to effectively manage their child's behavior
- Less confident that they could meet the needs of their child
- Less likely to report that the impact of the child on their family has been positive

These results suggest that, compared to the comparison group, TARGET participants were families who were struggling to provide adequate care for their child. As noted above, when families who are assigned to receive an intervention in an experimental study do not participate in the intervention, a comparison that examines the TARGET participants to the entire comparison group, may not be an apples-to-apples comparison. In other words, for this study, the comparison group was made up of all types of families – those who were not interested in services, and those who, if offered services, would have been interested in receiving services. But TARGET participants were higher-risk families interested in services. Therefore, to provide an alternative assessment of the effectiveness of TARGET, the goal is to compare TARGET participants with a sample of families who have a profile similar to them, and who may have similar concerns about their relationship with their child as those who were offered TARGET and agreed to participate.

Differences within the intervention group. The next test was to examine the intervention group as a whole and see if there were differences between those who were offered the service and opted to participate, and those who were assigned to the intervention group, were sent the materials about participation, but did not participate. Results found statistically significant differences between those who participated and those in the intervention group who did not participate (see Table 6.14 in the Appendix). On average, compared to non-participants within the intervention group, **TARGET participants** reported that they were:

- Less likely to have a warm relationship with their child
- Less confident that they could meet the needs of their child
- Less likely to report that the impact of the child on their family has been positive

In other words, those who participated in the intervention appear to be those who were struggling the most.

What do families say about why they do not want to participate? During the outreach process, staff working with the project in Illinois were able to make contact with about half of the adoptive and guardianship families they reached out to. Of the 135 families in the Central Region who spoke to a worker, declined services, and provided a reason for not wanting to participate, the following reasons were reported:

- **64% (87)** reported that everything was fine and that they did not need services at that time
- **5% (7)** reported that their needs were being met elsewhere
- **30% (41)** reported other reasons (e.g., not living in Illinois; too busy)

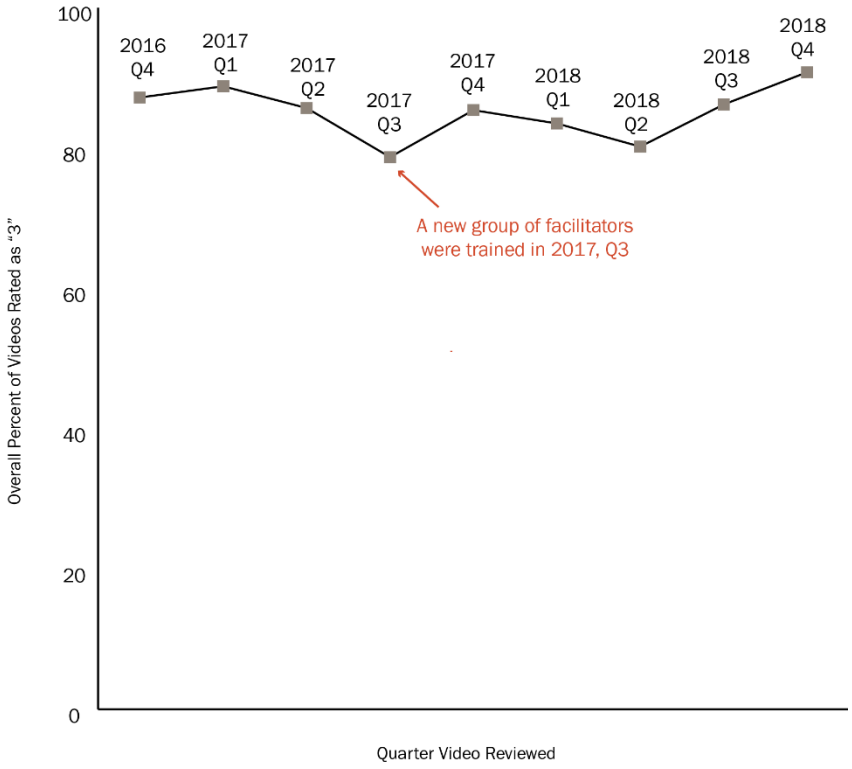
Process Evaluation

A process evaluation "determines whether program activities have been implemented as intended and resulted in certain output" (Centers for Disease Control and Prevention, 2015). The process evaluation tested whether the early phases of the initiative were associated with the expected program outputs of the intervention.

Fidelity and Adherence

Results of the reviewed taped sessions are summarized in the graph below. ATS provided information on the "percent of items rated 3," where "3" represents TARGET facilitators who met TARGET manual/guidelines for structure and content of the reviewed session. The graph below represents the average number of videos per quarter where the overall percent for structure and content of items were rated as "3."

Figure 6.10. Illinois: Average Number of Videos Rated as Proficient



In general, the graph shows that a large proportion of the facilitators' videos that the purveyor reviewed met the TARGET manual/guidelines (over 80% in all but one quarter). A dip in the percentage is observed in 2017Q3, and this corresponded with an influx of newly trained facilitators.

Who participated in TARGET sessions? TARGET is designed for family participation – youth and parental or guardian participation is encouraged.

Cook County

Of parents or guardians who were assigned to participate in TARGET:

- 27% attended all or most
- 63% attended some (more than 1, not all)
- 10% attended none

Youth

- 57% attended all or most
- 31% attended some (more than 1, not all)
- 25% attended none

Central Region

Of parents or guardians who were assigned to participate in TARGET:

- 72% attended all or most
- 16% attended some (more than 1, not all)
- 12% attended none

Youth

- 81% attended all or most
- 16% attended some (more than 1, not all)
- 3% attended none

Families who participated in TARGET were asked to complete satisfaction surveys, and generally reported feeling positive about their experiences with TARGET. This was true for both the youth and their parents or guardians. Examples of their responses to what they would change about the program are reported below.

From the youth who participated:

> **"They have done a great job explaining and going through the steps and do a great job discussing what was discussed at the last session as a reminder."**

> **"Once done with all lessons it would be a great last session to role play/go through the FREEDOM chart with examples to help solidify the lessons."**

> **"I enjoyed the games and think it would be nice to have more times to play games."**

From the adoptive parents or guardians who participated:

> **"TARGET is a great program that gives families more tools to work with to help save the family from dividing."**

> **"Love how the program was brought to us. The convenience for us was huge."**

> **"Might be worth noting to families that not all children will respond to TARGET. Once I changed my expectations it was easier."**

In 2017 and 2018, 48 adoptive parents or guardians and 71 youth completed satisfaction surveys. These results are summarized for both sites in Tables 6.9 and 6.10. Families were asked to complete satisfaction surveys at the mid-point (after 4 sessions) and at the end (after 10 sessions). The last response for each family was used. Multiple respondents per family were gathered, one parent or guardian response and one youth response per family were included in this summary.

Parents or guardians were asked to rate questions on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) with 4 of the questions listed in Table 6.4. Reaching almost the maximum rating of 5, parents or guardians reported they clearly understood how stress affected the alarm system in their child's brain (M = 4.74). They also reported feeling very skilled in using the Freedom Skills to handle their own and their child's stress and using the SOS skills to help their child focus in stressful situations.

Table 6.4. Parent or Guardian Satisfaction Survey

PARENTS AND GUARDIANS	N	M	SD	MIN	MAX
UNDERSTAND HOW STRESS AFFECTS THE ALARM SYSTEM IN MY CHILD'S BRAIN.	47	4.74	0.49	3	5
USE THE FREEDOM SKILLS TO HELP MY CHILD MANAGE STRESS REACTIONS.	47	4.45	0.80	2	5
USE THE SOS SKILLS TO HELP MY CHILD FOCUS IN STRESSFUL SITUATIONS.	47	4.57	0.65	2	5
USE THE FREEDOM SKILLS TO HANDLE STRESS EFFECTIVELY IN MY LIFE.	48	4.58	0.77	2	5

Youth who participated in TARGET were asked to rate questions on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) with 5 of the questions listed in Table 6.5. Similar to their parents or guardians, every question youth rated was at least a 4.5 or higher. The young people reported they understood how stress affected their brain's alarm system (M = 4.59). They also reported feeling skilled in using the SOS skills in helping them focus during stressful situation (M = 4.49).

Table 6.5. Youth Satisfaction Survey

YOUTH	N	M	SD	MIN	MAX
UNDERSTAND HOW STRESS AFFECTS THE BRAIN'S ALARM SYSTEM?	71	4.59	0.75	1	5
USE THE FREEDOM SKILLS TO MANAGE STRESS REACTIONS?	69	4.32	0.81	1	5
USE THE SOS SKILLS TO HELP YOU FOCUS IN STRESSFUL SITUATIONS?	71	4.49	0.83	1	5
USE THE STRESS AND CONTROL SCALES TO DO A SELF CHECK?	68	4.43	0.87	1	5
HANDLE STRESSFUL SITUATIONS SUCCESSFULLY?	69	4.30	0.90	2	5

Outcome Evaluation

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

- Reduced child behavioral issues. This was measured through the Behavioral Problem Index (BPI).
- Increased caregiver commitment. This was measured through the Belonging and Emotional Security Tool for Adoptive Parents and Guardians (BEST-AG).
- Reduced caregiver strain. This was measured through the Caregiver Strain (CS).
- Reduced school-based problematic behaviors. This was measured through a series of questions related to school outcomes.

The primary outcome survey was administered to all families assigned to both the intervention and comparison groups in both Cook County and the Central Region. The purpose of this survey was to gather data related to the project outcomes. In addition to completing the surveys, parents and guardians contacted the evaluation team to request services (these requests were referred to the agency staff). They also contacted the evaluation team to let us know that they appreciated the outreach. An example of this can be seen in what one adoptive parent said:

> **"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's 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."**

COOK COUNTY

The randomization method used in Cook resulted in two groups of families whose results were compared to see if there was a difference between TARGET participants and similar children in the comparison group (families who received services as usual). The two groups were:

- **Treatment (TARGET) participants:** Families were successfully contacted by the outreach worker and randomized into the intervention group. Families received at least 4 sessions of TARGET. Four sessions are the minimum dosage, according to the purveyor, needed to observe an intervention effect.

- **Comparison group:** Families were successfully contacted by the outreach worker and randomized into the services-as-usual group.

The response rates associated with these two groups can be found in Table 6.6. The comparison group in Cook are only families who were successfully contacted and agreed to participate in the intervention, a much smaller comparison group than in Central Region (see Table 6.7).

Cook County Terminology

INTERVENTION GROUP: The families assigned to the intervention group. In Cook County, families were randomly assigned to the intervention group while on the phone with the outreach worker.

TARGET PARTICIPANTS (ALSO CALLED TREATMENT PARTICIPANTS): Families who participated in the intervention, and received at least 4 TARGET sessions.

COMPARISON GROUP: Families assigned to the comparison (or control) group. In Cook, random assignment into the comparison group occurred while the family was on the phone with the outreach worker. These families were eligible to receive services as usual.

Table 6.6. Cook County: Primary Outcome Survey Response Rate

COOK COUNTY	SURVEYS SENT (N)	RESPONDED (N)	RESPONSE RATE
TARGET PARTICIPANTS	39	32	82%
COMPARISON GROUP	83	46	55%

As previously noted, simple randomization was used in Cook County. Randomization resulted in statistically equivalent groups at baseline when comparing intervention and comparison groups on observed baseline descriptive characteristics. The analysis of short-term outcomes found very little difference between the intervention and comparison groups. Primary outcomes are summarized below, and in Figure 6.11. Results are duplicated in the Appendix, Table 6.15, where all subscales are included.

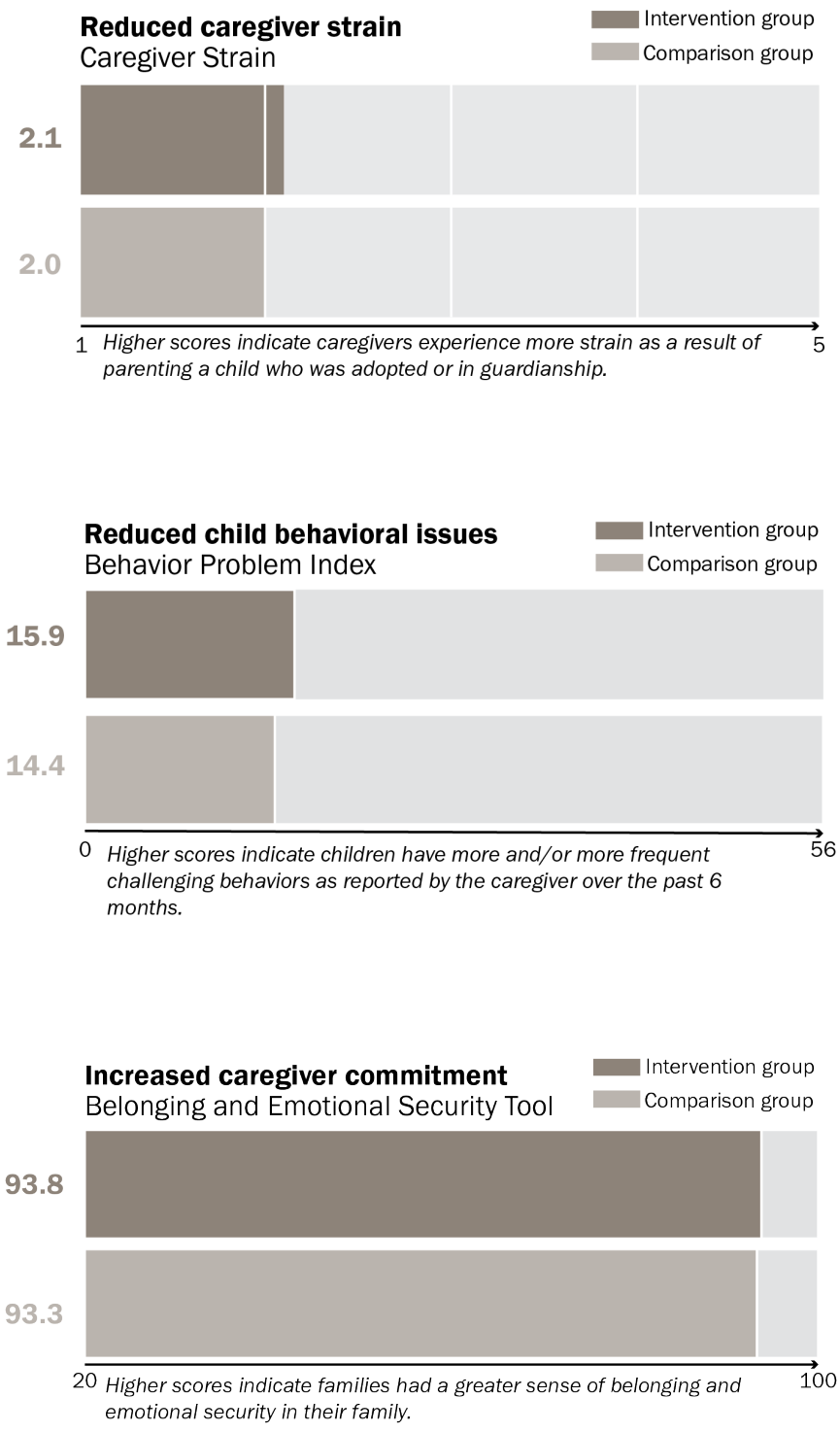
- **Behavioral Problem Index (BPI).** There was no statistically significantly difference in the mean BPI scores between the treatment and comparison group (M= 15.92 and 14.44 respectively).

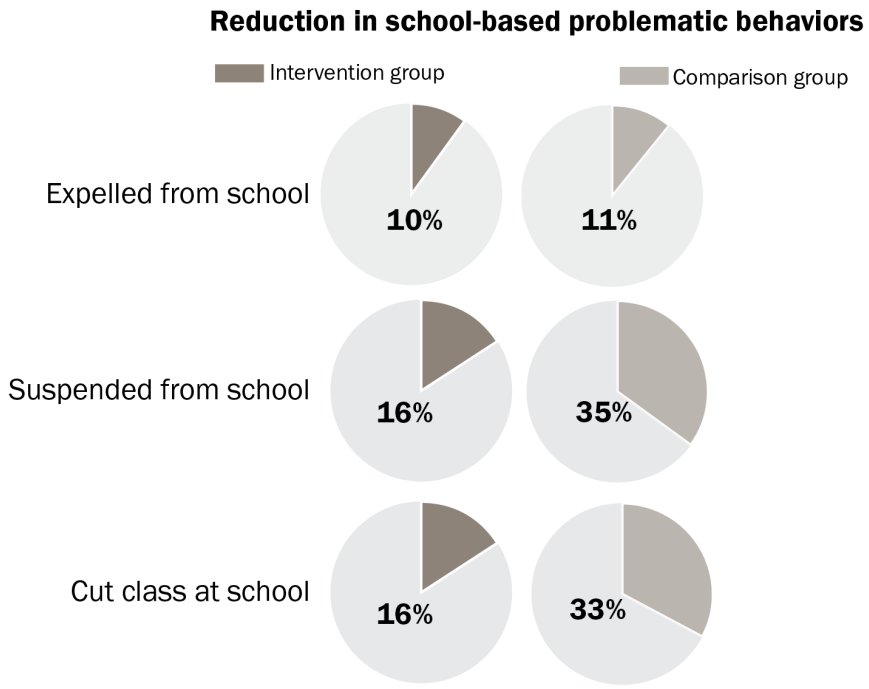
- **Caregiver Strain (CS).** On Caregiver Strain, there were no statistically significant differences between the treatment and comparison group (M= 2.07 and 1.99 respectively).

- **Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG).** There were no statistically significant differences in the mean BEST-AG scores between the treatment and comparison group (M=93.84 in the treatment and 93.26 in the comparison group).

- **School-based behaviors.** There were no statistically significant differences between the treatment and comparison groups. Results did show that the percentage of TARGET participants who cut classes at school or who experienced suspension from school was smaller than the percentage in the comparison group who experienced those school outcomes, a result that was trending towards statistical significance (for suspension from school, p = .072). However, caution should be used in interpreting these results given the small number of intervention participants.

Figure 6.11. Cook County Outcomes





CENTRAL REGION

The randomization method used in Central also resulted in two groups of study families whose results were compared to see if there was a difference between TARGET participants and similar children in families who received services as usual. The two groups were:

- **TARGET (treatment) participants:** Families were randomly assigned to the intervention group and received at least 4 sessions of TARGET. Four sessions is the minimum dosage, according to the purveyor, needed to observe an intervention effect.

- **Comparison Group:** Families were NOT contacted by the program. They were randomly assigned to the comparison group and could receive services-as-usual if they wanted services.

Central Region Terminology

INTERVENTION GROUP: The families assigned to the intervention group. In the Central Region, families were assigned at the start of the project. Outreach occurred with all families assigned to the intervention group in the Central Region.

TARGET PARTICIPANTS (ALSO CALLED TREATMENT PARTICIPANTS): Families who participated in the intervention, and received at least 4 TARGET sessions.

COMPARISON GROUP: Families assigned to the comparison (or control) group. In the Central Region, random assignment into the comparison group occurred prior to the start of the project. Outreach workers did not contact families assigned to the comparison group. These families were eligible to receive services as usual.

MATCHED COMPARISON GROUP: Statistically significant differences were observed when comparing TARGET participants to the comparison group on baseline measures of caregiver commitment (i.e., caregiver relationship and commitment variables assessed at pretest). Thus, propensity score analysis was conducted using matched groups, to provide a less biased comparison of outcomes. This group is referred to as a matched comparison group. Although differences are still possible between groups using propensity score matching, particularly on unobserved characteristics, it provides an alternative way to examine intervention effects, with some control for potential participation biases after randomization.

The response rates associated with these two groups is found in Table 6.7. Because the comparison group was not contacted in advance of the survey, the number of participants in this group is much larger than the comparison group in Cook County.

Table 6.7. Central Region: Primary Outcome Survey Response Rate

CENTRAL REGION	SURVEYS SENT (N)	RESPONDED (N)	RESPONSE RATE
COMPARISON GROUP	513	281	55%
TARGET PARTICIPANTS	66	49	74%

As noted above, the randomized consent design was used in the Central Region. Randomization resulted in statistically equivalent groups when comparing characteristics of the intervention and comparison groups overall. However, TARGET participants were statistically different from the comparison group. Therefore, the results of the experimental design compared: 1) the TARGET participants with the overall comparison group and 2) the TARGET participants with a matched sample from the comparison group.

(1) TARGET participants compared with the entire comparison group

The analysis of short-term outcomes found little differences between the intervention and comparison groups on a few key measures. Primary outcomes are summarized below (Figure 6.12), and are duplicated in the Appendix, Table 6.16, where all subscales are included:

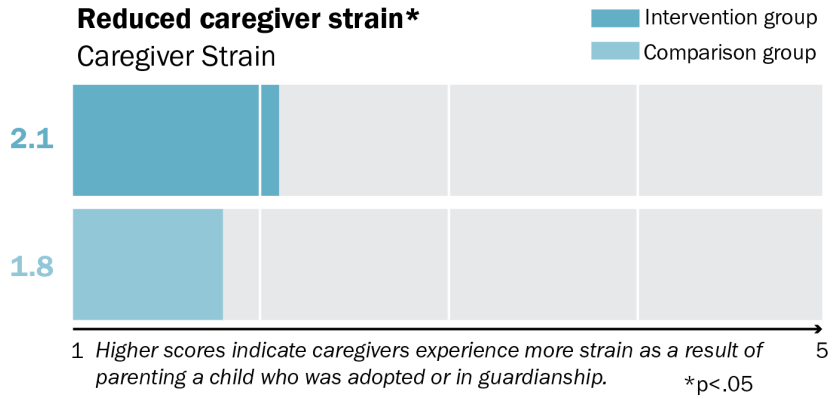
- **Behavioral Problem Index (BPI).** There was no statistically significant difference in the overall mean BPI scores between the treatment and comparison group (M= 16.22 and 13.74 respectively). However, higher levels of internalizing behavioral problems among the intervention group were observed relative to the comparison group (M=5.33 [SD=3.67] vs M=4.08 [SD=3.96], p=0.043 respectively).

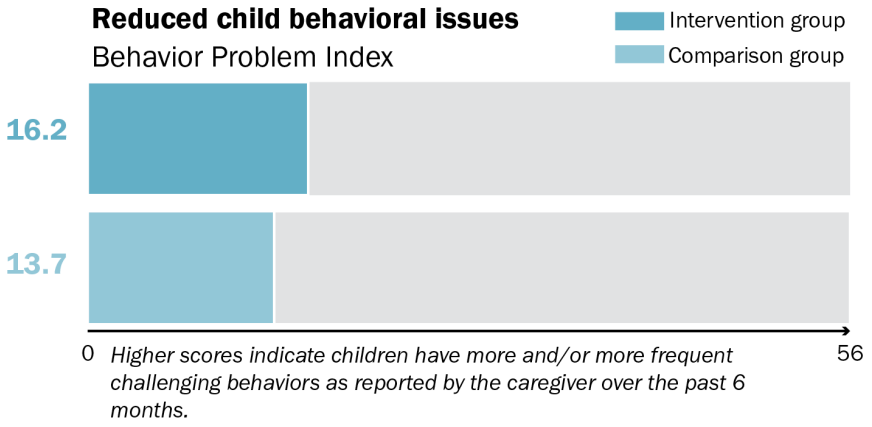
- **Caregiver Strain (CS).** Results found statistically significant differences in the Caregiver Strain measure, (M= 2.07 and 1.80 respectively). In other words, caregivers in the comparison group fared better on this measure than caregivers in the intervention group.

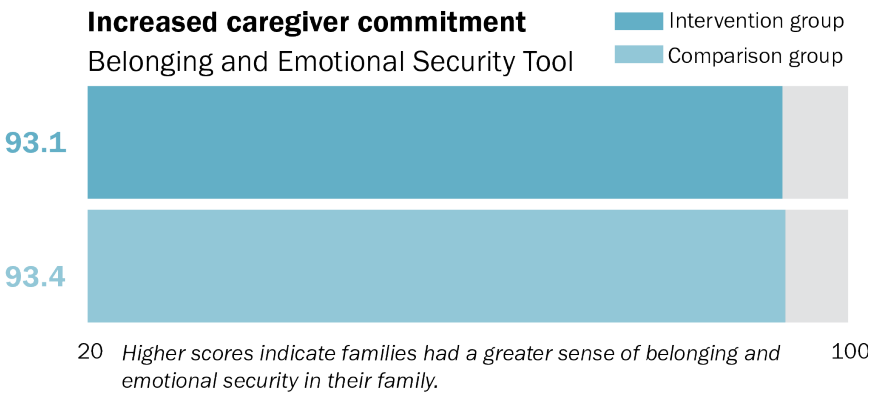
- **Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG)**. There were no statistically significant differences in the mean BEST-AG scores between the treatment and comparison group (M=93.06 in the treatment and 93.43 in the comparison group).

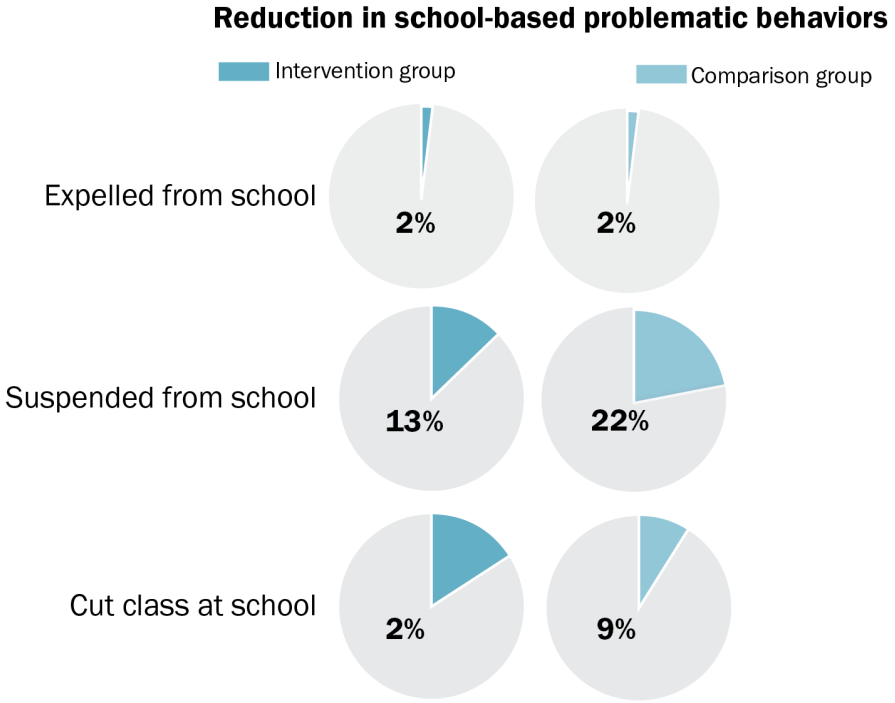
- **School-based behaviors**. There were no statistically significant differences between the treatment and comparison groups. However, similar to the results for Cook County summarized above, a smaller percentage of TARGET participants were suspended from school, and a smaller percentage cut classes, relative to the comparison group. However, this difference was not statistically significant, and caution should be used in interpreting these results given the small number of intervention participants.

Figure 6.12. Central Region Outcomes




Reduced child behavioral issues
Behavior Problem Index
Intervention group
Comparison group
16.2
13.7
0
56
Higher scores indicate children have more and/or more frequent challenging behaviors as reported by the caregiver over the past 6 months.


Increased caregiver commitment
Belonging and Emotional Security Tool
Intervention group
Comparison group
93.1
93.4
20
100
Higher scores indicate families had a greater sense of belonging and emotional security in their family.


Reduction in school-based problematic behaviors
Intervention group
Comparison group
Expelled from school
2%
2%
Suspended from school
13%
22%
Cut class at school
2%
9%

It is important to note again that for both Cook County and the Central Region, TARGET participants were substantively different on baseline measures of caregiver commitment than families in the overall comparison group. These baseline differences between groups may explain the lack of statistically significant differences between groups. To help address this issue, the second comparison, presented next, attempted to control for differences in baseline measures of caregiver commitment between intervention and comparison groups.

(2) TARGET participants with a matched comparison group

A sensitivity analysis using propensity scores to match groups was conducted, to provide a somewhat less biased comparison of outcomes between intervention participants and a matched comparison group. Specifically, the evaluation team:

1. Matched a group of children from the intervention group (n = 41) to a group of children in the comparison group (n = 41), based on the values of four caregiver commitment variables measured at pretest: the extent to which caregivers struggled to manage their children's behavior, the level of warmth in the child-caregiver relationship, the amount of confidence caregivers had to meet children's needs, and the extent to which children had a positive impact on families. After matching, intervention participants and the matched comparison group were statistically similar on the four pretest caregiver commitment variables.

2. The outcome variables were compared at posttest for the two matched groups.[2]

3. Bivariate t-tests were run to examine whether ATEs were statistically significant for each outcome.

Findings showed no statistically significant differences between matched intervention and comparison groups, and therefore provided no evidence of an intervention effect for any of the primary outcomes (see Table 6.17 in the Appendix). Specifically, after matching between the treatment and comparison groups on the following measures, no statistically significant differences were observed in any of these measures:

- Behavioral Problem Index (BPI)
- Caregiver Strain (CS)
- Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG)
- School-based behaviors

Limitations

As with any research study, there were several limitations for the QIC-AG evaluation in Illinois. First, Illinois has provided proactive, family support services (e.g., crisis counseling) to adoptive and guardianship families since at least the early 1990's (Smith, Howard, & Monroe, 1991), and was one of the first states in the U.S. to provide subsidized guardianship as a permanency option to caregivers (Testa & White, 2014). Thus, the post permanency experiences of families in Illinois may not be representative of other states in the U.S.

[2] The Average Treatment Effect (ATE) was estimated for each outcome (average score [Comparison Group] – average score [Treatment Group]).

Another limitation for this study was that only a small proportion of the eligible population in both sites participated in the research, and a significant proportion of those who agreed to participate in TARGET did not actually receive the full intervention. For example, in Cook County, 41% (39) of the 95 families who were randomized to the intervention group participated in the intervention (at least the minimum required four sessions of TARGET). Participation was higher in the Central Region, perhaps due to the use of the random consent design (Zelen, 1979, 1990), which may be useful for increasing participant enrollment in child welfare studies (Testa & White, 2014). In Central Region, 70% (66) of those caregivers who agreed to participate in the intervention attended at least four sessions of TARGET. These findings show the limitations and potential biases of sophisticated, randomized evaluation designs in child welfare research. Specifically, external validity may be compromised when only a small proportion of the eligible population agrees to participate in the study, and internal validity may also be compromised when those who agree to participate do not actually complete the required, full intervention (or the full "dose") at significant rates, a problem analogous to attrition in medical intervention studies. This problem with internal validity limits what is supposed to be a key advantage of random assignment to intervention groups: making groups comparable on baseline characteristics. But as noted above, it is unclear from the results whether non-participation in TARGET among those who were eligible led to biases in the outcome results, and future studies that examine TARGET with adoptive or guardianship families should specifically examine this potential issue.

Related to low intervention uptake, a final limitation of this study was that a small number of families had outcome data available for analyses (105 families in both sites combined). This meant diminished power to detect statistically significant differences between intervention and comparison groups. This limitation of small sample size, combined with a fairly small observation window to observe changes among the intervention group from enrollment until outcome data collection (i.e., about 6 months), made detecting any changes due to the intervention very challenging. Thus, future studies should increase sample sizes and observe families for longer periods of time to examine if TARGET has an impact on longer-term wellbeing or placement instability outcomes. However, the current study should be helpful for future research, to provide information about what proportion of families are likely to engage, the types of families who are likely to engage with TARGET and a better understanding of how families who have adopted or assumed guardianship are faring. As previously stated, the upside to the low uptake rates is that the majority of families reported not needing services at this time. This should help alleviate fears in jurisdictions that are considering offering post permanency services and supports, that they should not expect a large proportion of families to express a need for additional services.

Thoughts from Adoptive Parents and Guardians

At the end of the primary outcome survey sent to all adoptive parents and guardians, we asked respondents, *"Is there anything else about your experience of adoption or assuming guardianship of your child that you would like to share?"* Their responses reflect a wide variety of experiences within the narrow target population that we defined. Over 500 families (40% of respondents) provided us with their thoughts on their experiences. For those interested in helping families formed through adoption or guardianship, the direct responses from parents and guardians may assist in thinking through what is needed. Regarding the experience of being an adoptive parent or guardian:

The word "love" or "loved" is mentioned 114 times. There were 204 adoptive parents or guardians that commented on their positive experience with their adoptive or guardian child, and 20 commented about negative experience with their adoptive or guardian child. Here are several quotes from adoptive parents or guardians involved in this study:

"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."

"Just that I've adopted a wonderful son who and will always be a very big part of our family, and I don't use the word adopted; he is my son, period."

"My adoption experience has been positive. I think adoption can be more positive depending on the age of a child and the amount of information known about the child prior to finalization of the adoption."

"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."

"My adoption worker really worked hard to prepare for all possible needs when writing our subsidy. My daughter is a beautiful 17-year-old. We love her very much. Having raised 9 other children (3 adopted/6 bio), we thought we knew what to expect but this generation is more challenging!"

"We don't recommend to anyone that they adopt from foster care."

"We also adopted his bio sister who can now not live here because she is too dangerous."

Regarding things that have worked, or not, and thoughts on what could be improved, 98 adoptive parents and guardians commented about what has not worked, 15 commented on what has worked, examples include:

"It's been hard. I still have a 24-year old I adopted she don't want to work. I had a 22-year old that still feels like I owe her something, always begging, has a baby of her own… it does not stop."

"I have another adopted son. He [has] on-going emotional challenges. I was forced to do a lock-out on him after he was hospitalized multiple times. This was the only way to get him properly diagnosed and medicated."

"When children are in DCFS and get an IEP, DFCS should offer more help to these children. Schools do not want to support children that are through DCFS. Ever since my daughter has been in school I had to fight for services."

"The agency needs to be more willing to help a struggling family. My son has drug problems and needed to be in a drug residential treatment center for help with his drug problem before something happens that can damage for the rest of his life."

"I had a great adoption worker and attorney, therefore making it a smooth process."

"More guidance or support…She's 15 and wants to know her family history, especially on dad's side, never knew him."

"My adoption worker really worked hard to prepare for all possible needs when writing our subsidy."

"I feel that the social worker should call and check-up. I reached out for help and help was never given."

Cost Evaluation

The Illinois QIC-AG project implemented and tested the effectiveness of TARGET, an intervention that teaches youth and parents about trauma and skills to manage trauma responses. The project served 105 families formed by adoption and guardianship, across the two Illinois sites.

Cost Evaluation Approach

The cost-effectiveness research (CER) analysis provides information for policymakers and administrators to help maximize desired outcomes based on the associated cost of achieving them (Meunnig, 2002). CER analysis was applied to the outcomes identified by Illinois.

Assumptions, Conditions, and Constraints

The first step in this analysis was to identify issues which might impact the validity of our cost analysis findings. CER analyses typically rely on researchers making subjective decisions based on their judgments and perceptions of the available information. Thus, it is important to record assumptions, constraints, and conditions relevant to Illinois 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 of TARGET is long enough to achieve change in outcome measures. We are assuming that the impact of TARGET is achieved or not achieved within the timeframe of the project. However, it is likely that the intervention's true impact will not be seen until after the project period.

We also assume multiple positive outcomes are likely impacted by the QIC-AG site programs. For TARGET, the desired impact of the programs is to improve behavioral health and wellbeing. However, other positive outcomes may not necessarily be captured within the intervention. A final assumption is that the resource allocation captured in costs paid to sites is accurate. It is likely that staff time may be over or under-budgeted depending on the time constraints. For example, at the beginning of an intervention, more staff effort may be needed, but as a program continues, staff effort may be less intense because of the familiarity with the intervention.

CONSTRAINTS

Constraints are factors that have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For Illinois, constraints may include the availability and costs associated with the intervention purveyor, the availability of TARGET-trained facilitators in the locations where interested families reside. A constraint might also be agency staff turn-over, and state employees (internal to DCFS) who serve as champions for the project and oversee its implementation, and state budgetary concerns.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. For Illinois, conditions include the state's prior familiarity with implementing the intervention, the availability of TARGET-trained facilitators who were trained by prior to the start of this project. The ready availability of an on-line database at DCFS that can be easily modifiable for use on this project. Prior experience with rigorous research designs within the state.

Cost Estimation

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

KEY POINTS IN COST ESTIMATION

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

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. Prior to implementation, Illinois's intervention site, The Department of Children and Family Services, 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 are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates.

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

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

Both variable and fixed costs should be captured in cost estimation. For Illinois, 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 Illinois were taken from monthly budget forms and summarized into Table 6.8.

Table 6.8. Costs for Illinois

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL COSTS				
SITE IMPLEMENTATION MGR- SALARY	$24,460	$66,237	$62,910	$153,608
SITE IMPLEMENTATION MGR- FRINGE	$369	$4,953		$5,321
NON-PERSONNEL DIRECT COSTS				
CONTRACTED SERVICES: ATS	$1,742	$65,056	$56,051	$122,848
CONTRACTED SERVICES: FAMILYCORE		$24,755	$6,252	$31,007
CONTRACTED SERVICES: LEXISNEXIS		$2,758	$4,624	$7,382
CONTRACTED SERVICES: NORTHWESTERN	$3,697	$17,955	$3,135	$24,787
CONTRACTED SERVICES: THE BABY FOLD	$51,051	$160,278	$153,712	$365,042
CONTRACTED SERVICES: THE CRADLE		$1,146	$2,343	$3,489
CONTRACTED SERVICES: HEALTHY FAMILIES CHICAGO		$10,858		$10,858
CONTRACTED SERVICES: METROPOLITAN FAMILY SERVICES		$22,962		$22,962
CONTRACTED SERVICES: VIDEO SERVICES		$2,500		$2,500
CONTRACTED SERVICES: COMMUNICATION	$7,034	$20,354		$27,389
GIFT CARD INCENTIVES		$4,290	$487	$4,777
POSTAGE		$2,372	$747	$3,119
PROGRAM SUPPLIES	$947	$3,588	$4,615	$9,151
TELEPHONE	$371			$371
				INDIRECT COSTS
DISSEMINATION COSTS			$41	$41
IT SUPPORT		$473	$4,463	$4,935
OTHER: ASAP TRAINING		$4,784		$4,784
OTHER: TARGET TRAINING		$185	$1,819	$2,004
TRAVEL		$838	$3,464	$4,302
TOTAL	$89,671	$416,341	$304,664	$810,676

*FY2019 ended 3/31/19
**FY2017 began 3/1/17

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 6.8.

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 totaled $163,890 for staff time allocated to the project during the implementation phase. Personnel costs only included the salary of the SIM.

Fringe

Overall fringe for all employees totaled $5,321. Fringe was calculated based on state guidelines.

Contractual Expenses

Illinois contracted for services from ten entities.

- *Advanced Trauma Solutions (ATS)*. Advanced Trauma Solutions, Inc. (ATS) is the purveyor of TARGET. Costs are for consultations, fidelity and adherence reviews.
- *Northwestern*. Northwestern University provided training to facilitators in TARGET.
- *Baby Fold*. Baby Fold is a private agency in the Central Region of Illinois. Outreach workers and TARGET facilitators were employed by this agency and paid for by the program.
- *The Cradle*. The Cradle is a private adoption agency. Staff were paid to recruit private and intercountry adoptive families to participate in TARGET.
- *LexisNexis*. LexisNexis was used as a look-up agency, where the evaluation team would submit family contact information, and LexisNexis would return the most current contact information.
- *Family Core*. Family Core is a private agency in the Central Region of Illinois. Outreach workers and TARGET facilitators were employed by this agency and paid for by the program.
- *Healthy Families Chicago*. Healthy Families Chicago is a private non-profit agency that provided two facilitators the TARGET facilitators.

- *Communication Services*. A member of the Illinois Department of Children and Family Services, Department of Communications was hired to contribute Capacity Building activities.
- *Metropolitan Family Services*. Metropolitan Family Services is a private agency in the Chicago area. Additional part-time outreach coordinators were employed by this agency to assist with outreach in the Cook region.
- *Video Services*. A videographer who was employed by Spaulding for capacity building activities.
- *Adoption Support and Preservation Program*. ASAP are programs that are provided by private agencies throughout the state. These programs provide post adoption and guardianship children and families with a wide range of clinical, case management, advocacy, respite, and other support services. They are funded through the Illinois Department of Children and Family Services.

Gift Cards

Gift cards were provided to participants for completing surveys. A total of $4,776 was spent on gift cards. To incentivize participation, $25 gift cards were provided to each family at mid-point and at the conclusion.

Materials and Supplies

Over the implementation period, $8,054 was spent on program supplies that were specific to the operation of the intervention.

Travel

Over implementation and installation, $4,302 was paid for travel.

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 ($3,118), and phones ($371).

Estimation of Indirect Costs

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

IT Support

IT support includes all expenses related to IT including computers, contract with a person for IT work, database design, and software. Computer and IT network charges include $6,000 and an additional $4,935 for IT support.

Other

In addition, $41 was spent on dissemination costs; $4,784 for ASAP training; and $2,004 was spent on TARGET training.

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 Illinois 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 Illinois were $810,676.

Cost Calculations

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

COST PER PARTICIPANT

Based on the total costs of $810,676 and 105 participants, the cost per participant for this intervention was $7,721.

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 are most likely not needed have been removed from the cost calculation. Inclusion or exclusion of costs in a sensitivity analysis such as this one is subjective. A decision was made based on the following question: Is this expense critical to the functioning of the intervention? Another agency would want to adjust costs specific to their program needs. The following exclusions were made for this sensitivity analysis.

1. The salary and fringe for the Site Implementation Manager were removed. At this site, the Site Implementation Manager was not needed to implement the actual intervention. This position served as a liaison with external entities and managed internal processes. The implementation can be managed by TARGET facilitators.
2. Gift cards were removed from the cost calculation. Gift cards were provided to thank people for their time in completing evaluation materials.
3. Program supplies not related to Family Group Decision Making materials were excluded.
4. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings.
5. Fees related to postage, phone, IT support and dissemination costs were removed.
6. The amount of payment to The Baby Fold was reduced in 2019 because roughly $9,000 of funds were used for non-intervention related capacity building.
7. In year five, the amount paid to Northwestern was reduced because it was related to capacity building.
8. The amount paid to Communications Specialist was removed because that related to capacity building.
9. The amount paid to the videographer was removed because it was related to capacity building.
10. LexisNexis costs were removed. These costs were to assist in locating families to advertise the intervention. Other agencies would likely provide these services to their own clients.
11. Other direct charges were also excluded. These expenses were not necessary for the implementation of the intervention.
12. 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 6.9 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $574,423 which amounted to $5,471 per participant.

Table 6.9. Sensitivity Analysis: Adjusted Costs for Illinois

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
NON-PERSONNEL DIRECT COSTS				
CONTRACTED SERVICES: ATS	$1,742	$65,056	$56,051	$122,848
CONTRACTED SERVICES: FAMILYCORE		$24,755	$6,252	$31,007
CONTRACTED SERVICES: NORTHWESTERN	$3,697	$17,955	$3,135	$24,787
CONTRACTED SERVICES: THE BABY FOLD	$51,051	$160,278	$153,712	$365,042
CONTRACTED SERVICES: THE CRADLE		$1,146	$2,343	$3,489
CONTRACTED SERVICES: HEALTHY FAMILIES CHICAGO		$10,858		$10,858
CONTRACTED SERVICES: METROPOLITAN FAMILY SERVICES		$22,962		$22,962
INDIRECT COSTS				
OTHER: ASAP TRAINING		$4,784		$4,784
OTHER: TARGET TRAINING		$185	$1,819	$2,004
TOTAL	$43,132	$307,978	$223,313	$574,423

*FY2019 ended 3/31/19
**FY2017 began 3/1/17

Cost Evaluation Summary

Based on the total costs of $810,676 and 105 participants, the cost per participant for this intervention was $7,721. 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 $574,423, which results in $5,471 per participant.

Discussion

The QIC-AG project in Illinois tested TARGET, a strengths-based, psycho-educational intervention for children affected by trauma or exposed to adverse childhood experiences. This study extended previous research on TARGET to test the effectiveness of families formed through adoption and guardianship in two areas of Illinois: Cook County and the Central Region. Due to the different evaluation designs used in the two evaluation sites in Illinois (Cook County and specific counties within the Central Region), intervention-related results are presented for each evaluation site separately.

In Cook County, 39 families received the intervention, and 32 (82%) returned the primary outcome survey. In the Central Region, 66 families received the intervention and 49 (64%) returned the outcome survey. In addition, primary outcome surveys were administered to families in the comparison group, (46 were returned in Cook and 281 in Central). Based on the analysis of these data, the study did not find a strong intervention effect. In other words, on the outcomes measured (e.g., child behavioral issues and wellbeing measures) TARGET participants did not fare better than families who received services-as-usual. While not statistically significant, in both Cook County and Central Region, fewer school-based problematic behaviors were reported for children in the intervention group compared to children in the comparison group. However, the sample size was small, and the observation period rather limited (6 months).

It is possible that no intervention effects were observed in this study due to the limited observation window. Personal and interpersonal change is difficult and takes time, especially given the long history of trauma that many adoptive and guardianship youth have experienced due to maltreatment and previous placement moves (Jones & Schulte, 2019). The observation window in this study was only about 6 months post intervention. Thus, perhaps with additional time, and more families enrolled, different results regarding the TARGET intervention may have emerged.

One of the challenges of conducting prevention outreach is that it is difficult to know when an event has been prevented, such as post adoption and guardianship instability, since the goal is for the event to not occur. In prior research, and in this study, most families formed through adoption or guardianship report that they are doing well, with the supports and services they are currently receiving, and that they do not need additional services. As the project was unfolding, and the relatively low uptake rate was observed, one question that was asked was, are we reaching the right families? This study found that, in both Cook County and Central Region, families who chose to participate in the intervention were families who were struggling more. Specifically:

In Cook County families who said, ‘yes’ when the outreach worker asked them if they wanted to participate in the research study (agreed to be randomized into either the comparison or intervention group) were, on average:

- Less likely to report a warm relationship with their child
- Less confident that they could meet the needs of their child
- Less likely to report that the impact of their child’s adoption or guardianship on the family has been positive
- Less inclined to consider adopting or entering into guardianship again

They were also:

- More likely to struggle to effectively manage their child's behavior
- More likely to experience stress as a parent
- More likely to struggle to appropriately respond to their child
- More likely to think of ending the adoption or guardianship

For families in Cook County who said they were not interested in participating in the study, the majority (65%) reported that everything was fine and that they did not need services at that time.

In the Central Region, a similar pattern emerged in terms of the profile of families who selected into the intervention. On average, compared to the comparison group, TARGET participants reported that they were:

- Less likely to have a warm relationship with their child
- More likely to struggle to effectively manage their child's behavior
- Less confident that they could meet the needs of their child
- Less likely to report that the impact of their child's adoption or guardianship on the family has been positive

Similar to Cook County, 64% of families in the Central Region who spoke to a worker & declined services reported that everything was fine and that they did not need services at that time.

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

Consistent with previous studies on the experiences of adoptive and guardianship families, this study provides evidence that the majority of families are adjusting well (White, Rolock, Testa, Ringeisen, Childs, Johnson, & Diamant-Wilson, 2018). To enhance preventative services for adoptive and guardianship families, the field may want to identify families most at risk for instability. For example, researchers could examine rates of service utilization (e.g., mental health counseling or respite) or indicators of poor school adjustment (e.g., low grades, frequent referrals to in-school suspension) to indicate those families who most need services and supports, or responses to key questions that might suggests familial struggles (e.g., the caregiver-child relationship questions asked in this study).

The target population, families with children or youth with similar experiences and ages, was heterogeneous. There is a wide variety of families, with a wide variety of needs. Some of these families are struggling – the project has heard stories of families in crisis – and some seem to be doing well. In the primary outcome survey, parents and guardians were asked to share their experiences of adoption or guardianship. Their responses reflect this wide variety of experiences within the narrow target population that the project defined. Over 500 families (40% of respondents) provided reflections. Notably, the word "love" or "loved" is mentioned 114 times in their responses. Many reported positive responses (204 commented about their positive experience with their adoptive or guardian child):

> **"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."**

> "Just that I've adopted a wonderful son who and will always be a very big part of our family and I don't use the word adopted… he is my son period."

> "My adoption experience has been positive. I think adoption can be more positive depending on the age of a child and the amount of information known about the child prior to finalization of the adoption."

> "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."

> "My adoption worker really worked hard to prepare for all possible needs when writing our subsidy. My daughter is a beautiful 17-year-old. We love her very much. Having raised 9 other children (3 adopted/6 bio) we thought we knew what to expect but this generation is more challenging!"

Some families (20) reported a negative experience with their adoptive or guardian child (e.g., "We don't recommend to anyone that they adopt from foster care," "The kids are angry with us, the people that raise them, 'cause they want their parents."). Some provided specific examples of what has not worked, for example:

> "Finding psychiatric care for her was difficult."

> "He has a lot of issues we were not told about prior to adoption."

> "Our foster care agency was horrible."

Families also provided suggestions for what could be improved:

> "When children are in DCFS and get an IEP. DFCS should offer more help for these children. Schools do not want to support children that are through DCFS. Ever since my daughter has been in school I had to fight for services."

> "My child receives bimonthly therapy and medications to address mental health. I think this is something the needs more awareness."

> "The agency needs to be more willing to help a struggling family. My son has drug problems and needed to be in a drug residential treatment center for help with his drug problem before something happens that can damage for the rest of his life."

> "Need more resources to find locations for a neuropsychological evaluation. Somewhere that will take her insurance or have grants of funding to cover the cost of testing. We need more answers about her neurological development or lack thereof."

> "More guidance or support…She's 15 and wants to know her family history especially on dad's side, never knew him."

> "I feel that the social worker should call and check-up. I reached out for help and help was never given."

The majority of families reported positive adoption and guardianship experiences. Yet families also report ongoing issues, including service gaps, child emotional and behavioral difficulties, and limited agency support. In addition, project staff in one of the Illinois sites reported that many (over half) of the TARGET recipients became engaged in services-as-usual after receiving TARGET. This suggests that perhaps a single intervention is not what was needed for some of these families. Similar to other prevention efforts, preventing post permanency discontinuity and promoting the wellbeing of families formed through adoption and guardianship may require an approach that takes into account the diversity of issues families face. There are developmental considerations, cultural issues, lifestyle choices, and work or other life stressors that may need to be considered in future prevention work intended to better understand and support the needs of adoptive and guardianship families.

References

Advanced Trauma Solutions (ATS). Retrieved from http://www.advancedtrauma.com/

Brannan, A. M., Helfinger, C. A. & Bickman, L. (1997). The caregiver strain questionnaire: Measuring the impact of the family of living with a child with a serious emotional disturbance. *Journal of Emotional and Behavioral Disorders, 5(4),* 212-222.

Calculating the Costs of Child Welfare Services Workgroup. (2013). *Cost analysis in program evaluation: A guide for child welfare researchers and service providers*. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2015). Types of evaluation. Retrieved from https://www.cdc.gov/std/Program/pupestd/Types%20of%20Evaluation.pdf

Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration. (1993). *Feasibility, Alternatives, And Cost/Benefit Analysis Guide*. Washington DC. Retrieved from http://archive.acf.hhs.gov/programs/cb/systems/sacwis/cbaguide/c1intro.htm

Ellenberg, S. (1984). *Randomization designs in comparative clinical trials*. New England Journal of Medicine, 310, 1401-1408.

Ford, J. & Hawke, J. (2012). Trauma affect regulation psychoeducation group and milieu intervention outcomes in juvenile detention facilities. *Journal of Aggression, Maltreatment, & Trauma,* 4(21), 365-384.

Ford, J., Steinberg, K. L., Hawke, J., Levine, J. & Zhang, W. (2012). Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child & Adolescent Psychology*, 41(1), 27-37.

Framework Workgroup. *A framework to design, test, spread, and sustain effective practice in child welfare.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Frey, L., Cushing, G., Freundlich, M., & Brenner, E. (2008). Achieving permanency for youth in foster care:

Assessing and strengthening emotional security. *Child & Family Social Work, 13,* 218-226. doi: 10.1111/j.1365-2206.2007.00539.x

Illinois Adoption Advisory Council (IAAC). Retrieved from https://www2.illinois.gov/dcfs/lovinghomes/adoption/Pages/com_communications_stateadptadv.aspx

Illinois Department of Children and Family Services (2017). Retrieved from https://www2.illinois.gov/dcfs/lovinghomes/families/Pages/Family-Preservation-Services.aspx

Jones, V. F., & Schulte, E. E. (2019). Comprehensive health evaluation of the newly adopted child. *American Academy of Pediatrics, 143*(5), 1-16. doi:10.1542/peds.2019-0657

Liao, M., & Testa, M. (2016). Post adoption and guardianship. *Research on Social Work Practice, 26*(6), 675-685. http://dx.doi.org/10.1177/1049731514564600

Liao, M., & White, K. R. (2014). Post-permanency service needs, service utilization, and placement discontinuity for kinship versus non-kinship families. *Children and Youth Services Review, 44*, 370-378. http://dx.doi.org/10.1016/j.childyouth.2014.07.007

Meunnig , P. (2002). *Designing and conducting cost-effectiveness analyses in medicine and health care*. San Francisco: Jossey-Bass.

Peterson, J. L. & Zill, N. (1986). Marital disruption, parent=child relationships, and behavioral problems in children. *Journal of Marriage and the Family,* 48, 295-308.

Richardson, W., Wilson, M., Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club, 123*(3), A12.

Rolock, N. (2015). Post-permanency continuity: What happens after adoption and guardianship from foster care? *Journal of Public Child Welfare, 9*, 153-173. doi: 10.1080/15548732.2015.1021986

Rolock, N. & White, K. R. (2016). Post-permanency discontinuity: A longitudinal examination of outcomes for foster youth after adoption or guardianship. *Children and Youth Services Review, 70,* 419-427. http://dx.doi.org/10.1016/j.childyouth.2016.10.025

Smith, S. L., Howard, J. A., Garnier, P. C., & Ryan, S. D. (2006). Where are we now?: A post-ASFA examination of adoption disruption. *Adoption Quarterly, 9*(4), 19-44. Smith, S. L., Howard, J. A., & Monroe, A. D. (1998). An analysis of child behavior problems in adoptions in difficulty. *Journal of Social Service Research, 24*(1-2), 61-84. doi:10.1300/J079v24n01_03

Testa, M.F., & Poertner, J. (Eds.). (2010). Fostering accountability: Using evidence to guide and improve child welfare policy. New York, NY: Oxford University Press

Testa, M. F., Snyder, S. M., Wu, Q., Rolock, N., & Liao, M. (2015). Adoption and guardianship: A moderated mediation analysis of predictors of post-permanency continuity. *American Journal of Orthopsychiatry, 85*(2), 107-118.

Testa, M.F. & White, K. R. (2014) Insuring the integrity and validity of social work interventions: The case of the subsidized guardianship waiver experiments, *Journal of Evidence-Based Social Work,* 11:1-2, 157-172, DOI: 10.1080/15433714.2013.847260

United States Census Bureau (2019). Retrieved from https://www.census.gov

United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Bureau (2017). *Child welfare outcomes report data*. Retrieved from https://cwoutcomes.acf.hhs.gov/cwodatasite/

United States Department of Health and Human Services, Administration for Children and Families. (2017). *Quarterly Financial Reports, Form CB-496. (compiled data from states' Title IV-E Programs).*

White, K. R., Rolock, N., Testa, M. F., Ringeisen, H., Childs, S., Johnson, S., & Diamant-Wilson, R. (2018). Understanding post adoption and guardianship instability for children and youth who exit foster care: Literature review and conceptual framework (report submitted to the Office of Planning, Research, & Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services).

Zelen, M. (1979). A new design for randomized clinical trials. *New England Journal of Medicine*, 300, 1242–1245.

Zelen, M. (1990). Randomized consent designs for clinical trials: An update. *Statistics in Medicine*, 9, 645–656.

Appendix

Table 6.10. Cook County: Baseline Differences Between Families Randomized into the Intervention and Families Not Randomized

COOK COUNTY: BASELINE DIFFERENCES BETWEEN FAMILIES RANDOMIZED INTO THE INTERVENTION AND FAMILIES WHO WERE NOT RANDOMIZED									
	RANDOMIZED			NOT RANDOMIZED			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	*t*	*df*	*p*
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	102	4.10	1.06	811	4.38	0.86	3.03	911	0.003
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	102	2.99	1.42	803	2.40	1.39	-4.00	903	<0.001
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	102	3.36	1.26	803	2.66	1.36	-4.94	903	<0.001
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	99	2.81	1.45	783	2.36	1.51	-2.82	880	0.005
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	101	3.97	0.92	813	4.23	0.87	2.82	912	0.005
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	101	1.52	0.87	812	1.34	0.78	-2.26	911	0.024
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	101	6.04	1.65	808	6.40	1.20	2.73	907	0.007
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	102	4.23	1.15	808	4.58	0.92	3.55	908	<0.001

Table 6.11. Cook County: Baseline Differences Between Families Randomized into the Comparison Group and TARGET Participants

COOK: BASELINE DIFFERENCES BETWEEN COMPARISON GROUP AND TARGET PARTICIPANTS									
	COMPARISON GROUP			TARGET PARTICIPANTS			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	*t*	*df*	*p*
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	65	4.03	1.15	37	4.22	0.89	0.85	100	0.397
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	65	2.86	1.47	37	3.22	1.32	1.22	100	0.226
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	65	3.32	1.34	37	3.43	1.12	0.42	100	0.675
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	63	2.76	1.48	36	2.89	1.43	0.42	97	0.678
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	64	3.94	0.99	37	4.03	0.80	0.47	99	0.640
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	64	1.56	0.96	37	1.46	0.69	-0.57	99	0.568
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	64	5.98	1.74	37	6.14	1.51	0.44	99	0.661
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	65	4.34	1.09	37	4.03	1.24	-1.32	100	0.190

Table 6.12. Central Region: Baseline Differences Between Families Assigned to the Comparison and Intervention Groups

CENTRAL: BASELINE DIFFERENCES BETWEEN COMPARISON AND INTERVENTION GROUP									
	COMPARISON GROUP			ALL INTERVENTION GROUP			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	*t*	*df*	*p*
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	212	4.18	0.93	247	4.15	0.98	0.33	457	0.742
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	211	2.46	1.25	244	2.61	1.33	-1.20	453	0.231
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	210	3.15	1.33	246	3.17	1.26	-0.22	454	0.823
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	211	2.36	1.33	246	2.47	1.44	-0.89	455	0.374
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	210	4.24	0.89	248	4.16	1.02	0.90	456	0.370
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	213	1.29	0.78	249	1.31	0.78	-0.19	460	0.846
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	212	6.15	1.58	247	6.02	1.68	0.85	457	0.396
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	213	4.60	0.94	249	4.55	0.85	0.50	460	0.614

Table 6.13. Central Region: Baseline Differences Between Families Randomized into the Comparison Group and TARGET Participants

CENTRAL: BASELINE DIFFERENCES BETWEEN FULL C AND PARTICIPANTS									
	COMPARISON			TARGET PARTICIPANTS			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	*t*	*df*	*p*
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	212	4.18	0.93	42	3.81	1.06	2.30	252	0.022
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	211	2.46	1.25	41	2.98	1.33	-2.36	250	0.019
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	210	3.15	1.33	42	3.45	1.27	-1.36	250	0.174
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	211	2.36	1.33	42	2.67	1.44	-1.37	251	0.173
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	210	4.24	0.89	42	3.88	1.09	2.28	250	0.023
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	213	1.29	0.78	42	1.45	0.97	-1.18	253	0.240
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	212	6.15	1.58	42	5.36	1.95	2.84	252	0.005
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	213	4.60	0.94	42	4.62	0.85	-0.15	253	0.884

Table 6.14. Central Region: Baseline Comparisons Within the Intervention Group

CENTRAL: WITHIN INTERVENTION GROUP (NON-PARTICIPANTS VS FULL PARTICIPANTS)									
	NON-PARTICIPANTS			TARGET PARTICIPANTS			BASELINE DIFFERENCES WITHIN INTERVENTION		
	N	M	SD	N	M	SD	*t*	*df*	*p*
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	205	4.22	0.95	42	3.81	1.06	2.5	245	0.013
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	203	2.54	1.32	41	2.98	1.33	-1.93	242	0.055
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	204	3.12	1.25	42	3.45	1.27	-1.57	244	0.117
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	204	2.43	1.44	42	2.67	1.44	-0.96	244	0.336
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	206	4.21	0.99	42	3.88	1.09	1.95	246	0.053
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	207	1.28	0.74	42	1.45	0.97	-1.33	247	0.183
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	205	6.15	1.60	42	5.36	1.95	2.82	245	0.005
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	207	4.54	0.85	42	4.62	0.85	-0.54	247	0.589

Table 6.15. Cook County Outcomes

COOK COUNTY	INTERVENTION PARTICIPANTS					COMPARISON GROUP							
MEASURE	**N**	**M**	**SD**	**MIN**	**MAX**	**N**	**M**	**SD**	**MIN**	**MAX**	***t***	***df***	***p***
BEHAVIORAL ISSUES													
BEHAVIORAL PROBLEM INDEX	32	15.92	12.31	0	43	42	14.44	11.89	0	43	0.89	106	0.375
BPI - EXTERNALIZING	32	11.11	8.62	0	30	42	10.69	8.57	0	32	0.74	106	0.463
BPI - INTERNALIZING	32	5.44	5.11	0	17	42	4.44	4.50	0	16	0.98	106	0.331
CAREGIVER STRAIN													
CAREGIVER STRAIN (CS)	32	2.07	0.77	1	4	46	1.99	0.86	1	5	0.53	108	0.599
CS - OBJECTIVE STRAIN	32	1.90	0.96	1	4	46	1.68	0.90	1	4	1.3	108	0.195
CS - SUBJECTIVE STRAIN	32	2.21	0.73	1	4	46	2.25	0.92	1	5	-0.27	108	0.791
CAREGIVER COMMITMENT													
BEST-AG	32	93.84	5.09	81	100	46	93.26	6.87	74	100	-0.5	111	0.617
BEST-AG EMOTIONAL SECURITY	32	59.56	4.13	49	65	46	59.74	4.74	47	65	-0.72	111	0.476
BEST-AG CLAIMING	32	34.28	1.51	28	35	46	33.52	2.62	23	35	0.01	111	0.993
MEASURE	**N**	**%**				**N**	**%**				***χ2***	***df***	***p***
SCHOOL-RELATED OUTCOMES													
HAVE CUT CLASSES AT SCHOOL	5	16%				15	33%				2.56	1	0.110
HAVE BEEN SUSPENDED FROM SCHOOL	5	16%				16	35%				3.25	1	0.072
HAVE BEEN EXPELLED FROM SCHOOL	3	10%				5	11%				0.50	1	0.479

Table 6.16. Central Region Outcomes

CENTRAL REGION	INTERVENTION PARTICIPANTS					COMPARISON GROUP							
MEASURE	**N**	**M**	**SD**	**MIN**	**MAX**	**N**	**M**	**SD**	**MIN**	**MAX**	***t***	***df***	***p***
BEHAVIORAL ISSUES													
BEHAVIORAL PROBLEM INDEX	48	16.22	11.04	0	42	276	13.74	11.97	0	50	1.34	322	0.180
BPI - EXTERNALIZING	48	11.71	8.27	0	34	276	10.29	8.92	0	38	1.03	322	0.305
BPI - INTERNALIZING	48	5.33	3.67	0	15	276	4.08	3.96	0	19	2.04	322	0.043
CAREGIVER STRAIN													
CAREGIVER STRAIN (CS)	47	2.07	0.75	1	4	272	1.80	0.79	1	5	2.14	317	0.033
CS - OBJECTIVE STRAIN	47	1.86	0.80	1	4	272	1.61	0.84	1	5	1.9	317	0.059
CS - SUBJECTIVE STRAIN	47	2.24	0.80	1	4	272	1.97	0.81	1	5	2.17	317	0.030
CAREGIVER COMMITMENT													
BEST-AG	48	93.06	7.64	58	100	278	93.43	9.48	27	100	-0.26	324	0.797
BEST-AG EMOTIONAL SECURITY	48	59.23	6.11	33	65	278	59.87	6.65	16	65	-0.63	324	0.532
BEST-AG CLAIMING	48	33.83	2.02	25	35	278	33.56	3.22	11	35	0.57	324	0.572
MEASURE	**N**	**%**				**N**	**%**				***χ2***	***df***	***p***
SCHOOL-RELATED OUTCOMES													
HAVE CUT CLASSES AT SCHOOL	1	2%				25	9%				2.73	1	0.099
HAVE BEEN SUSPENDED FROM SCHOOL	6	13%				61	22%				2.25	1	0.133
HAVE BEEN EXPELLED FROM SCHOOL	1	2%				6	2%				0.00	1	0.960

The results of propensity score matching, shown in Table 6.17, indicated no statistically significant Average Treatment Effects (ATE). The ATE's were estimated as mean differences between intervention and comparison groups for each outcome. Intervention and comparison groups were matched using four caregiver commitment and relationship questions measured at pretest[3]. The initial matched data set contained 82 matched cases (41 intervention and 41 comparison), but only 62 of these cases (32 intervention and 30 comparison) were available for the analyses due to some cases missing data on the outcomes.

Table 6.17. Central Region: Comparison of Outcomes for TARGET Participants and Comparison Groups: Average Treatment Effect

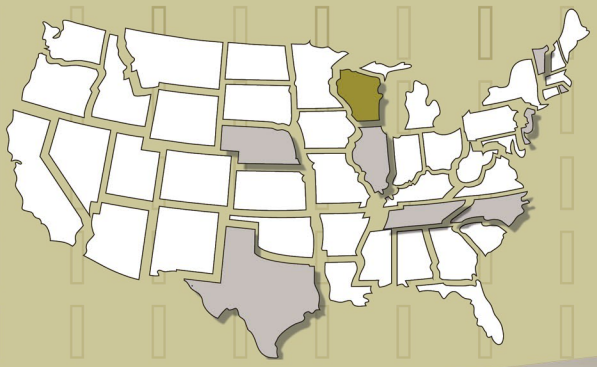
CENTRAL REGION: COMPARISON OF OUTCOMES FOR TARGET PARTICIPANTS AND COMPARISON GROUPS A:					
OUTCOMES	AVERAGE TREATMENT EFFECT (ATE) B			*t*	*p*
	ATE	95% CI			
BEHAVIORAL PROBLEM INDEX (BPI)	-3.48	-8.88	1.92	-1.29	0.202
BPI - INTERNALIZING	-1.21	-3.04	0.61	-1.33	0.189
BPI - EXTERNALIZING	-2.39	-6.41	1.63	-1.19	0.240
BEST-AG	0.80	-4.05	5.65	0.33	0.743
BEST-AG CLAIMING	0.28	-1.04	1.59	0.42	0.676
BEST-AG EMOTIONAL SECURITY	0.52	-3.17	4.22	0.28	0.778
CAREGIVER STRAIN (CS)	-0.21	-0.61	0.18	-1.10	0.276
CS - SUBJECTIVE STRAIN	-0.21	-0.65	0.23	-0.96	0.340
CS - OBJECTIVE STRAIN	-0.22	-0.62	0.17	-1.12	0.268

Notes:
[a] Nearest neighbor within-caliper matching, with the logit used as the propensity score, and caliper = .25 * standard deviation
[b] ATE = Mean (Comparison Group) – Mean (Intervention Group)

[3] The four questions used for matching were: (1) Which phrase best describes your relationship with your child? [Responses on a 5-point scale from 'not at all warm' to 'extremely warm'], (2) How often have you or your significant other struggled to effectively manage your child's behavior in the last 30 days? [Responses on a 5-point scale from 'never' to 'every day'], (3) How confident are you that you can meet your child's needs? [Responses on a 5-point scale from 'not at all confident' to 'extremely confident'], and (4) Overall, how would you rate the impact of your child's adoption or guardianship on your family? [responses on a 7-point scale from 'extremely' negative to 'extremely positive'])

Evaluation Results from

Wisconsin



Final Evaluation Report

September 2019

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

This report was designed by staff at the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work. We thank them for their partnership and dedication to the work of translational research.

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

Report Authors

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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

Joan Blakey, PhD | Associate Dean of Academic Affairs
School of Social Work
Tulane University

Lixia Zhang, PhD | Assistant Professor
University of Northern Iowa
Department of Social Work

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

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

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

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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

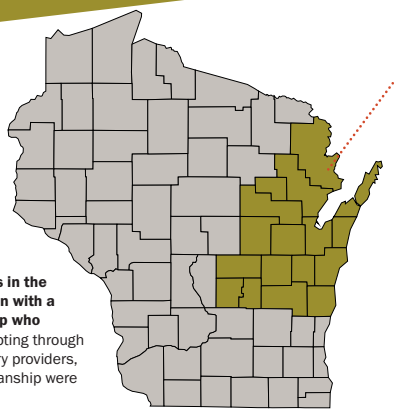
Indicated

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

77 FAMILIES CALLED → **42** SCREENED IN → **32** FAMILIES SERVED ☑

COMMON ISSUES

89% complicated mental health and medical issues

89% difficulty managing child's behaviors

65% children were struggling in school

62% experienced caregiver burnout

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 Child & Family Wellbeing Steve Hicks School of Social Work

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Jack, Joseph and Morton Mandel School of Applied Social Sciences Case Western Reserve University

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

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

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

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

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Executive Summary

Overview

The 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 7

WISCONSIN: ADOPTION AND GUARDIANSHIP ENHANCED SUPPORT (AGES)

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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.

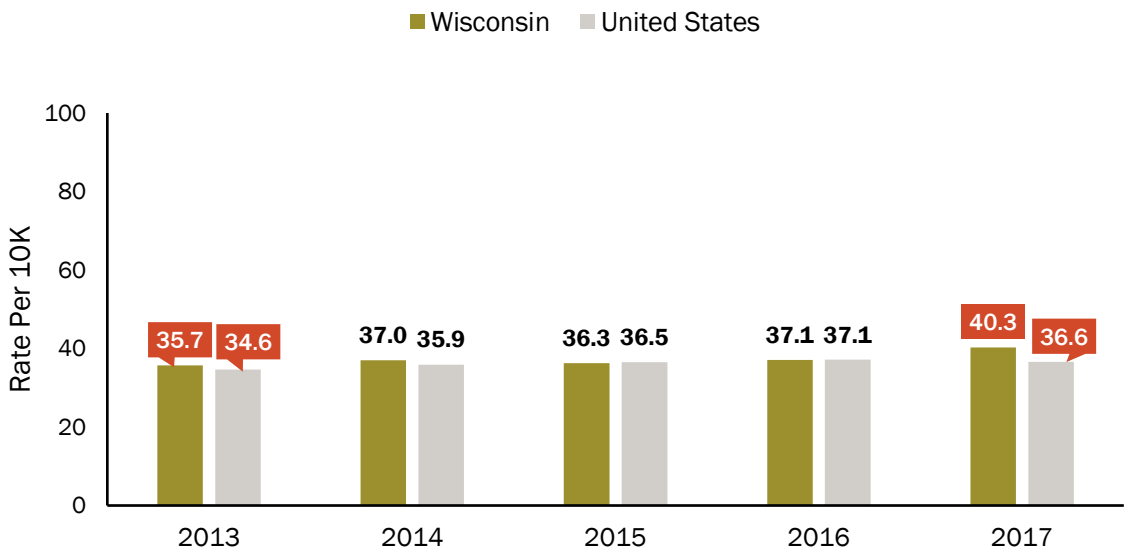
The QIC-AG project in Wisconsin had strong buy-in from the DCF leadership team, including the Division Administrator and Bureau Director and also from the local county and tribal leaders in the Northeastern Region. Three teams, the Project Management Team (PMT), the Stakeholder Advisory Team (SAT) and 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 site 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 rate[1] 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)

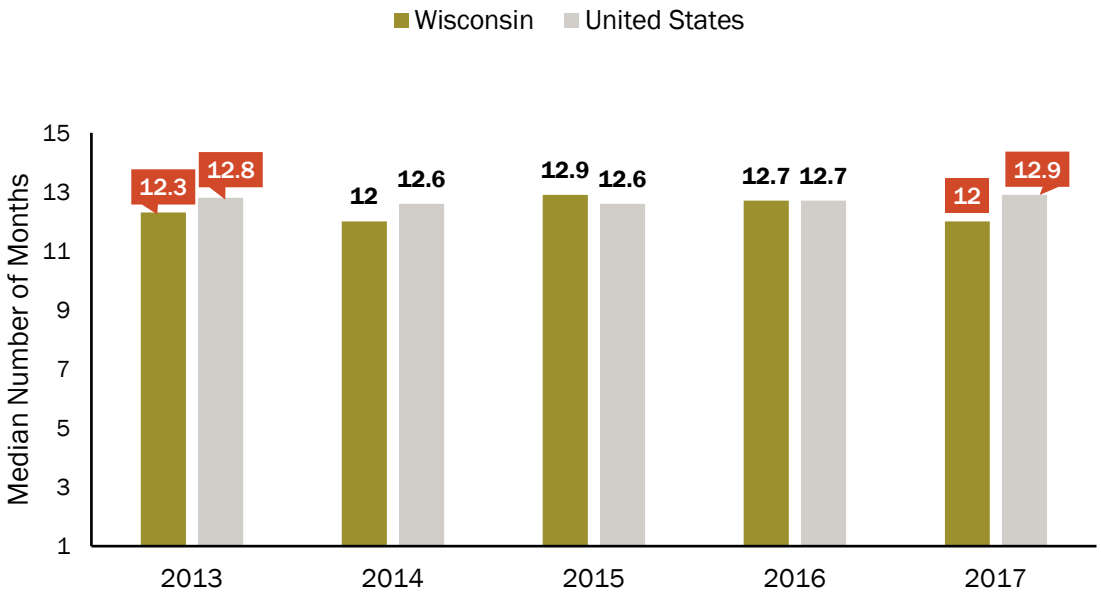


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https:/cwoutcomes.acf.hhs.gov/cwodatasite/

[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.

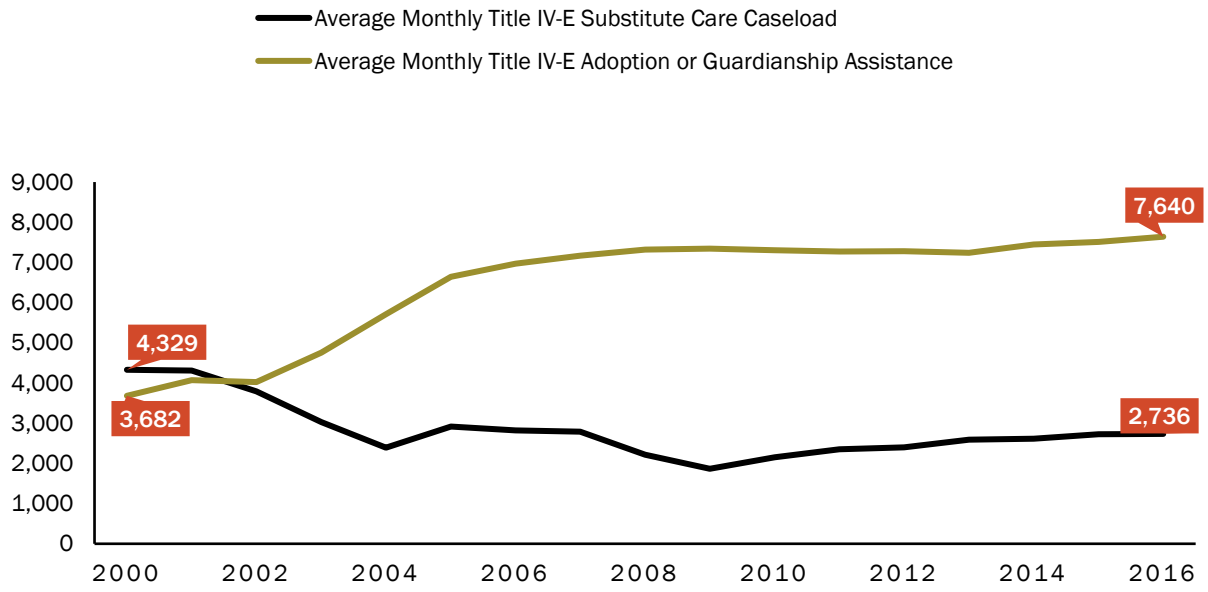
Figure 7.2. Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)



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



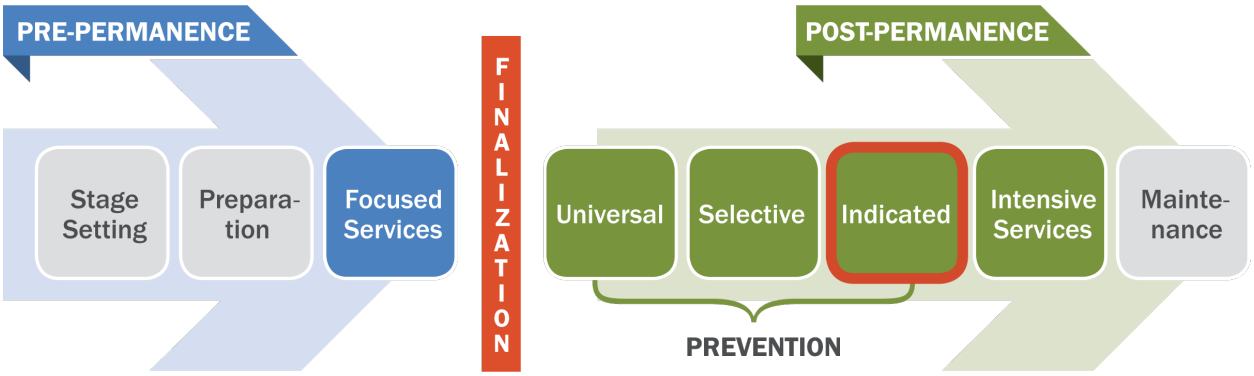
Data sources: Title IV-E numbers: U. S. Department of Health and Human Services / Administration for Children and Families, compiled data from states' Title IV-E Programs Quarterly Financial Reports, Forms IV-E-1 (for years prior to 2011) and CB-496 (for 2011 and later).

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

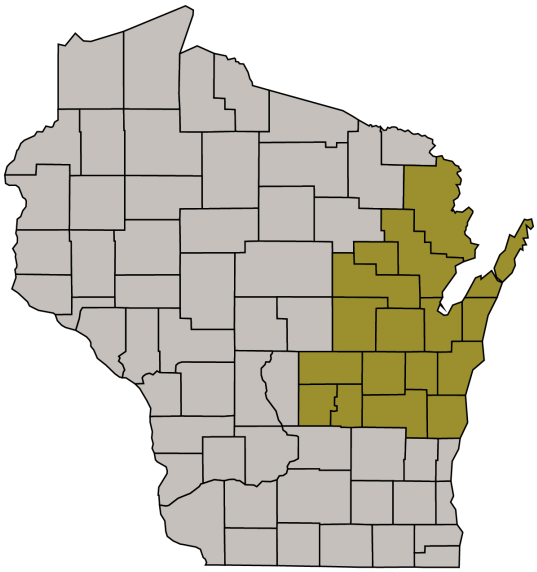
The well-built research question using the Population, Intervention, Comparison Group, Outcome (PICO) framework (Richardson, Wilson, Nishikawa & Hayward, 1995; Testa & Poertner, 2010) was:

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?

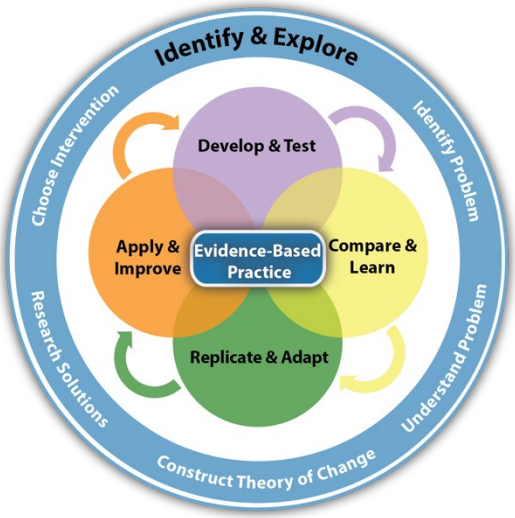
Each component of the PICO is described below. For Wisconsin, a pre-post test design was originally planned, but this had to be changed to a descriptive study only, in the **Develop and Test** phase of evidence-building.

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.



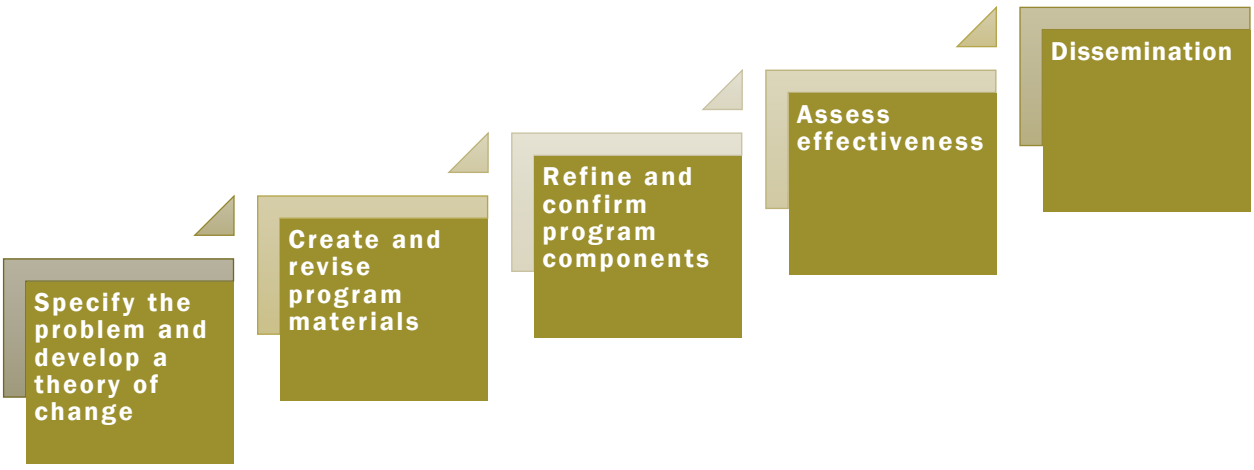
Intervention



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

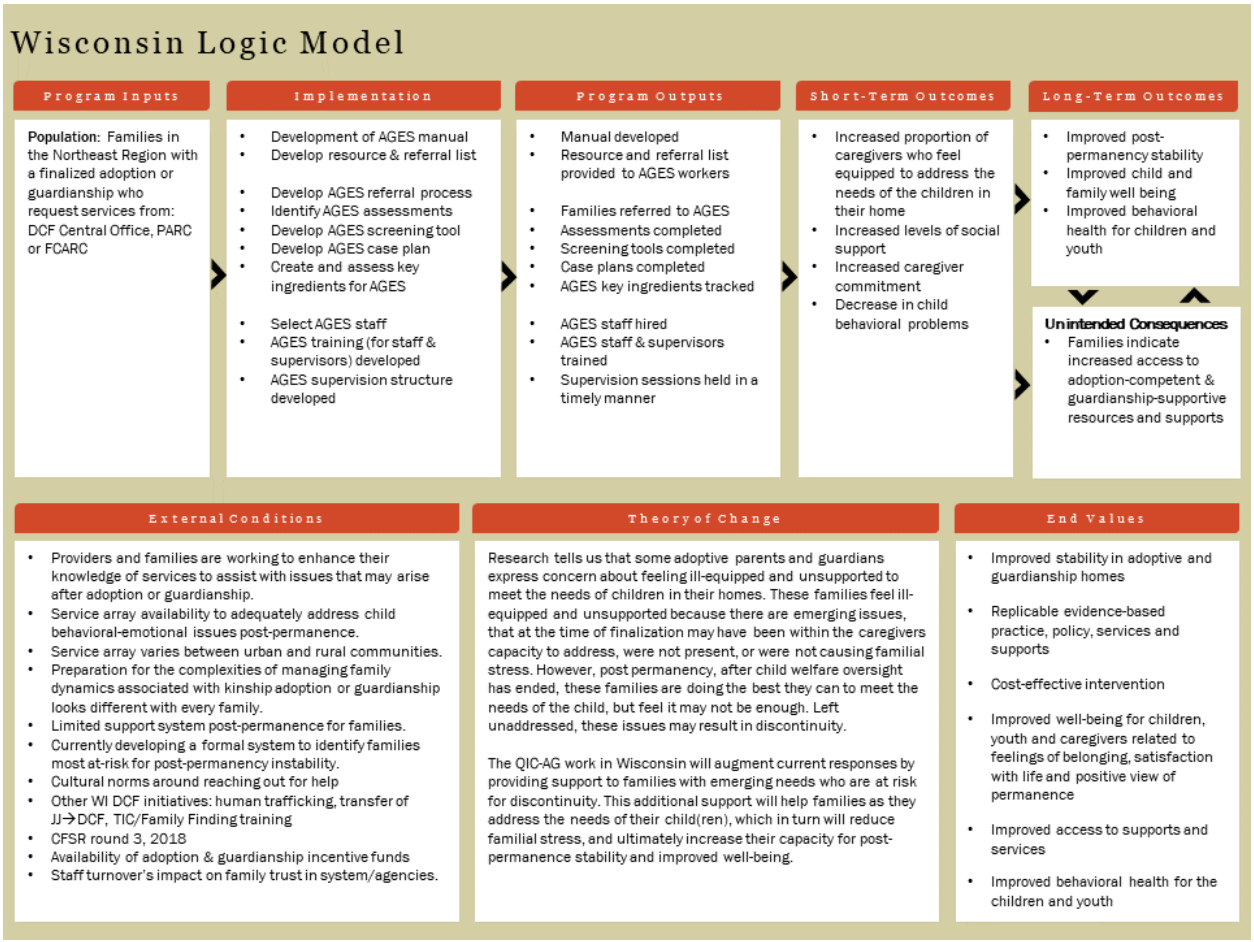
The project's long-term outcomes, set *a priori* by the funder were:

- 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 measures 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 AGES[2], the calls came from the following sources.

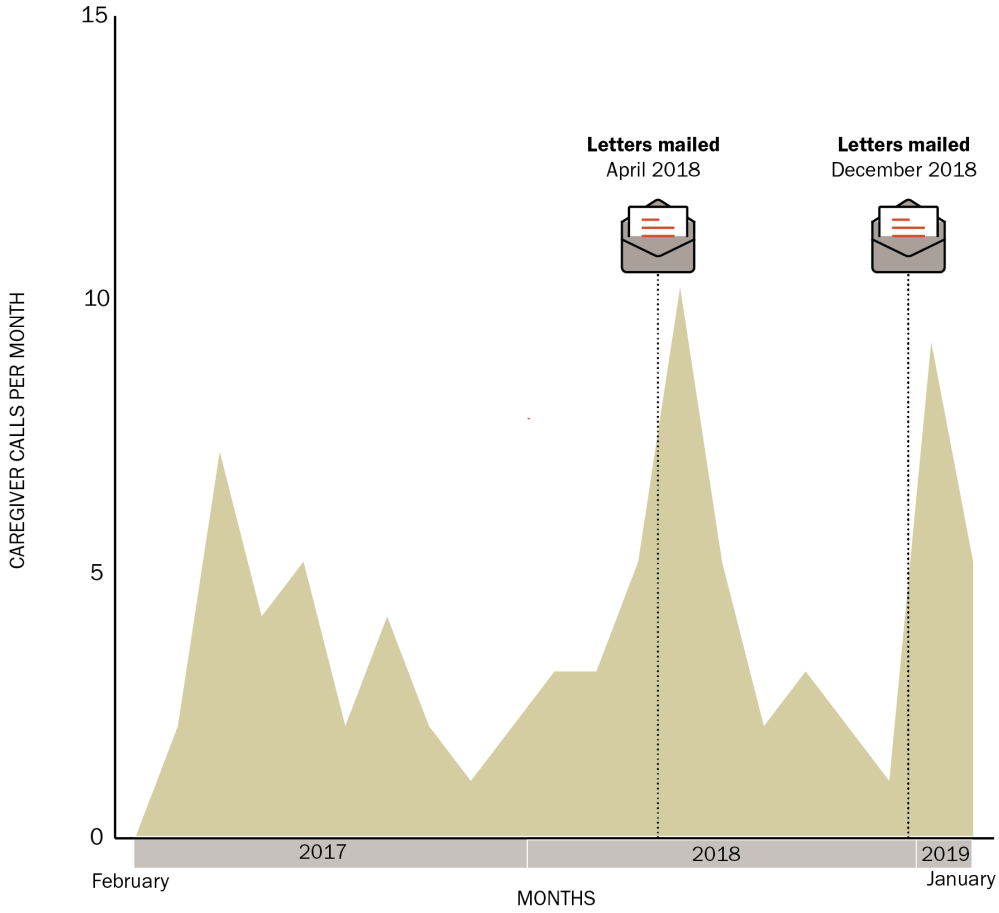
- 73% (56) PARC
- 22% (17) DCF Central Office
- 5% (4) FCARC

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.

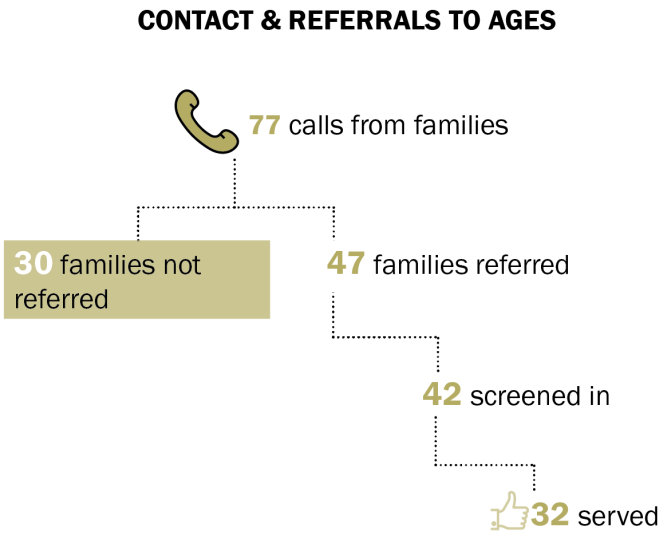
Figure 7.7. AGES Project Timeline



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.

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 evaluation[3].

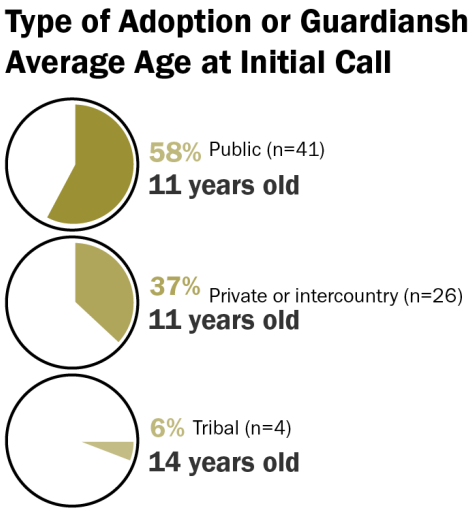
Figure 7.8. AGES Project Case Flow



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



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 keys steps were tracked and are reported below. This summary is based on the records of the 25 families served by AGES *after usability* when times 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.

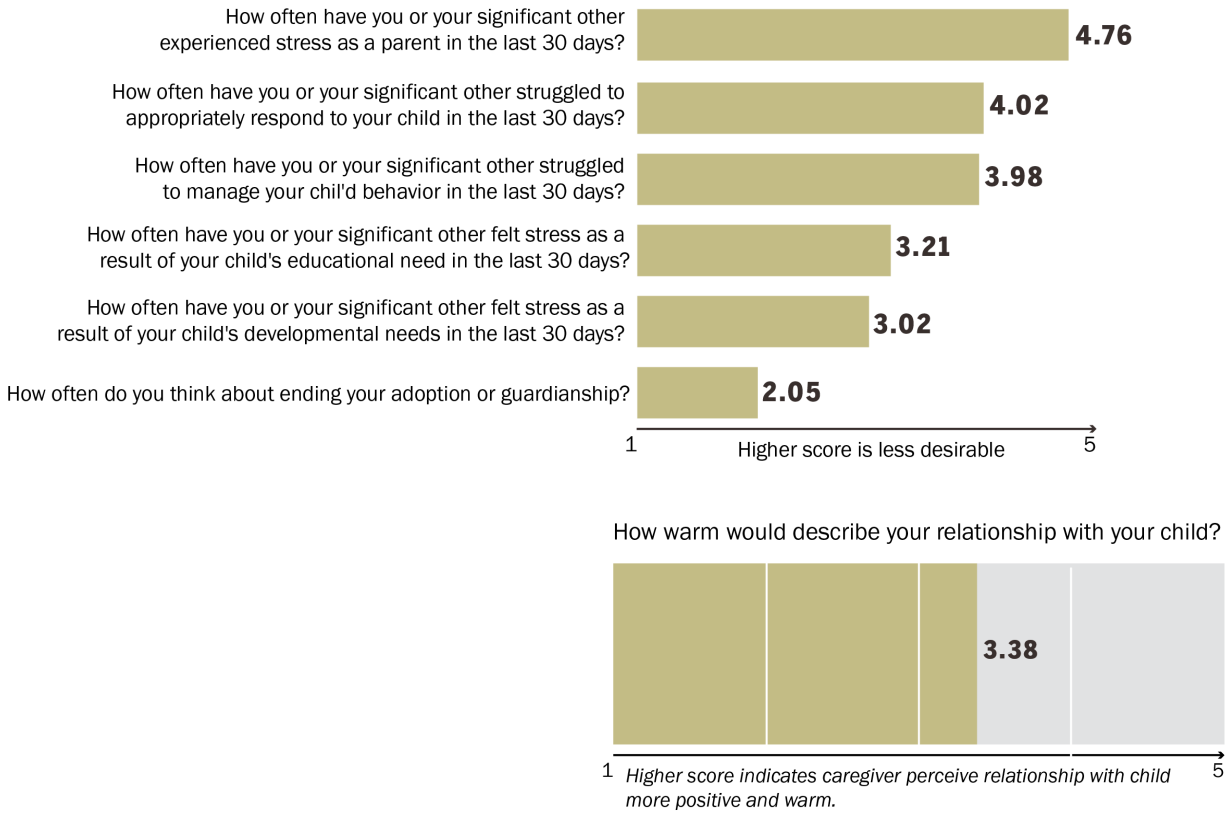
- Assessment phase: While it was initially thought that this would take 30 days, on average, it took 33.21 days, and in some cases, the process took up to 60 days.
- Support planning phase: The goal was 45 days, yet this took, on average, 52 days, and up to 101 days.
- Time to reassessment: The goal 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

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
ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN						
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
ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN						
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

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

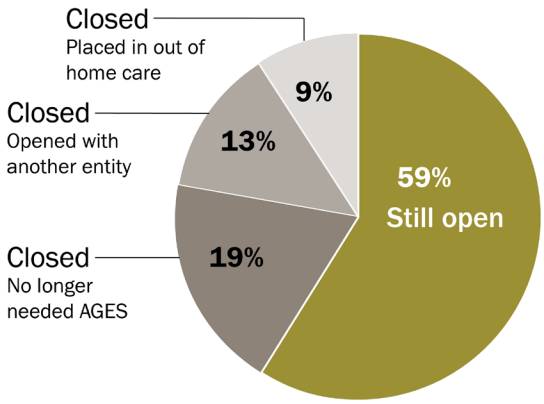
The third theme that ran through the cases was AGES workers being direct and candid not only with family members but also with other service providers. According to the notes, workers wrote that they communicated with families honestly and directly albeit in a gentle manner. For example, one adoptive 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 workd 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.

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.

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 $763,661and 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 $763,661and 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 keys 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 are 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.

References

Brannan, A. M., Helfinger, C. A. & Bickman, L. (1997). The caregiver strain questionnaire: Measuring the impact of the family of living with a child with a serious emotional disturbance. *Journal of Emotional and Behavioral Disorders*, 5(4), 212-222.

Broadhead, W. E., Gehlbach, S. H., DeGruy, F. V., & Kaplan, B. H. (1988). The Duke-UNC Functional Social Support Questionnaire: Measurement of social support in family medicine patients. *Medical Care*, 26(7), 709-23. This citation is not written correctly in the text.

Calculating the Costs of Child Welfare Services Workgroup. (2013). *Cost analysis in program evaluation: A guide for child welfare researchers and service providers*. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2015). Types of Evaluation. Retrieved from https://www.cdc.gov/std/Program/pupestd/Types%20of%20Evaluation.pdf

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage

Child Welfare Information Gateway. (2012). *Providing postadoption services*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway (2018). *Finding and working with adoption-competent therapists*. Retrieved at https://www.childwelfare.gov/pubPDFs/f_therapist.pdf

Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration. (1993). *Feasibility, Alternatives, And Cost/Benefit Analysis Guide*. Washington DC. Retrieved from http://archive.acf.hhs.gov/programs/cb/systems/sacwis/cbaguide/c1intro.htm

Eaves, Y. D. (2001). A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing*, 35(5), 654-663.

Faulkner, M., Adkins, T., Fong, R., & Rolock, N. (2017). *Promoting permanency in adoption: A review of the literature*. Southfield, MI: Quality Improvement Center for Adoption & Guardianship Support and Preservation and Spaulding for Children.

Font, S., Berger, L., Cancian, M., & Noyes, J. (2018). Permanency and the educational and economic attainment of former children in early adulthood. *American Sociological Review, 83,* 716-743. https://doi.org/10.1177/0003122418781791

Framework Workgroup. *A framework to design, test, spread, and sustain effective practice in child welfare.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Fraser, M. W., Richman, J. M., Galinsky, M. J., & Day, S. H. (2009). *Intervention research: Developing social programs*. New York, NY: Oxford University Press.

Frey, L., Cushing, G., Freundlich, M., & Brenner, E. (2008). Achieving permanency for youth in foster care: Assessing and strengthening emotional security. *Child & Family Social Work, 13,* 218-226. doi: 10.1111/j.1365-2206.2007.00539.x

Meunnig, P. (2002). *Designing and conducting cost-effectiveness analyses in medicine and health care*. San Francisco: Jossey-Bass.

Peterson, J. L. & Zill, N. (1986). Marital disruption, parent child relationships, and behavioral problems in children. *Journal of Marriage and the Family*, 48, 295-308.

Richardson, W., Wilson, M., Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. ACP Journal Club, 123(3), A12.

Testa, M.F., & Poertner, J. (Eds.). (2010). Fostering accountability: Using evidence to guide and improve child welfare policy. New York, NY: Oxford University Press.

United States Census Bureau (2017). Retrieved from https://www.census.gov

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/

United States Department of Health and Human Services, Administration for Children and Families, compiled data from states' Title IV-E Programs Quarterly Financial Reports, Form CB-496.

Wisconsin Annual Progress and Services Report June 30, 2017. Retrieved from https://dcf.wisconsin.gov/files/cqi-cfsr/pdf/plans/apsr18.pdf

Wisconsin Department of Family and Children. Retrieved from https://dcf.wisconsin.gov/

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
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.
DIFFICULTY IN MANAGING BEHAVIORS
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.
PROBLEMS AT SCHOOL
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.
CAREGIVER FATIGUE OR BURNOUT
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.
DEVELOPMENTAL ISSUES
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.
OTHER ISSUES
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.

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.

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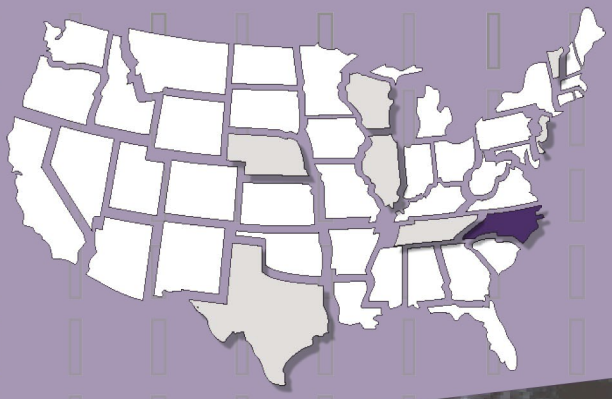
Evaluation Results from

Catawba County, NC



Final Evaluation Report

September 2019

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

This report was designed by staff at the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work. We thank them for their partnership and dedication to the work of translational research.

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

Report Authors

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

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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

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

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

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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 of the Catawba County Social Services, 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.

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Evaluation Results from Catawba County, NC

PROJECT PARTNERS

QIC-AG partnered with **Catawba County Social Services.**

CONTINUUM PHASE

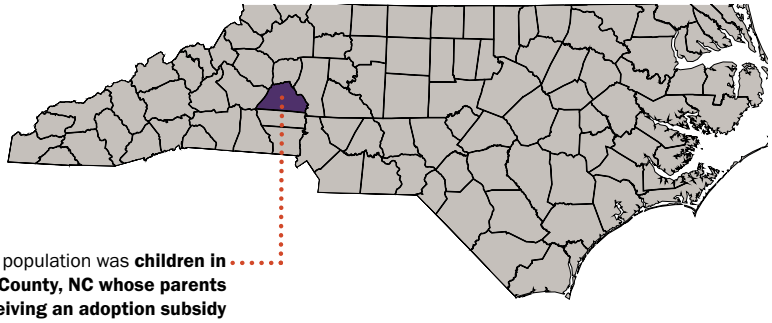
Indicated

INTERVENTION

Reach for Success is a proactive outreach program which aims to increase post-adoption engagement with Success Coach Services, which are designed to improve wellbeing and prevent adopted youth from re-experiencing foster care. The intervention was comprised of a survey to assess risk, followed by proactive outreach to families.

STUDY DESIGN

Experimental



The target population was **children in Catawba County, NC whose parents were receiving an adoption subsidy** and were subsequently identified for outreach.

RESEARCH QUESTION

Will the target population who receive Reach for Success experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health as compared to children who do not receive the additional Reach for Success outreach?

Findings

DEMOGRAPHICS

Snapshot of Survey Respondents' Target Child:

- **75%** white
- **58%** female
- **69%** parents were married
- Average age at permanence: **6.18 years old**
- Average time in foster care: **1.97 years**

OUTREACH

- **240** families were sent surveys
- **128** took the survey
- **94** designated for outreach
- **39** successfully contacted
  - **37** high score
  - **57** low score
- **3** participated in Success Coach services
  - **2** high score
  - **1** low score

Score groups are based on survey responses about service needs and parental assessments of their child's behavioral issues. The survey results supported the classification of families into high and low-score groups with high-score families having higher scores on the Behavioral Problem Index (BPI), and could be a useful way to identify families in need.

128 FAMILIES RESPONDED

OVERALL, FAMILIES ARE THRIVING!

- **94%** of caregivers said they never thought about ending adoption or guardianship
- **71%** said that adoption/guardianship had an extremely positive impact on their family
- **35%** identified services their family needed (mental health, specialized medical or dental care, educational supports, and child developmental services)
- only **10%** reported youth experienced negative school and legal outcomes.

RECOMMENDATION

A small, but significant proportion of families reported unmet needs. Perhaps with additional time, families may contact the Success Coach program for services. CCSS should continue to track families over the next few years to see if families identified for additional outreach end up requesting services. In addition, it may be beneficial if CCSS would follow up with families 1-2 years after finalization to determine if they have any unmet needs and introduce them to services.

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

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Jack, Joseph and Morton Mandel School of Applied Social Sciences Case Western Reserve University

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

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

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

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

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Executive Summary

Overview

North Carolina is a county-administered, state-supervised child welfare system. The North Carolina Department of Health and Human Services (NCDHHS) encourages counties across the state to identify emerging best practices that strengthen families and stabilize placements in child welfare. In that spirit, the Catawba County Social Services (CCSS), in partnership with The Duke Endowment, established the Child Wellbeing Project. The Child Wellbeing Project originally created an intervention, the Success Coach program, to support post reunification stability in reunified families. However, Success Coach services were later expanded to address the needs of families who had adopted children through the foster care system. Specifically, Success Coach services were designed to address concerns that current services to families who had adopted children through the foster care system might not be sufficient to prevent youth from reentering state care (Wilson, Brandes, Ball, & Malm, 2012).

In 2010, Success Coach services were made available to all families in Catawba County formed through adoption. Success Coach Services included mentors, or Success Coaches, who engaged with families and provided in-depth assessments; case management; skill-building training; service coordination; advocacy; educational support; and referrals to other support services including mental health services.

Despite the initial promising results of Success Coach services in Catawba County, staff reported that by the time many families called to request services, the families were already in crisis. The CCSS staff felt they were missing the opportunity to proactively serve and intervene early with adoptive families who were either unaware of the support services available or reluctant to initiate contact with CCSS. Their idea was that if services were offered to families through direct, proactive outreach, then these previously unidentified families would receive the services that they needed. Given the need to reach out to families in a different manner, the National Quality Improvement Center for Adoption and Guardianship Support (QIC-AG) in conjunction with CCSS embarked upon a process for developing an outreach program, named *Reach for Success*, to increase post adoption engagement with Success Coach services. *Reach for Success* was implemented at the Indicated Interval of the QIC-AG Permanency Continuum Framework

The Theory of Change for *Reach for Success* was that adoptive families may experience challenges, but not ask for support because they are unaware of the availability of services, unsure of how to access services, or are not comfortable asking for assistance. Through proactive outreach, adoptive families in need can become aware of available services and participate in services.

Intervention

Reach for Success is located in the **Develop and Test** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. Developed by the QIC-AG project, *Reach for Success* comprised two major components:

1) A survey sent to all adoptive families in order to identify those who reported significant child behavior problems or current service needs (i.e., a *high-score* group of families) and

2) Outreach to families identified for additional contact (i.e., Groups 1 and 3 below) to engage them in Success Coach services, with the goal of preventing post permanency difficulties.

The survey was sent to all adoptive families receiving a subsidy in Catawba County, which also allowed program staff to develop a profile of characteristics for all adopted youth and caregivers in the county who responded to the survey.

Primary Research Question

The primary research question in Catawba County was:

Will children in Catawba County whose parents are receiving an adoption subsidy and are subsequently identified for outreach who also receive *Reach for Success* experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health as compared to children who do not receive the additional *Reach for Success* outreach?

To answer this research question, a three-group experimental design was employed. After initial survey responses were received for each cohort of potential respondents, an algorithm was applied to survey responses to classify respondents into either a high-score group or a low-score group based on current family service needs and behavior issues of the focal child, which was the oldest adoptive child in the family. Higher scores on the Behavior Problems Index [BPI] reflected more child behavior issues for the focal child.

Once respondents were assigned to one of the two score groups (i.e., high-score or low-score), the high-score group was randomly assigned to either the *Reach for Success* outreach group or to a no outreach group (the comparison group). All low-score respondents were allocated to a third outreach group. Those assigned to the high-score outreach group or the low-score outreach group were offered the Success Coach Services, and those assigned to the high-score no outreach group were not. In summary, there were three groups for comparison:

- Group #1: High-score outreach group
- Group #2: High-score no outreach group
- Group #3: Low-score outreach group

This experimental design allowed the evaluation team to compare the intervention group of interest (Group #1) to two different comparison groups: one that was similar in risk but did not receive the outreach intervention (Group #2) and one that had lower risk than the intervention group but received the outreach intervention (Group #3). All families randomized into the comparison group could still access the Success Coach services if they requested the service or were referred by a professional (these were the services as usual).

Key Findings and Discussion

During the project period, 240 families in Catawba County were sent surveys. These 240 families represent all adoptive families who had not previously received Success Coach services in Catawba County. Of those 240 families, 128 (53%) completed and returned surveys.

FINDINGS FROM THE OUTREACH EFFORTS TO ENGAGE FAMILIES IN INTERVENTION:

- Of the 128 families who returned surveys, 94 were designated for outreach (57 in the low score group and 37 in the high-score outreach group)
- Of the 94 families designated for outreach, 39 parents were able to be contacted by CCSS (or 41% of those designated for outreach, with 23 contacted in the low-score group and 16 contacted in the high-score outreach group)
- A significant proportion of the 39 parents who were successfully contacted by CCSS were interested in either learning more about Success Coach services or receiving Success Coach services. Specifically, 21 of the 39 families (54%) who were successfully contacted through outreach were interested in either Success Coach information or services, with seven interested in services and 14 interested in information only.
- Of the seven families who were interested in services, three (43%) entered into a service agreement and actually participated in Success Coach services.
- Of the three families who entered into a service agreement for Success Coach services, two were from the low-score group and one was from the high-score group. It is important to note that with such a low uptake of Success Coach services, it is impossible to discern if low-score or high-score families were more likely to enter into a service agreement.
- Families who were contacted through outreach but declined services largely reported they did not need extra support.

In sum, this study did not find that the additional outreach to families resulted in additional uptake of Success Coach services. Furthermore, the low number of families who engaged in services does not allow us to sufficiently assess the impact of the algorithm to distinguish families who may be interested in services. Perhaps with additional time, CCSS will observe a different level of uptake based on the algorithm and additional analysis can be pursued to understand the characteristics of families in need of Success Coach services.

FINDINGS FROM THE SURVEY:

- The survey results indicated that most adoptive families were adjusting well to permanence. For example, a large majority of respondents said that they felt extremely positive about the impact of the adoption on their family (71%) and almost all respondents stated that they never thought about ending the adoption (94%). Regarding youth academic performance, most adopted children were reported to be doing “excellent” or “good” in both reading and math (72% and 66%, respectively).
- Only a small proportion of caregivers (10% or less of respondents) reported that youth experienced negative school and legal outcomes, such as in- or out-of-school suspension, skipping school, expulsions from school, runaway behavior, or legal and juvenile justice system involvement.

- In relation to the scales measuring child behavioral health and family wellbeing, the survey results supported the classification of families into high and low-score groups with high-score families who returned surveys (*n* = 71) having higher scores on the BPI than low-score families who returned surveys (*n* = 57). Results suggest that the instruments were effective indicators of child and family wellbeing and may be used to identify families at risk for post adoption difficulties and placement instability.
- Respondents were asked about an array of service needs, and if they were able to obtain the services they needed. Overall, less than 35% of respondents indicated that their family needed any of the services asked about the survey. The four most commonly reported services were: mental health, specialized medical or dental care, educational supports, and child developmental services. Most adoptive parents who tried to obtain services reported that they were successful and were typically happy with the services they received.

In sum, the purpose of outreach provided through *Reach for Success* was to engage more adoptive families in Success Coach services, particularly families who may be struggling with unmet service needs, difficult child behaviors, poor family cohesiveness, or other issues related to child and family wellbeing. Although *Reach for Success* was successful in contacting over half of the families eligible for outreach, and a little over a third of those contacted were interested in at least more information about Success Coach, less than 20% of those families contacted were interested in participating in the Success Coach program. It is important to note that most caregivers who did not want services reported that they were doing well and that they did not need or want additional services. Furthermore, families who had previously engaged with Success Coach services were excluded from this study. Low service uptake in *Reach for Success* may have occurred because Catawba County Social Services (CCSS) offers Success Coach services to all adoptive families at the time of finalization, and has a history of implementing proactive, innovative programs to prevent difficulties for adoptive families.

The findings of this study were consistent with previous post adoption literature, which indicates that most children and families adjust well after adoption from foster care, although a small but significant proportion of families (i.e., about 5-20%) also report unmet needs, child behavior problems, placement instability, and other issues, and might benefit from additional services (Rolock, 2015; Rolock & White, 2016; Rolock & White, 2017; White, 2016).

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.

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Chapter 8

CATAWBA COUNTY, NC: REACH FOR SUCCESS

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List of Figures & Tables

Site Background

North Carolina is a county-administered, state-supervised child-welfare system. The North Carolina Department of Health and Human Services (NCDHHS) encourages counties across the state to identify emerging best practices that strengthen families and stabilize placements in child welfare. In that spirit, the Catawba County Social Services (CCSS), in partnership with The Duke Endowment, established the Child Wellbeing Project. The Child Wellbeing Project originally created an intervention called the Success Coach program to support post reunification stability in reunified families. However, Success Coach services were later expanded to address the needs of families who had adopted children through the foster care system. Specifically, Success Coach services were designed to address concerns that current services to families who had adopted children through the foster care system might not be sufficient to prevent youth from reentering state care (Wilson, Brandes, Ball, & Malm, 2012).

In 2010, Success Coach services were made available to all families in Catawba County formed through adoption. Success Coach Services included mentors, or Success Coaches, who engaged with families and provided in-depth assessments; case management; skill-building training; service coordination; advocacy; educational support; and referrals to other support services including mental health services. Of the 72 adoptive families who actively participated in the Success Coach Service during this initial test of the program, 100% maintained permanent placement with no children re-entering foster care (CCSP, 2017).

Despite the initial promising results of Success Coach services in Catawba County, staff reported that by the time many families called to request services, the families were already in crisis. The CCSS staff felt they were missing the opportunity to proactively serve and intervene early with adoptive families who were either unaware of the support services available or reluctant to initiate contact with CCSS.

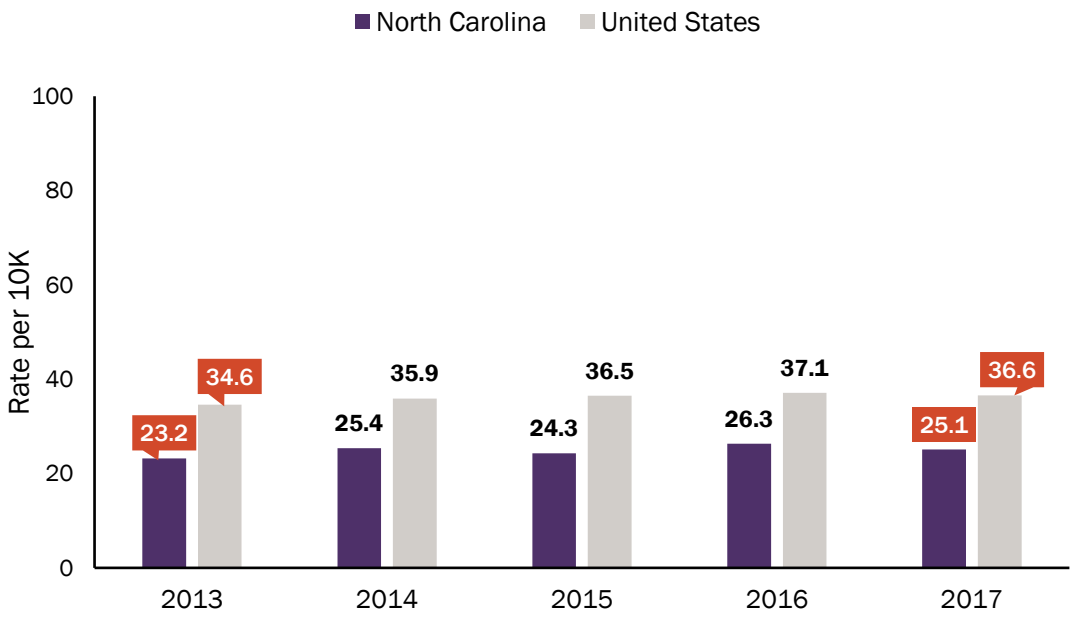
The Theory of Change in Catawba County suggested that adoptive families may experience challenges but not ask for post adoption support. Families may not ask for services because the families are unaware of the availability of post adoption services, are unsure how to access services, or are not comfortable asking for assistance. Thus, the idea behind *Reach for Success* was that through proactive outreach, families would become aware of available services, and those in need would participate in existing services.

National Data: Putting North Carolina in Context

The data in this section is provided to put North Carolina in context with national data. Through comparing data from North Carolina to that of the nation we are able to understand if North Carolina is a site that removes more or fewer children than the national average and compare the median lengths of stay of children in foster care in the state to the rest of the U.S. Finally, we also use data to understand the number of children receiving IV-E adoption or guardianship assistance over time (note that North Carolina did not adopt a guardianship assistance program [KinGAP] until 2017). All of these comparisons are provided over the past five years to give a sense of recent trends.

As displayed in Figure 8.1, between Fiscal Years 2013 and 2017, the rate[1] of children entering foster care in both North Carolina and the U.S. increased. Between 2013 and 2017, the state's foster care entry rate increased from 23.2 per 10K (5,300 children) to 25.1 per 10K (5,777 children). This per capita rate is lower than the per capita rates for the U.S. The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. In other words, fewer children, per capita, entered foster care in NC than in the US, although increases over the past five years occurred at both the state and national levels. As a point of comparison, the per capita rate for children entering foster care in Catawba County in 2016 was similar to the state rate and lower than the national rate. For example, in 2016, 25.8 per 10K children entered care in Catawba[2] (Fostering Court Improvement website, 2018).

Figure 8.1. North Carolina Foster Care Entry Per Capita Rate (2013-2017)



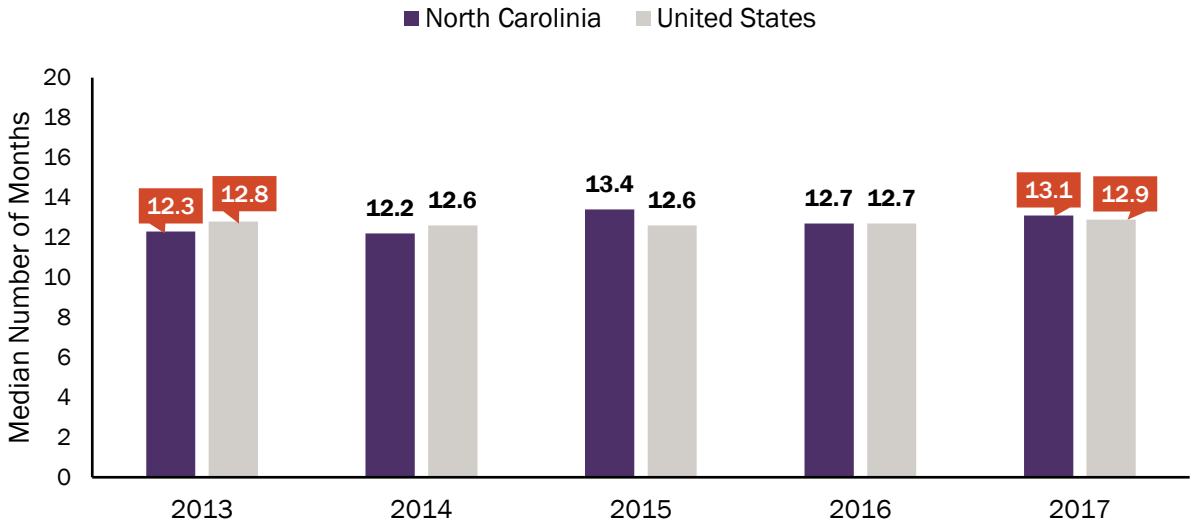
Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

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).

2 Data on Catawba County from 2016 is the most recent available to the evaluation team

Between 2013 and 2017, the median length of stay for children in foster care as of September 30th of each year (shown in Figure 8.2) was similar and fairly constant for both North Carolina and the U.S. The length of stay increased slightly in North Carolina from 12.3 months in 2013 to 13.1 months in 2017 while in the U.S. it increased slightly from 12.8 months in 2013 to 12.9 months in 2017. The median length of stay for children in care in 2016 Catawba County was 17.9 months[3], which was longer than the state or national rates (Fostering Court Improvement website, 2018).

Figure 8.2. North Carolina Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)

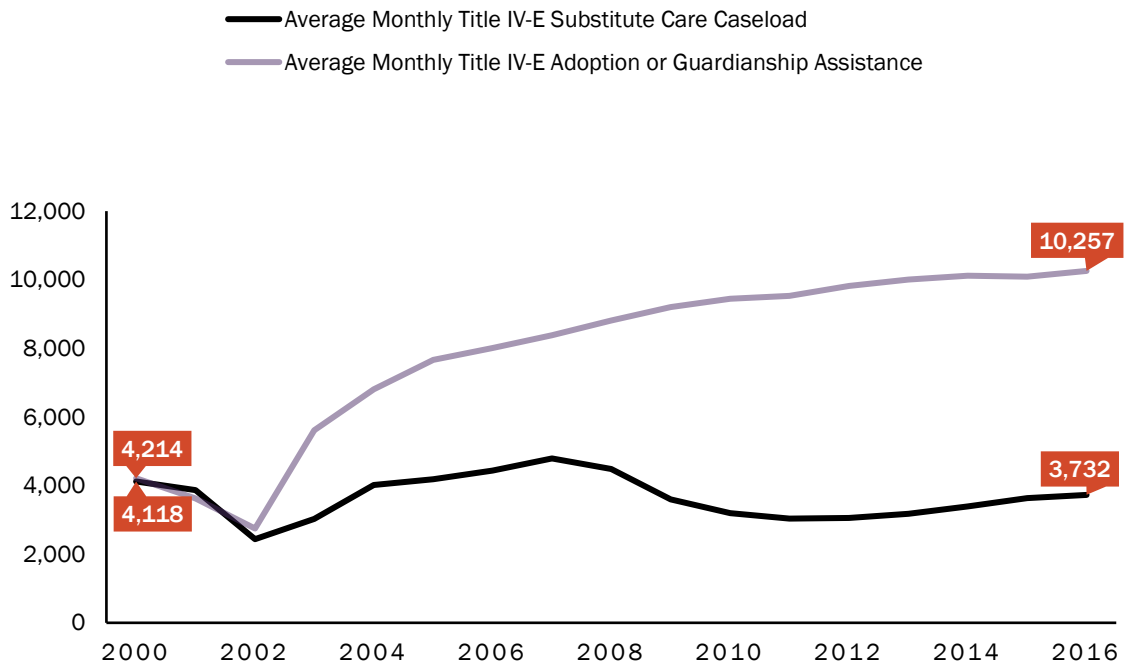


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/.

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 8.3, the number of children in North Carolina in IV-E funded foster care and the number of children in IV-E funded adoptive homes was approximately the same in 2000 (4,118 and 4,214 respectively), yet by 2016 these numbers had diverged. In 2016 there were 3,732 children in IV-E funded substitute care and 10,257 children in IV-E funded adoptive homes.

[3] Data on Catawba County from 2016 is the most recent available to the evaluation team

Figure 8.3. North Carolina 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).

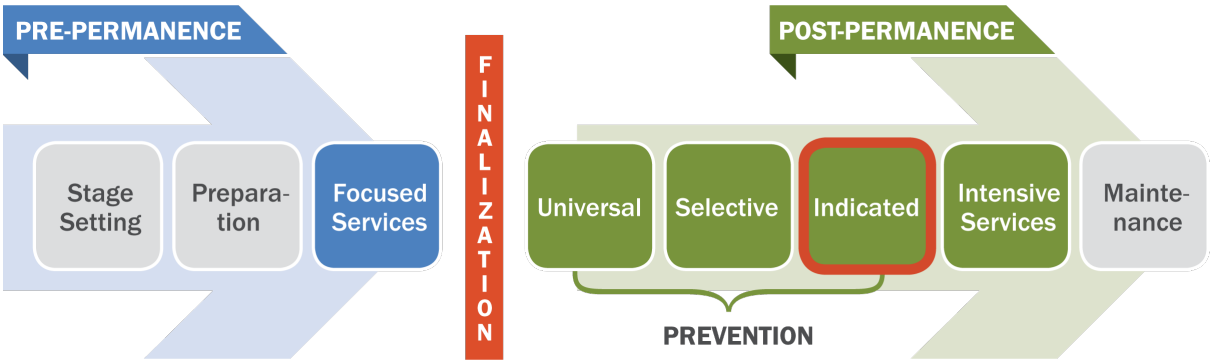
QIC-AG Permanency Continuum Interval

The Catawba County QIC-AG team focused its intervention efforts 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.

Reach for Success targeted services to families who were selected for additional outreach, including a group of families who were identified as potentially being at an elevated risk for post permanency discontinuity based on their responses to a post adoption survey.

Figure 8.4. QIC-AG Permanency Continuum-North Carolina



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:

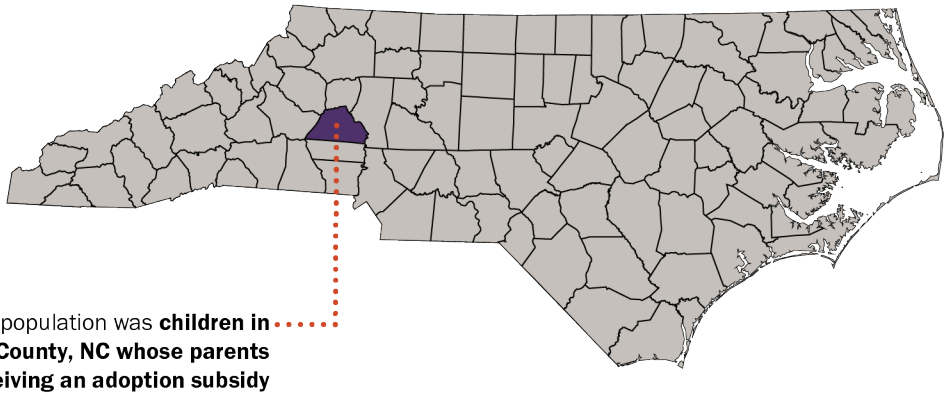
Will children in Catawba County whose parents are receiving an adoption subsidy and are subsequently identified for outreach (P) who receive *Reach for Success* (I) experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health (O) as compared to children who do not receive the additional *Reach for Success* outreach (C)?

Target Population

The target population for the Catawba County QIC-AG team included all the children in the county whose parents were receiving an adoption subsidy and were subsequently identified for outreach. Post permanency discontinuity refers to situations in which children leave their homes after adoption or guardianship, prior to becoming an adult (Rolock, 2015).

Children adopted through international or private domestic channels were also included in the Catawba County QIC-AG project. At the time the project began, Catawba County, North Carolina did not have a subsidy for guardianship, and thus, guardianship was not included as part of the target population. Also, adoptive families were excluded from the target population if: 1) children and youth were not currently residing in the home of their adoptive parent, 2) families had ever received Success Coach services.

Figure 8.5. Map of Catawba County, North Carolina



The target population was **children in Catawba County, NC whose parents were receiving an adoption subsidy** and were subsequently identified for outreach.

REACH FOR SUCCESS

In selecting *Reach for Success*, the QIC-AG site team followed the guidance of the National Implementation Research Network (NIRN). During this process, a search for possible interventions occurred. In their search of existing interventions, the Catawba County team did not find an existing intervention that addressed their Theory of Change. As such, the North Carolina QIC-AG team created the *Reach for Success* intervention. *Reach for Success* is located in the **Develop and Test** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. The **Develop and Test** phase should result in "a set of specific practices, program components, and intervention guidelines that do not require adjustment, have been defined well enough that others can replicate them, and show an initial improvement in outcomes that can most likely be traced to the intervention" (Framework Workgroup, p. 11).

In order to identify families most in need of support, *Reach for Success* was comprised of two components:

1) A survey sent to all adoptive families in order to develop a descriptive profile of adoptive families in Catawba County, as well as to identify families who reported significant child behavior problems or current service needs (a *high-score* group of respondents). In contrast, those families who responded to surveys but reported low/no child behavior problems and no current service needs were designated as the *low-score* group of respondents.

2) Outreach to families to engage them in Success Coach services, with the goal of preventing post permanency difficulties.

The Success Coach services aligned well with the values of both CCSS and NCDHHS in serving all families who needed post adoption support. CCSS hoped that early identification of, and outreach to, adoptive families would ultimately help families engage in services early (prior to a crisis) and ultimately prevent post permanency discontinuity.

Comparison

The main comparison group in *Reach for Success* for the group of high-score families who received outreach from CCSS (i.e. the intervention group) was high-score families who did not receive outreach. Higher risk for families was based on current family service needs and more behavior issues of the focal child in the home. An additional comparison group, low-score families who received outreach from CCSS, was also created by allocating all low-score families to receive outreach (see Figure 8.7). The evaluation design was modified after the usability evaluation to include outreach to low-score families because of low uptake among high-score families for the Success Coach intervention (see Methods below).

Outcomes

The primary outcome for the *Reach for Success* program was increased engagement in the Success Coach Program.

In addition, an analysis of survey responders vs. non-responders was examined. Survey results were used to describe the characteristics of adoptive families in Catawba County.

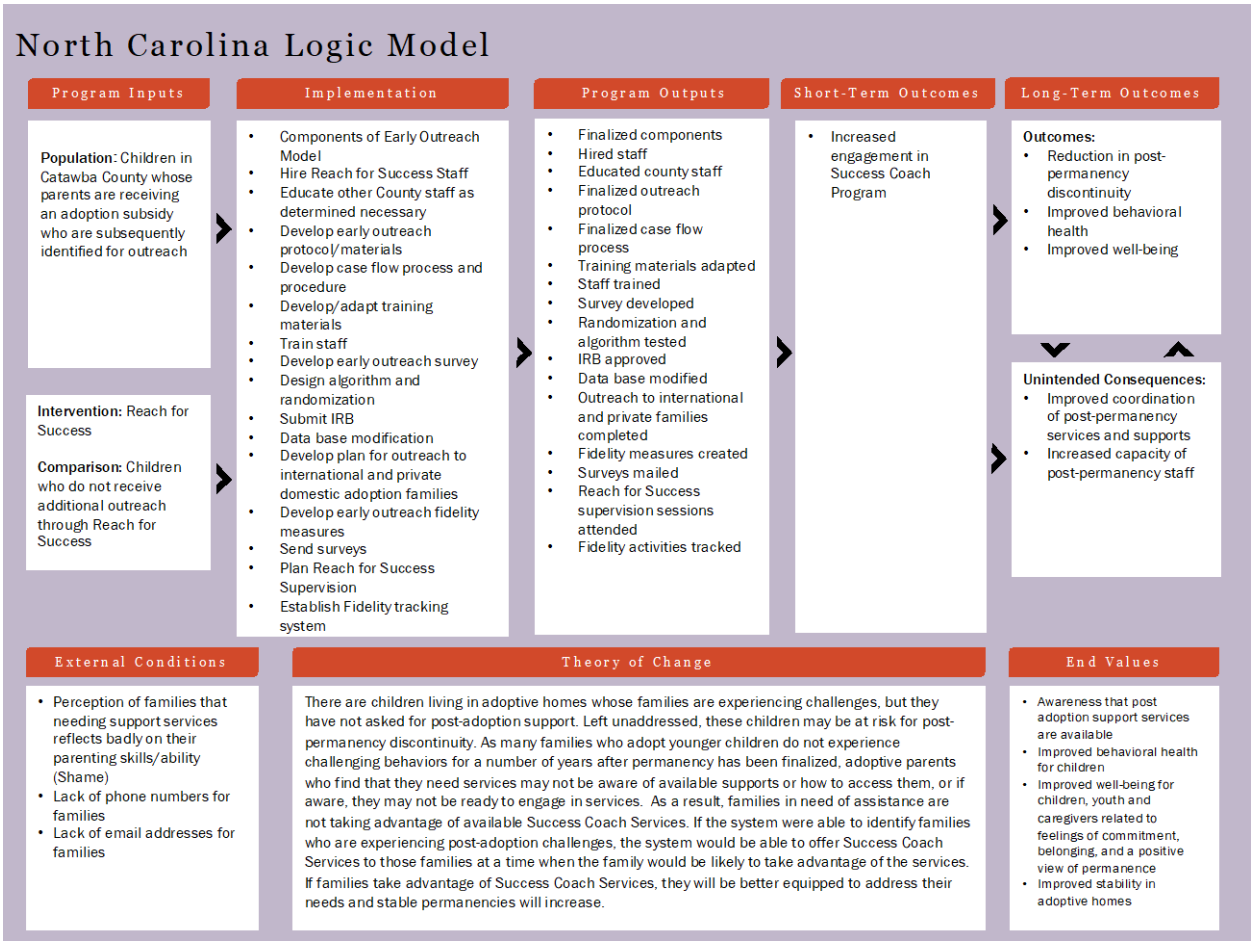
The project-defined long-term outcomes were:

- Reduction in post permanency discontinuity
- Improved behavioral health
- Improved wellbeing

Logic Model

The Logic Model (Figure 8.6) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and 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 8.6. North Carolina Logic Model



Evaluation Design & Methods

Reach for Success included reaching out to adoptive families through a survey, and then subsequently inviting subgroups of those who responded to the survey to participate in Success Coach services. After survey responses were returned for each cohort, an algorithm was applied to responses. An algorithm classified respondents into either a high-score group or a low-score group, based on current family service needs and behavior issues of the focal child, which was the oldest adoptive child in the family (higher scores on the Behavior Problems Index [BPI] reflected more child behavior issues). Once respondents were assigned to one of the two score groups (i.e., high-score or low-score), the high-score group was randomly assigned to either the *Reach for Success* outreach group or to a no outreach group (the comparison group). All low-score respondents were allocated to a third outreach group. Thus, through this project three experimental groups were created:

- Group #1: High-score outreach group
- Group #2: High-score no outreach group
- Group #3: Low-score outreach group

Families assigned to the high-score outreach group or the low-score outreach group were offered the Success Coach services, and those assigned to the high-score no outreach group were not. This experimental design allowed the evaluation team to compare the intervention group of interest (Group #1) to two different comparison groups: a group that was similar in risk but did not receive the outreach intervention (Group #2) and a group that had lower risk than the intervention group but received the outreach intervention (Group #3). However, all families randomized into the comparison group could still access the Success Coach services if they requested the service or were referred by a professional.

The evaluation design and protocol for *Reach for Success* were reviewed by the Institutional Review Board (IRB) at the University of Wisconsin-Milwaukee (UWM), the University of Illinois at Chicago (UIC), and East Carolina University (ECU). All researchers associated with the project fulfilled all requirements of their university Institutional Review Boards (IRBs). The project involved two types of data: the paper surveys completed by adoptive families and the electronic data collected by Catawba County and shared with the evaluation team. Consent forms clearly detailed the risks and benefits of participation in the study for participants. Analyses with electronic records involved the use of secondary data only, with no direct contact with human subjects. No identifying information for participants was shared with the Survey Research Labrator (SRL) at the University of Illinois at Chicago, and a study identification (ID) number was assigned by CCSS and used to track participation.

Procedures

USABILITY TESTING

The outreach protocol for *Reach for Success* was initially tested and evaluated for its effectiveness. Questions related to eligibility, engagement/uptake, and survey completion/responses were as follows:

1) Did the Algorithm Accurately Differentiate Between High-Score and Low-Score Families?

The metrics used for this question included the proportion of high-score families that allowed a first visit and the proportion of families with high- scores that enrolled in the services. Based on initial findings from responses received during usability, changes were made to the algorithm. In addition to the BPI score, the algorithm was modified to include families with unmet service needs.

2) Could the Success Coaches Make the First Calls Within the Required Time Frame?

The metrics used were the number of calls made within the proposed timeframe. Results indicated Success Coaches made the first call within the required timeframe.

3) Would the Families Sign the Success Coach Service Agreement and Engage in the Services?

The metrics used included the proportion of families who allowed a home visit and signed the service agreement (with a target goal of 70%) as well as an examination of the disposition codes for those that refused services after a home visit. During the timeframe of the usability testing, only one family out of the 46 who completed surveys were interested in services. The family signed a service agreement and engaged in the Success Coach services.

4) Were the Completed Surveys Returned?

The metrics used were the percent of surveys that were returned (with a target goal of 70%) and the percent of surveys returned that were fully completed. For the usability testing phase, the response rate was 37%; all 17 returned surveys were fully completed. Due to the low response rate two changes were made to the survey administration protocol: 1) a follow-up phone call was included after the survey was administered, and 2) a $5 gift card incentive was added to the survey when mailed the first and second time. Response rates increased in subsequent rounds after these two changes were made, and the overall response rate for all five cohorts of surveys was 53% (128 out of 240 valid surveys completed and returned).

RECRUITMENT

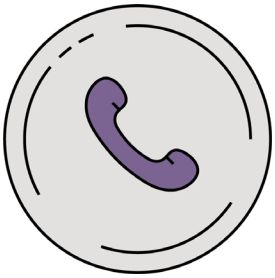
The *Reach for Success* survey was sent to cohorts (groups) of adoptive families, with approximately 50 families in each cohort. Surveys were mailed to families residing in Catawba County who (1) had adopted through the public child welfare system, (2) were receiving an adoption subsidy, and (3) had not received and were not currently receiving Success Coach services. The project also served families who had adopted children through a private domestic or intercountry process. Additional information regarding private domestic and intercountry adoptive families can be found in a separate report conducted by the QIC-AG, but not part of this evaluation report.

Careful consideration was given to which organization should administer the survey, with discussion centering on an outside research firm versus CCSS. Ultimately, the Catawba County site team decided the survey should be sent by CCSS, with survey responses sent directly to the survey firm at the University of Illinois at Chicago (UIC) to ensure respondents' confidentially. Stakeholders and the site team felt that a letter directly from the CCSS would be better received by families than a letter from an organization that was unknown to the families. Once completed surveys were received, SRL sent de-identified survey results to the QIC-AG evaluation team for analysis. During the initial implementation of *Reach for Success*, the outreach protocol included the following steps:

1. Mail a questionnaire packet, including a cover letter, an overview of the study, a survey instrument, and a reply envelope. Included a $5 gift card (with all first mailings after the usability cohort). One week after the initial mailing, mail a postcard reminder to families who have not returned the survey.

2. Two weeks after the reminder postcard was sent, mail a duplicate questionnaire packet with the materials described in Step 1 to families who have not returned a completed survey. Include a $5 gift card (with all second mailings after the usability cohort).

3. Send a $25 gift card to families who completed the survey.



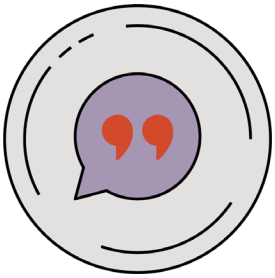
The second outreach component involved contacting families whose survey responses indicated they might benefit from the Success Coach services. These families received a phone call from a Success Coach. The protocol for the Success Coach engagement component included (1) making initial contact via a phone call, (2) mailing an initial contact letter to families the Success Coach was unable to reach by phone, and (3) scheduling a time for the Success Coach to visit the family. During the first visit, the Success Coach introduced the program, described the support services, shared program goals, and expectations, and—if the parents were interested in participating in the program—obtained the parents' signatures on and date on the service agreement.

PRIVATE DOMESTIC/INTERCOUNTRY ADOPTIONS

Outreach efforts to private domestic or intercountry adoptive families in Catawba County started with agency staff attending community events (e.g., ball games) where they thought adoptive families might attend. Catawba County staff distributed information about Success Coach services and gift bags at these events. Catawba County staff also 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. The ASPs were identified by location, with Catawba specifically reaching out to agencies who were likely to work with families in Catawba's eight county post permanency service regions. After contacting the ASPs, Catawba then developed a curriculum and set up trainings with them to raise awareness about adoption issues and advance adoption-competent practice. Specifically, trainings were designed to raise awareness that families who adopt through a private domestic or intercountry domestic process are eligible for post adoption services in North Carolina. 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 CCSS to ask for information about post adoptive services, but the family did not enter into a service agreement for Success Coach. Additional information regarding private domestic and intercountry adoptive families can be found in a separate report conducted by the QIC-AG, but not part of this evaluation report.

REFINEMENTS TO RECRUITMENT

Outreach Protocol



Lower than anticipated response rates to the survey among the first cohort precipitated changes to the outreach protocol. These changes included adding a follow-up reminder phone call to determine why the parents had not completed the survey and to encourage survey completion. This phone call was made by the *Reach for Success* staff and scheduled one week after the reminder postcard was mailed. Moreover, the phone call included the family's adoption worker, based on the idea that a call from a familiar person might increase families' buy-in to the program. To ensure consistency across the phone contacts, the calls were guided by a structured script. To accommodate this change in the protocol, the second questionnaire packet was mailed 2 weeks after the reminder call.

Incentives

To help increase response rates, the incentive process was changed from a single incentive provided after the survey was completed to a multiple incentive process. As previously indicated, a $5 gift card was included in the first and second questionnaire packets mailed to families, in addition to the $25 gift card families received upon completion of the survey.

Engagement

Originally, the Success Coach contacted only those families whose survey responses suggested they may be at higher risk for post permanency discontinuity and who may benefit from support services (i.e., high-score families). However, based on responses from the first two cohorts that completed the survey, the site team decided that in addition to contacting families whose response suggested they may need additional services, CCSS staff also reached out to respondents whose responses did not suggest a high need for services. Through these efforts, CCSS learned about the characteristics of families who may benefit from additional post adoption services and supports.

IMPLEMENTATION

As noted above, the goal for *Reach for Success* was to develop a structured early-outreach program to identify adoptive families who might be experiencing post adoption challenges, are at risk for post permanency discontinuity, and may benefit from Success Coach post adoption services. Developing and administering a survey required careful planning. Catawba County worked in conjunction with the QIC-AG evaluation team and SRL at the University of Illinois Chicago to design the survey and develop the outreach protocol. It was important that the team worked together to capitalize on the expertise of the diverse array of team players. This included practitioners who brought practice wisdom, the project evaluation team who brought the expertise in the area of post adoption research, and SRL who brought survey development expertise. Steps involved in this process included:

1. Selection of Survey Questions

General areas of inquiry were discussed among the team. Once general areas were agreed upon, the research team selected standardized measures, as well as developed any additional questions to be included in the survey. Standardized measures (e.g., the Behavioral Problem Index) were selected because previous research showed that they were important intermediate outcomes to understand post permanency discontinuity.

2. Mailing Protocol

The second critical element in survey administration was developing a process for getting the highest number of survey responses. Because of their expertise in survey development and administration, the Catawba team followed the suggestion of SRL, who recommended mailing hard copies as opposed to sending an electronic survey. The protocol detailed each step in the survey mailing process as described above. The selection of approximately 50 families for each cohort was based on the number of calls and follow-up that seemed reasonable for the Catawba staff to add to their workload, in addition to all their other typical work-related responsibilities.

3. Data Sharing Process

The third aspect of successful survey administration was the creation of a data-sharing process between the state, the county, the SRL, and the QIC-AG evaluation team. This process was developed based on feedback from Stakeholders, who shared they were more likely to respond to a mailing from CCSS than the researchers.

4. Tracking of Protocol Steps

The fourth aspect of a successful survey administration was tracking. For each step in the survey protocol, Catawba noted the dates and other important details (such as gift card ID number) in a spreadsheet in order to track protocol adherence and fidelity to the outreach intervention. This allowed evaluators and other QIC-AG leaders to ensure the mailing process was the same for each cohort and did not impact the response rate.

5. Follow up with Non-Responders

The fifth and final component of the survey administration process was following up with telephone calls to non-responders to better understand why they chose not to respond to the survey.

6. Follow up with Families Identified through the Algorithm

The next part of *Reach for Success* was contacting the families who fell into one of the two outreach groups once the algorithm was applied. After applying the algorithm to survey responses, the evaluation team referred families who obtained a high score (and were assigned to the intervention group) and families who obtained a low score to the *Reach for Success* staff. The *Reach for Success* staff (a Success Coach) called the family within 14 days of the referral. If the Success Coach was unable to reach the family by a telephone call within 14 calendar days, he or she called twice more (at different times of day). A letter and brochure were also sent to the family informing them of the Success Coach service and a number to call if they would like to learn more. When the Success Coach reached the family by telephone, the Success Coach tailored the introduction of the Success Coach service to the needs of the family by indicating how the service could help address the needs they reported on their self-report survey. The Success Coach then scheduled a face to face visit with the family within 2 weeks of the successful outreach call.

ADHERENCE

For adherence, CCSS tracked by cohort the number of surveys sent for each of the three rounds of mailings, the number, and proportion of survey responses by date of response, and the numbers and dates that thank you letters and gift cards were mailed. Regarding fidelity, CCSS also kept track of the dates of outreach phone calls made for those in the high- score group and notes about the results of each phone call (e.g., the family requested information but not services).

Measures

PROCESS MEASURES

Data related to the *Reach for Success* outreach activities were collected by Success Coach staff and shared with the evaluation team. This data allowed the evaluation team to examine adherence to the protocol. Information collected included:

- Number of surveys sent: initial, second, and third mailings (when applicable)
- Dates of survey responses
- Number and dates of thank you and gift cards mailed
- Number and dates of phone calls to families selected for outreach

DESCRIPTIVE AND OUTCOME MEASURES

Administrative Data

Administrative data were used to characterize adoptive families in Catawba County from the Adoption and Foster Care Analysis and Reporting System (AFCARS). Federal law and regulation require state child welfare agencies to collect case-level information on all children for whom the agency is responsible for placement, care, or supervision and on children adopted under the auspices of the agency. These data are derived from the bi-annual NC AFCARS submissions to the Administration for Children and Families of the Department of Health and Human Services (ACF). These data allowed us to understand the pre adoption experiences of children and examine how they may impact later outcomes

Participant Surveys

The QIC-AG contracted with the SRL at the University of Illinois at Chicago (UIC), who assisted with the development of the survey instrument and related protocol. This survey was administered by CCSS to all families who meet the eligibility criteria. The consent forms associated with these surveys also asked permission for the responses to be linked to the administrative and service data. The survey collected information on services families needed and received, and on the measures listed below.

Behavior Problem Index (BPI)

The Behavior Problems Index measures the frequency, range, and type of childhood behavior problems children ages four and older may exhibit (Peterson & Zill, 1986). It is based on responses by the primary caregiver as to whether a set of 28 problem behaviors are “not true,” “sometimes true,” or “often true.” Scores on the BPI range from 0 to 56, where higher scores indicate a child may be exhibiting more challenging 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 Guardianships (BEST- AG)

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

Caregiver Strain Questionnaire – FC/AG17

The Caregiver Strain Questionnaire-Adoption/Guardianship Form (CGSQ-FC/AG17) is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger, & Brickman, 1997). This 17-item measure is a self-report measure that assesses the extent to which caregivers experience additional demands, responsibilities, and difficulties as a result of caring for a child who is in foster care, legal guardianship, or who was adopted. The scale includes two subscales that measure objective and subjective strain. Higher scores indicate higher levels of strain.

Education Outcomes

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

Illinois Post Permanency Commitment Items

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

Protective Factors Survey (PFS)

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

the Nurturing and Attachment Subscale, higher scores indicate a higher level of emotional bonding and positive interaction between the parent and child.

Missing Data

Missing data imputation was done by replacing any item missing a 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 as missing.

Findings

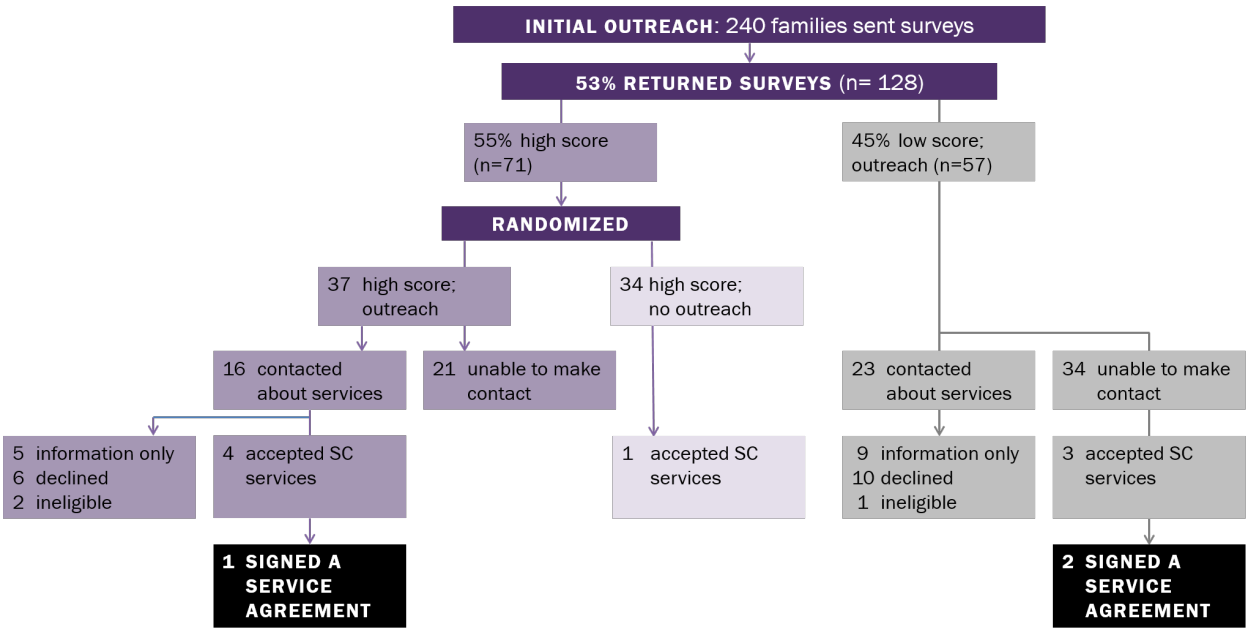
Sample Frame and Participant Profile

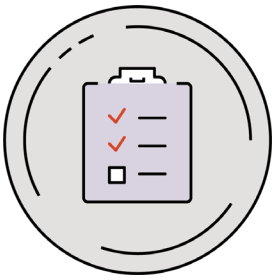
This section describes the population of adoptive families that received outreach from CCSS in Catawba County, including the number of families who were targeted and who participated. Also, characteristics of the adoptive families who received outreach are described, including a comparison of variables for those who responded to outreach versus those who did not respond to outreach. It is important to note that all of the analyses presented below include the usability cohort in addition to the other four cohorts. The decision was made to include the usability cohort in order to obtain information from as many families as possible, and because the outreach procedure for the survey between usability and formative stages did not change significantly in NC.

UPTAKE

The tree diagram in Figure 8.7 below displays the number of adoptive families who were initially targeted for outreach, how they were classified as high or low-score, and the results of outreach.

Figure 8.7. Survey and Outreach in Catawba County





For this study, we were interested in whether there were significant differences between those families who responded to outreach versus those who did not respond to outreach. To examine this, we matched all potential survey respondents (i.e., those who responded and those who did not respond) to administrative records from AFCARS where a match was possible (for 103 cases, or about 43% of the original 240 who were sent surveys). Then we compared those who responded to the survey to those who did not respond to the survey on several demographic and foster care variables shown in Table 8.1 below. One statistically significant difference, for child race, was found between those who responded and those who did not respond to the survey. Specifically, in the sample that matched to AFCARS data, caregivers of White children made up a larger proportion of those who responded to the survey (75%) than those who did not respond to the survey (just 53%). In contrast, only 8% of those who responded to the survey were caregivers of Black children, in comparison to 22% of those who did not respond to the survey. Finally, caregivers of children from other races made up just 17% of those who responded to the survey as compared to 26% who did not respond to the survey. These findings suggest that caregivers of White children were more likely to respond to the survey than caregivers of Black children or caregivers of children from other races.

Table 8.1. Child Characteristics: Comparing Respondents and Non-Respondents

NORTH CAROLINA	SAMPLE FRAME WHO MATCH TO AFCARS	SURVEY RESPONDENTS WHO MATCH TO AFCARS	NON-RESPONDENTS WHO MATCH TO AFCARS	BIVARIATE COMPARISON (RESPONDENTS VS. NON-RESPONDENTS)[A,B]		
	103 OF 240 SURVEYS (42.9%)	52 OF 103 (50.5%)	51 OF 103 (49.5%)	χ^2	*df*	*p*
CHILD HAS A DISABILITY	13%	12%	14%	0.00	1	0.970
3+ MOVES IN FOSTER CARE	46%	46%	45%	0.00	1	1.000
CHILD'S RACE				6.17	2	0.046
WHITE	64%	75%	53%			
BLACK	15%	8%	22%			
OTHER	21%	17%	26%			
CHILD IS HISPANIC	10%	15%	4%	N/A		
CHILD IS FEMALE	50%	58%	41%	2.19	1	0.139
PARENTS MARRIED OR TWO-PARENTS*	65%	69%	55%	0.74	1	0.390
	M	M	M	*t*	*df*	*p*
CHILD AGE AT PERMANENCE	5.81 (4.02)	6.18 (3.63)	5.44 (4.38)	0.88	89	0.378
MEAN YRS IN FOSTER CARE	1.83 (.72)	1.97 (.68)	1.70 (.73)	1.85	91	0.067

Notes:
[A] Bivariate comparisons were for the previous two columns in the table only—i.e., those who responded to the survey versus those who did not respond to the survey
[B] Chi-square not valid for comparisons where expected cell sizes are less than 5

Process Evaluation

A process evaluation "determines whether program activities have been implemented as intended and resulted in certain output" (Centers for Disease Control and Prevention, 2015). Initial implementation of *Reach for Success* first began when the first clients received services. At that time, the evaluators began the formative (process) evaluation and tested whether the early phases of the initiative were associated with the expected program outputs of the intervention. Also, through the rest of implementation, evaluators continued to use the metrics related to adherence described above to keep track of whether processes for each cohort happened as intended.

ADHERENCE

Adherence variables were measured in terms of the degree of practitioners' adherence to the best practice model of service delivery as intended by the developers and the numbers of children families reached. Adherence variables provided information about the number and proportion of families who received mailings and phone calls to complete surveys as well as the proportion of thank you cards mailed after survey receipt. Table 8.2 below displays the results of adherence measures for all five cohorts, including the first cohort for usability (which had slightly different follow-up procedures as described above). Results indicated that adherence was extremely high across all five cohorts, with 95% to 100% of respondents receiving second mailings as needed, and 100% of respondents who were eligible receiving third mailings and thank you cards. Going into the process, the team was confident that mailing addresses would be high quality (since they were the addresses families used to receive their adoption subsidy), so the team was surprised to find that several surveys were returned because of invalid addresses.

Another aspect of the research protocol was that CCSS staff provided outreach to high and low-score families who were designated for outreach. The staff made 100% of these outreach attempts to designated families. All data related to outreach was collected by the Success Coach team and shared with the evaluation team. Finally, the evaluation team also closely monitored the development and testing of the algorithm that was utilized to determine high- score families to make sure that the algorithm correctly identified families at higher risk for difficulties after adoption (e.g., higher BPI scores, lower BEST scores, more service needs).

Table 8.2. Adherence Tracking: Reach for Success

	COHORT 1	COHORT 2	COHORT3	COHORT 4	COHORT 5
FIRST SURVEY MAILED	46	50	52	47	45
NUMBER OF NON-RESPONDERS (WITHIN 2 WEEKS OF INITIAL SURVEY)	37	32	44	43	45
SECOND MAILING (REMINDER LETTER) TO NON-RESPONDERS*	95%	100%	100%	100%	100%
NUMBER OF NON-RESPONDERS (WITHIN 4 WEEKS OF INITIAL SURVEY)	36	31	18	32	31
REMINDER PHONE CALLS TO NON-RESPONDERS	N/A	100%	100%	100%	100%
NUMBER OF NON-RESPONDERS (WITHIN 6 WEEKS OF INITIAL SURVEY)	29	22	16	38	26
THIRD MAILING (SURVEY)	N/A	100%	100%	100%	100%
TOTAL NUMBER OF RESPONDERS	20	28	36	22	22
THANK YOU LETTER WITH GIFT CARD SENT (TO THOSE WHO RETURNED SURVEYS)	100%	100%	100%	100%	100%
TOTAL NUMBER OF FAMILIES IN THE OUTREACH GROUP WHO RECEIVED PHONE CALLS	100%	100%	100%	100%	100%

*Note: The process for retrieving addresses was updated after Cohort 1

Outcome Evaluation

There was one short-term outcome in Catawba County: Engagement in Success Coach Services. This was measured in two ways, the number of families who expressed interest in services, and the number of families who participated in Success Coach services.

ENGAGEMENT IN SUCCESS COACH SERVICES

Findings from the outreach efforts to engage families in intervention:

- Of the **128** families who returned surveys, **94** were designated for outreach (**57** in the low score group and **37** in the high-score outreach group).
- Of the **94** families designated for outreach, **39** parents were able to be contacted by CCSS (or **41%** of those designated for outreach, with **23** contacted in the low-score group and **16** contacted in the high-score outreach group).
- A significant proportion of the **39** parents who were able to be contacted by CCSS were interested in either learning more about Success Coach services or receiving Success Coach services. Specifically, results showed that **21** of the **39** families (**54%**) who were successfully contacted through outreach were interested in either Success Coach information or services, with **7** interested in services and **14** interested in information only.
- Of the **7** families who were interested in services, **3** (**43%**) entered into a service agreement and actually participated in Success Coach services.
- Of the **3** families who entered into a service agreement for Success Coach services, **2** were from the low-score group and **1** was from the high-score group. It is important to note that with such a low uptake of Success Coach services, it is impossible to discern if low-score or high-score families were more likely to enter into a service agreement.

In sum, this study did not find that the additional outreach to families resulted in additional uptake of Success Coach services. Furthermore, the low number of families who engaged in services does not allow us to sufficiently assess the impact of the algorithm to distinguish families who may be interested in services. Perhaps with additional time, CCSS will observe a different level of uptake based on the algorithm and additional analysis can be pursued to understand the characteristics of families in need of Success Coach services.

An additional area of inquiry related to families in Catawba County, NC was whether the target population of interest, adoptive families, was participating in and receiving the Success Coach intervention as intended. This study found that families who were contacted through outreach but subsequently declined services largely reported they were adjusting well and did not need extra supports (see the discussion below regarding how CCSS front-loads supportive services for adoptive families). For example, among the five high-score families who received outreach but explicitly declined Success Coach services, three caregivers reported that their family was doing fine, one caregiver did not provide further information, and one caregiver reported that their family was not adjusting well. Thus, it may be that in Catawba County, most families who do not receive Success Coach services are those that feel they are doing fine and do not need more services or supports.

In regard to barriers for families to obtain Success Coach services, a significant proportion of the families in this study who were contacted through outreach requested information about the program (36%). Therefore, one barrier to service engagement may be a lack of information about the availability of Success Coach services, eligibility criteria, or even the potential benefits of services for families. Related, outreach efforts were unsuccessful for over half of those eligible for outreach in this study (55 out of 94 families, or 59%). Thus, another barrier to service engagement may be that adoptive parents change addresses, phone numbers, and/or living arrangements after adoption and lose contact with CCSS. Outreach efforts to families after adoption, such as a general survey, may help adoptive parents both remain in contact with the agency and stay aware of potential supportive programs like Success Coache services.

COMPARING LOW VS. HIGH-SCORE RESPONDENTS

Behavioral Health and Wellbeing

In regard to child behavioral health and child/youth and family wellbeing, the results of the scales used in the survey are summarized in Table 8.3 below. These scales provide information about levels of child behavior problems (BPI: higher values indicate more reported behavior problems in the home); child belonging and emotional security (BEST-AG: higher values indicate more belonging and emotional security), protective factors in the family (PFS: higher values indicate higher family functioning, nurturing, and attachment), and caregiver stress or strain (STRAIN: higher values indicate higher caregiver stress or strain).

These scales also provide information about differences in these scale scores between those families who were identified as “high-score” (i.e., caregivers reported more behavior problems and unmet needs) and those families identified as “low-score” (i.e., caregivers reported fewer behavior problems and unmet needs). However, please note that because total BPI score was a primary factor used in the algorithm to classify families as high or low-score, differences between the two groups on the BPI would be expected.

The scale results presented in Table 8.3 below support the classification of families into high and low-score groups, with high-score families having not only higher scores the BPI scale and subscales, but also higher average scores on the STRAIN scale and subscales, lower average scores on the PFS-Nurturing and Attachment scale, and lower total scores on the BEST scale and subscales. These results suggest that the families who were classified as high-score have a lower level of child, caregiver, and family functioning as compared to those families classified as low-score. These findings suggest that these scales and subscales may be used to identify families who are struggling. However, as noted above, uptake for Success Coach services was low overall, with only 21 families reporting an interest in Success Coach information or services (12 in the low-score group and 9 in the high-score group) and just 3 families actually entering into a service agreement for Success Coach services (2 in the low score group and 1 in the high score group), Therefore, with such a small number of participants in Success Coach, this study was unable to provide information about whether low- or high-score families were more likely to engage in the program, and more research is needed in this area.

Table 8.3. Measures of Wellbeing: Comparing Low vs. High-Score Respondents

		OVERALL	LOW-SCORE GROUP	HIGH-SCORE GROUP	BIVARIATE COMPARISON (LOW-SCORE VS. HIGH-SCORE)		
MEASURE	RANGE	MEAN (SD)	MEAN (SD)	MEAN (SD)	*t*	*df*	*p*
ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN							
BEHAVIOR PROBLEM INDEX	0-56	9.75 (10.42)	2.96 (3.17)	15.32 (10.99)	-8.77	79	< .000
BPI EXTERNALIZING	0-38	7.48 (8.08)	2.30 (2.45)	11.68 (8.61)	-8.57	80	< .000
BPI: INTERNALIZING	0-22	2.96 (3.74)	0.75 (1.24)	4.76 (4.12)	-7.55	80	< .000
CAREGIVER STRAIN (CGSQ-FA22)	1-5	1.61 (0.64)	1.34 (0.31)	1.83 (0.75)	-4.91	96	< .000
OBJECTIVE STRAIN	1-5	1.47 (0.76)	1.16 (0.29)	1.72 (0.91)	-4.91	86	< .000
SUBJECTIVE STRAIN	1-5	1.71 (0.67)	1.47 (0.43)	1.90 (0.76)	-4.00	112	< .000
ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN							
PFS FAMILY FUNCTIONING	1-7	6.12 (0.86)	6.26 (0.83)	6.01 (0.87)	1.65	120	.102
PFS NURTURING AND ATTACHMENT	1-7	6.19 (0.91)	6.50 (0.53)	5.95 (1.06)	3.74	108	< .000
BEST-AG	20-100	95.49 (6.50)	97.54 (2.98)	93.85 (7.95)	3.61	93	< .000
BEST-AG EMOTIONAL SECURITY	13-65	61.18 (5.11)	62.84 (2.65)	59.84 (6.14)	3.70	100	< .000
BEST-AG CLAIMING	7-35	34.32 (1.61)	34.71 (0.71)	34.01 (2.03)	2.71	90	.008

Note: Bivariate relationships between BPI total scale and subscales were expected because total BPI scores were used in the algorithm to classify families as high or low-score.

PROFILE OF ADOPTIVE PARENTS IN CATAWBA COUNTY

The survey responses provided an opportunity to also examine the characteristics of adoptive families in Catawba, County. These results are summarized below.

Caregiver Commitment:

The survey results from caregiver commitment questions, shown below, indicate that most adoptive families are adjusting well to permanence. A large majority of respondents said that they felt positive about the adoption, that they understood their children most of the time, and that they could meet their child's needs. In addition, almost all respondents stated that they never thought about ending the adoption. Finally, most adopted children were reported to be doing "excellent" or "good" in school for both reading and math.

Overall, how would you rate the impact of your child's adoption on your family?

- **71%** of respondents felt extremely positive about the impact of the adoption.

During the past month, how often have you felt that you just did not understand your child?

- **73%** of all respondents responded 'never' or 'less than once a week.'

How often do you think of ending the adoption?

- **94%** of respondents reported that they never thought about ending the adoption,

How confident are you that you can meet your child's needs?

- **84%** of respondents reported being "extremely" or "very" confident that they could meet their child's needs.

How would you describe your child's school performance in reading and language arts?

- **72%** responded "excellent" or "good."

How would you describe your child's school performance in math?

- **66%** responded "excellent" or "good."

School and legal involvement:

Table 8.4 below shows the percentage of adopted children who were reported to have experienced specific negative school or legal outcomes. Results were generally positive, with 10% or less of caregivers reporting that students experienced in- or out-of-school suspension, skipping school, and expulsions from school. Also, only 1% of caregivers reported that their child had run away and 3% reported legal and juvenile justice system involvement.

Table 8.4. School Experiences

CHILD'S EXPERIENCES	%
SKIPPED SCHOOL OR CUT CLASSES WITHOUT YOUR PERMISSION	7%
RECEIVED AN IN-SCHOOL SUSPENSION	10%
RECEIVED AN OUT-OF-SCHOOL SUSPENSION	5%
BEEN EXPELLED FROM SCHOOL	2%
BEEN IN TROUBLE WITH THE LAW OR JUVENILE JUSTICE SYSTEM	3%
RUN AWAY FOR A PERIOD OF MORE THAN 7 DAYS	1%

After-School Activities:

Survey respondents indicated that many of the adopted children were involved in after-school activities. Table 8.5 below shows the percentage of survey respondents who indicated their children were involved in various activities. The highest proportions were for religious instruction/youth groups and sports (60% or more of respondents). The activity with the lowest participation among adopted children/youth was a part-time job or internship (only 15%). These results provide evidence that most adopted youth are adjusting to their placement enough to become involved in activities outside of the home.

Table 8.5. Extracurricular Activities

EXTRACURRICULAR ACTIVITIES	%
RELIGIOUS INSTRUCTION OR YOUTH GROUP	66%
SPORTS OR ATHLETIC ACTIVITIES	60%
LESSONS IN ART, PERFORMING ARTS, MUSIC, OR DANCE	42%
ACADEMIC SUPPORT OR TUTORING	28%
CLUBS OR ORGANIZATIONS	48%
VOLUNTEER ACTIVITIES	40%
PART-TIME JOB OR INTERNSHIP	15%

Services families need and use

Families who responded to the survey indicated whether they needed a variety of individual services and if they tried to obtain those services. Among those who tried to obtain services, they were asked if they were successful in obtaining them. Finally, among those who obtained services, they were asked about their level of satisfaction with those services. Table 8.6 below summarizes the results of these questions for the four most commonly needed services: mental health, specialized medical or dental care, educational support, and child developmental services. Overall, 35% or less of respondents indicated needing any of the services, with less than 15% of caregivers reporting a need for three other individual services not shown in the table below—respite, adoption support groups, or summer enrichment. Results indicated that the majority of those who tried to obtain services were successful (83% or more for the four services shown in the table) and that those who obtained services were typically happy with the services provided. However, a significant minority of respondents (20-32% for the four services shown in the table) did not report being satisfied with services (i.e., they found services "slightly helpful," "not at all helpful," or they did not respond to this follow-up question).

Table 8.6. Service Needs and Use

SERVICES MOST FAMILIES REPORTED NEEDING:	% OF FAMILIES WHO RESPONDED TO SURVEY AND REPORTED THAT THEY NEEDED	OF THOSE FAMILIES THAT TRIED TO OBTAIN, THE % THAT WERE SUCCESSFUL	OF THOSE FAMILIES THAT OBTAINED SERVICES, THE % 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%

Limitations

There are several limitations to keep in mind regarding the QIC-AG evaluation in Catawba County. First, Catawba is an innovative county, often an early adopter of innovative practices. CCSS has developed an agency culture and infrastructure that supports evidence building. It has a long history of partnering with local, state, federal partners, both public and private, to advance child welfare practice. CCSS has a proactive social service system that provides post permanency services and has experimented with new programs that have the potential to benefit families both before and after adoption. Thus, Catawba County may not be representative of other county social service agencies in NC or other social service agencies in the U.S. For example, Catawba County offers mental health services to all families in foster care, provides coordinated child welfare services using clinical teams, and has a Success Coach program already in place for adoptive families (that started prior to the QIC-AG project). Thus, it may be that front-loading child welfare services in Catawba prevents issues after adoption and/or lowers the reported needs of adoptive families.

Another limitation to consider is that the types of caregivers and families who responded to the outreach survey in Catawba may be different from those caregivers and families who do not respond in ways that were not captured in analyses presented above. Indeed, one statistical test found child racial differences between respondents versus non-respondents, with caregivers of White children more likely among respondents than non-respondents (see Table 8.1 above). Therefore, care should be used in interpreting the results for those families who responded to the survey—for example, they may have more (or less) needs and/or challenges than other adoptive families.

Finally, the results of statistical tests presented above should be interpreted with some caution because the sample sizes used in analyses were somewhat small (i.e., 103 cases possible for comparisons of respondents versus non-respondents and 128 cases possible for comparisons of low versus high- score families). Also, many statistical tests were estimated, so statistically significant findings may be obtained simply due to chance.

Thoughts from Parents

At the end of the survey, parents were asked, *"Is there anything else about your experience of adoption of your child that you would like to share?"* Their responses reflected a wide variety of experiences within the narrow target population that we defined.

The following are direct quotes from participants about the experience of being an adoptive parent:

> **"I thoroughly enjoyed raising my granddaughter. I would do it all over again! She is a joy to have around!"**
>
> **"Our children are our children, loved no different than biological children. They are loved and cared for. They are our life. Thanks to Catawba County, it has been an awesome journey."**
>
> **"My daughter makes me happy and proud. At times it has been a little difficult because she's going through puberty, but she's still a joy. She makes straight A's at school and is liked by all her teachers. She is very motivated and has been a cheerleader for 6 years."**
>
> **"Our adopted child has been a bundle of joy in our lives. We are so grateful!"**
>
> **"Our daughter has been with us since her birth. She is our daughter and we love her as if she were our own because she truly is our little girl. We would not want our family to have happened any other way."**
>
> **"Love her to the moon and back!"**

The following are direct quotes from participants about the challenges with their adopted child:

> **"He is my son now. I would never leave him for anything in this world. He has problems but we are trying to take care of them with his counselors, psychiatrists, school."**
>
> **"Very demanding yet very rewarding."**
>
> **"Adoption has definitely enriched my life in ways I never imagined. But often I feel there's more I should be doing for my child - but don't have time, energy or patience to do it. So, I just do what I can and hope for the best."**
>
> **"I have had to learn a lot about trauma attachment, and sensory issues in order to meet my daughter's needs. I strongly believe adopted or biological, that all parents need to rise up and meet their child's needs."**
>
> **"Sometimes it 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 maintained limited birth family connections. I feel this has helped (child's name)."**
>
> **"Honestly, the best experience that we have ever had as far as the child is concerned. Really frustrating trying to handle birth families though."**

The following are direct quotes from participants regarding services that could be improved:

> "If the parents are on drugs or have mental issues, they should let the adoptive parents know. They should stay on Medicaid till at least 21. And also receive a check."

> "Fighting for mental health services is exhausting."

> "I feel like my child's needs were not assessed properly while in foster care due to the foster parents being extremely neglectful."

> "It really depends on your social worker as to how your experience will be."

> "We allowed birth mom to visit and have access to our child. This was a mistake. We work with a counselor to help control the situation. We would not recommend trying to work with birth parents."

In sum, most parents noted a strong bond to their children, as well as maintaining the adoption, even in the face of challenges. Some specific difficulties were noted that related to inadequate or inconsistent services and the mental health and behavioral needs of children, However, parents indicated that timely, supportive services have the potential to mitigate difficulties that adoptive families face (e.g., better communication with the school and adoption-competent mental health services).

Cost Evaluation

The Catawba County, North Carolina QIC-AG project implemented and tested the effectiveness of *Reach for Success*, a service-engagement intervention. The project reached 128 families formed by adoption and guardianship through a survey to identify families with elevated risk for post permanency discontinuity. Seven families were in need of and agreed to participate in Success Coach Services.

Cost Evaluation Approach

The cost-effectiveness research (CER) analysis will provide information for policymakers and administrators to help maximize desired outcomes based on the associated cost of achieving them (Meunnig, 2002). CER analysis will be applied to the outcomes identified by North Carolina.

Assumptions, Conditions, and Constraints

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

ASSUMPTIONS

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

We also assume multiple positive outcomes are likely impacted by the QIC-AG site programs. For the North Carolina site, the desired impact of the programs is to improve behavioral health and wellbeing. However, other positive outcomes may not be necessarily captured by the intervention.

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

CONSTRAINTS

Constraints are factors that have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For Catawba County, constraints may include the fact that North Carolina does not have a unique child ID that is used across counties, and possibly that the counties are run as independent systems in North Carolina, with less central support than a state-run system might have.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. For Catawba County, conditions may include recent policy changes in North Carolina, including the availability of subsidized guardianship as a permanency option, and the availability to extend foster care to the age of 21.

Cost Estimation

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

KEY POINTS IN COST ESTIMATION

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

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. Prior to implementation, North Carolina's intervention site, Catawba County Social Services, had substantial infrastructure as a county agency. Infrastructure costs specific to the agency were not estimated for this cost evaluation. Additionally, Catawba County had already implemented the Success Coach model with substantial support from the Duke Endowment. Thus, sites wanting to implement the Success Coach model would need to budget for additional costs during their installation phases. The sites also received substantial technical support from consultants and evaluators during implementation. Although the consultation was crucial to moving sites into implementation, the costs associated with the consultation will only be noted in the conclusion as additional costs for future programs to consider. Evaluation costs are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates.

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

Cost estimation should include the passage of time in order to account for inflation. Given that Catawba County implemented this intervention over a relatively short period, costs did not change dramatically. The major cost that would be impacted in this short time frame is staff salary and this change is accounted for in the direct expenses that North Carolina incurred each year.

Both variable and fixed costs should be captured in cost estimation. For Catawba County, 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.

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 Catawba County were taken from monthly budget forms and summarized into Table 8.7. It should be noted that North Carolina ended up providing outreach on its own due to issues with payments and accounting procedures. Some of those efforts may have resulted in increased costs.

Table 8.7. Costs for North Carolina

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL COSTS				
SIM SALARY	$3,837	$7,390	$10,950	$22,178
SIM FRINGE BENEFITS	$1,049	$2,163	$2,867	$6,079
SUCCESS COACH	$8,103	$53,036	$30,542	$91,681
PROJECT MANAGER	$3,323			$3,323
FRINGE	$7,300	$16,431	$8,968	$32,699
NON-PERSONNEL COSTS				
CONTRACTED SERVICES: U OF ILLINOIS		$14,597	$16,579	$31,176
FACILITIES/OFFICE SPACE		$487	$837	$1,324
GIFT CARD INCENTIVES	$50	$3,185	$1,710	$4,945
POSTAGE			$522	$522
PRINTING/DUPLICATION		$32		$32
PROGRAM SUPPLIES		$72	$224	$296
TELEPHONE		$758	$389	$1,147
TRAVEL		$4,291	$3,664	$7,955
OTHER: CERTIFIED MAIL		$1,296		$1,296
OTHER: MATERIAL SUPPORT FUNDING		$30	$3,666	$3,696
OTHER: NON-SPECIFIED		$7,902		$7,902
NON-PERSONNEL INDIRECT COSTS				
BOOKS	$1,636			$1,636
TRAVEL			$414	$414
TOTAL	$25,298	$111,670	$81,332	$218,300

*FY 2019 through 3/31/19 only

**FY 2017 started 3/1/29

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 8.7.

Collect data on Resource Allocation

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

Estimation of Direct Costs

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

Personnel

Personnel costs totaled $117,182 for staff time allocated to the project. Personnel costs included the salary of the SIM which was $22,178; salary of the Success Coach $91,680; and $3,323 for the salary of the Project Manager.

Fringe

Overall fringe for all employees totaled $38,777. Fringe was calculated based on guidelines set by Catawba County.

Contractual expenses

North Carolina contracted for services with the University of Illinois/Survey Research Lab for $31,176 for all survey related tasks and technical assistance to assist with a protocol on the engagement of adoptive families.

Gift cards

$4,944 were provided to caregivers who completed the survey.

Materials and supplies

Over the implementation period, $295 was spent on program supplies that were specific to the operation of the intervention.

Travel

Over implementation and installation, $8,369 was paid for travel. Travel costs included travel to the state Family Preservation Meeting.

Facilities/Office space

$1,324 was spent for 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 ($1,817), phones ($1,146), printing and duplication ($31), and funds for material support of families ($3,696).

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. Only one indirect cost was billable to the project. The purchase of books was $1,635 were billed to the project as general overhead costs. Travel was billed at $414.

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 North Carolina state agency had substantial infrastructure. Because the evaluation team assumed that other interested child welfare agencies would also have the infrastructure in place to run programs, we did not attempt to portion out the infrastructure costs that another agency would likely need. Likewise, we assumed that indirect costs will vary greatly by state due to cost of living issues influencing real estate prices and wages and thus, more detailed indirect cost calculations would not be useful to other entities. In order to run a similar program in another area, programs would need building space with heating, air, electricity and water; and some administrative support for contracting and financial management.

Summary of Costs

Total implementation costs for North Carolina were $218,299.

Cost Calculations

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

COST PER PARTICIPANT

North Carolina conducted a survey to find families who may have needed extra support. They identified 240 families and had 128 families respond. Based on the total costs of $218,299, each survey cost $910 to send.

COST-EFFECTIVENESS ESTIMATION

For North Carolina, the survey was intended to identify families who might be needing assistance. Given that so few families reported needing assistance, there were no significant outcomes related to the Success Coach intervention.

However, an effective outcome is a completed survey which can be used in a cost-effectiveness estimation. In total, 128 caregivers completed a survey. Thus, the cost per positive outcome or cost-efficiency ratio is:

$$\text{COST-EFFECTIVENESS RATIO} = \frac{\text{Cost of mailing surveys}}{\text{Number of completed surveys}}$$

which results in a cost of $1,705 per completed survey.

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

For this sensitivity analysis, costs that are most likely not needed have been removed from the cost calculation. Inclusion or exclusion of costs in a sensitivity analysis such as this one is subjective. A decision was made based on the following question: Is this expense critical to the functioning of the intervention? Another agency would want to adjust costs specific to their program needs. The following exclusions were made for this sensitivity analysis:

1. The salary and fringe for the Site Implementation Manager were removed. At this site, the Site Implementation Manager was not needed to implement the actual intervention. This position served as a liaison with external entities and managed internal processes. The internal management could be provided by the Success Coach.

2. The costs for the site coordinator were removed. As with the Site Implementation Manager's role, administrative tasks directly related to the intervention could be absorbed by the Success Coach.

3. Gift cards were removed from the cost calculation. Gift cards were provided to thank people for their time in completing survey materials so that they could be identified to program staff. In other agencies, recruitment would likely occur differently.

4. Program supplies were excluded as there was no specification that these were directly related to the intervention.

5. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings.

6. Fees related to office space rental were excluded. Other agencies would likely have the office space available for the Success Coach. Additionally, rental space varies significantly by area and other agencies would need to adjust for their own community and agency needs.

7. Contracted costs for the University of Illinois were also removed because those expenses related to survey costs and data collection. Some sites could opt to do the survey and collect the data with in-house resources.

8. Other non-intervention related charges were excluded including other non-specified costs and material support. These expenses were not necessary for the implementation of the intervention.

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

Costs that remain include telephone and postage charges. These were included because the intervention model called for outreach to families who may need services but were not receiving them. Based on these exclusions, Table 8.8 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $127,376 which amounted to $530 per participant or $995 per completed survey.

Table 8.8. Sensitivity Analysis: Adjusted Costs for North Carolina

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL COSTS				
SUCCESS COACH	$8,103	$53,036	$30,542	$91,681
FRINGE	$7,300	$16,431	$8,968	$32,699
NON-PERSONNEL COSTS				
POSTAGE			$522	$522
PRINTING/DUPLICATION		$32		$32
OTHER: CERTIFIED MAIL		$1,296		$1,296
TOTAL	**$15,403**	**$71,552**	**$40,421**	**$127,376**

*FY 2019 through 3/31/19 only

**FY 2017 started 3/1/29

Cost Evaluation Summary

Total implementation costs for North Carolina were $218,299. North Carolina conducted a survey to find families who may have needed extra support. They identified 240 families and had 128 families respond. Based on the total costs of $218,299, each survey cost $910 to send.

For North Carolina, the survey was intended to identify families who might be needing assistance. Given that so few families reported needing assistance, there were no significant outcomes related to the Success Coach intervention. However, a measurable outcome for North Carolina was a completed survey. The site achieved a 55% response rate with 128 surveys returned. Thus, the cost per returned survey was $1,705.

A sensitivity analysis demonstrates that many costs could be reduced or eliminated in a replication of the site activities. Based on that analysis, the reduced total cost of the project was $127,376 which amounted to $530 per participant or $995 per completed survey.

Discussion

The purpose of outreach provided through *Reach for Success* was to engage more adoptive families in Success Coach services, particularly families who may be struggling with unmet service needs, difficult child behaviors, poor family cohesiveness, or other issues related to child and family wellbeing. The Theory of Change suggested that early outreach and intervention would increase participation in Success Coach services, resulting in improved child and family wellbeing and decreased post adoption instability. Through *Reach for Success*, 94 families were selected for additional outreach based on survey responses (57 in the low-score group and 37 in the high-score group). CCSS was able to make contact with just 39 of these 94 families (41%). Then of these 39 who were contacted, only seven (18%) were interested in participating in the Success Coach program (three in the low-score group and four in the high-score group). Finally, follow-up by CCSS indicated that three of these seven families (43%) who were interested in Success Coach services actually entered into a service agreement and subsequently participated in services. Given the low number of families who engaged in services, it is difficult to know if *Reach for Success*, either through the survey or subsequent outreach, was successful in identifying families who may be in need of Success Coach services. Additional time and tracking of who contacts the Success Coach program would help understand this question better. However, one positive finding of outreach was that low uptake was largely the result of most caregivers feeling that families were doing well and did not need or want additional services.

Low uptake in Catawba County may also have occurred because Catawba County Social Services (CCSS) front-loads adoption services and has a history of implementing proactive, innovative programs to support adoptive families. However, the findings of this study are consistent with previous post adoption literature which indicates that most children and families adjust well after adoption from foster care, although a small but significant proportion of families (i.e., about 5-20%) also report unmet needs, child behavior problems, placement instability, and other issues, and might benefit from additional services (Rolock, 2015; Rolock & White, 2016; Rolock & White, 2017; White, 2016). The most commonly needed services reported by caregivers in Catawba County were mental health, specialized medical or dental care, educational support, and child developmental services. However, typically less than a third of families reported needing each service. In fact, only a few families reported needing several other services, including respite, adoption support groups, and summer enrichment. Another positive finding of this study was that most caregivers and youth who tried to obtain services were successful and that those who obtained services were typically happy with the services provided.

Many of the measures used in this study were effective in both identifying youth and families who may be at-risk for poor adjustment after adoption (e.g., caregivers who report high parenting strain) and showing high reliability in statistical tests (i.e., Cronbach's alphas greater than .70; DeVellis, 2003). Reliable and valid measures are needed in post adoption research, so the scales used in this study could be used and/or adapted in future research studies, including the BPI, BEST, STRAIN, and PFS scales and subscales.

Finally, the results from surveys obtained in this study provided a descriptive profile of adoptive families in Catawba County who responded to the survey. Although those who responded to the survey may not be representative of all adoptive families in Catawba (e.g., younger adoptive children in multi-adoption homes would not be included), the survey results may be useful to policy-makers and practitioners in child welfare. For example, the average age of adopted children and youth at the time of the survey was about 13, and the pre-teen and teenage years have been identified in previous literature as high-risk ages for post adoption instability (Rolock & White, 2016). Further, the age of primary caregivers was 52, 80% of families had a racial match between the caregiver and child, and 43% of adoptive caregivers had a kinship relationship to the child. Thus, descriptive results suggest strategies for post adoptive intervention, such as providing education for adoptive

caregivers to effectively parent high-risk adolescents, or engaging families to process their new kinship roles after adoption.

As noted above, we asked families to share additional thoughts with us when we surveyed them. Of the 128 survey respondents, 51 (40%) provided comments, and the majority of those respondents (35) reported something positive about their adoption experiences. For example:

> **"My adoption experience has been a positive nature. I would not have it any other way. Love my daughter so much and I will be her mother forever. I appreciate the foster adoption process."**

> **"Our lives are complete now because of our kids. I would never change a thing! They are perfect. Our DHSS staff was wonderful during our process."**

In many comments, the parents described a deep love and appreciation for their adopted children. However, for some adoptive parents, their child also presented unanticipated challenges including attachment issues from past trauma experienced, problems at school, and identity concerns. Difficulties interacting with birth families were also problematic for some families. Challenges were compounded when parents could not obtain the services their children needed. Therefore, culturally sensitive, developmentally-appropriate, trauma-informed services that are requested and delivered in a timely fashion have the potential to help avert difficulties that adoptive families experience after legal permanency.

References

Brannan, A. M., Helfinger, C. A. & Bickman, L. (1997). The caregiver strain questionnaire: Measuring the impact of the family of living with a child with a serious emotional disturbance. Journal of Emotional and Behavioral Disorders, 5(4), 212-222.

Calculating the Costs of Child Welfare Services Workgroup. (2013). Cost analysis in program evaluation: A guide for child welfare researchers and service providers. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (2015). Types of Evaluation. Retrieved from https://www.cdc.gov/std/Program/pupestd/Types%20of%20Evaluation.pdf

Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: A self-report measure of protective factors against child maltreatment. Child Abuse & Neglect, 34(10), 762-772.

Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration. (1993). Feasibility, Alternatives, And Cost/Benefit Analysis Guide. Washington DC. Retrieved from http://archive.acf.hhs.gov/programs/cb/systems/sacwis/cbaguide/c1intro.htm

DeVellis, R.F. (2003). Scale development: Theory and applications (2nd ed.). Thousand Oaks, CA: Sage Publications.

Framework Workgroup. *A framework to design, test, spread, and sustain effective practice in child welfare.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Fostering Court Improvement (2018). North Carolina, Statistics for Catawba County. Retrieved from http://fosteringcourtimprovement.org/nc/County/Catawba/

Frey, L., Cushing, G., Freundlich, M., & Brenner, E. (2008). Achieving permanency for youth in foster care: Assessing and strengthening emotional security. Child & Family Social Work, 13, 218-226. doi:10.1111/j.1365-2206.2007.00539.x

Liao, M., & Testa, M. (2016). Post adoption and guardianship. Research on Social Work Practice, 26(6), 675-685. http://dx.doi.org/10.1177/1049731514564600

Liao, M., & White, K. R. (2014). Post-permanency service needs, service utilization, and placement discontinuity for kinship versus non-kinship families. Children and Youth Services Review, 44, 370-378. http://dx.doi.org/10.1016/j.childyouth.2014.07.007

Meunnig, P. (2002). Designing and conducting cost-effectiveness analyses in medicine and health care. San Francisco: Jossey-Bass.

Peterson, J. L. & Zill, N. (1986). Marital disruption, parent-child relationships, and behavioral problems in children. Journal of Marriage and the Family, 48, 295-308.

Richardson, W., Wilson, M., Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. ACP Journal Club, 123(3), A12.

Rolock, N. (2015). Post-permanency continuity: What happens after adoption and guardianship from foster care? Journal of Public Child Welfare, 9(2), 153-173. doi:10.1080/15548732.2015.1021986

Rolock, N., & White, K.R. (2016). Post-permanency discontinuity: A longitudinal examination of outcomes for foster youth after adoption or guardianship. Children and Youth Services Review, 70, 419-427. doi:10.1016/j.childyouth.2016.10.025

Rolock, N., & White, K. R. (2017). Continuity for children after guardianship versus adoption with kin: Approximating the right counterfactual. Child Abuse & Neglect, 72, 32-44. doi:10.1016/j.chiabu.2017.07.001

Springer, F. & Phillips, J. L. (2006). The IOM model: A tool for prevention planning and implementation. Prevention Tactics, 8(13).

Testa, M.F., & Poertner, J. (Eds.). (2010). Fostering accountability: Using evidence to guide and improve child welfare policy. New York, NY: Oxford University Press.

Testa, M. F., Snyder, S. M., Wu, Q., Rolock, N., & Liao, M. (2015). Adoption and guardianship: A moderated mediation analysis of predictors of post-permanency continuity. American Journal of Orthopsychiatry, 85(2), 107-118

United States Census Bureau (2017). Retrieved from https://www.census.gov.

United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Bureau (2018). Child welfare outcomes report data. Retrieved from https://cwoutcomes.acf.hhs.gov/cwodatasite/.

White, K. R. (2016). Placement discontinuity for older children and adolescents who exit foster care through adoption or guardianship: A systematic review. Child and Adolescent Social Work Journal, 33(4), 377-394. doi:10.1007/s10560-015-0425-1

Wilson, D., Brandes, B., Ball, H., & Malm, K. (2012, July). Building the Child Wellbeing Project: Practitioners' perspectives on the role of implementation science in strengthening post-care child welfare services (Publication #2012-18). Washington, D.C: Child Trends. Retrieved from http://dukeendowment.org/sites/default/files//evalutaion-reports/Child_Trends-2012_07_01_RB_Catawba3_0.pdf

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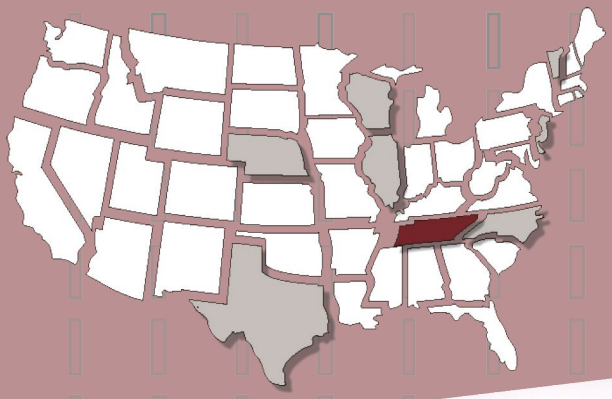
Evaluation Results from

Tennessee



Final Evaluation Report

September 2019

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

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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Report Authors

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

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

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

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

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

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

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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 Tennessee Department of Children's Services and at Harmony Family Services, 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.

A special appreciation goes to the The ChildTrauma Academy, the purveyors of NMT, who supported the site in adapting their model for this study.

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Evaluation Results from Tennessee

PROJECT PARTNERS

QIC-AG partnered with the **Tennessee Department of Children's Services (DCS)** and **Harmony Family Center**.

CONTINUUM PHASE

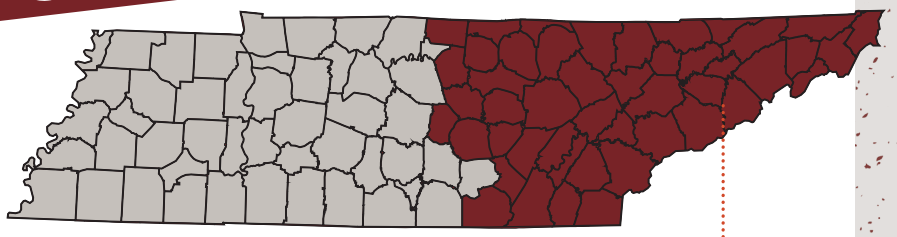
Intensive Services

INTERVENTION

The **Neurosequential Model of Therapeutics (NMT)** includes training/capacity building for family counselors to use the NMT with adopted children, assessment of trauma experiences on brain development and individualized, comprehensive treatment plans based on the assessment.

STUDY DESIGN

Quasi-Experimental



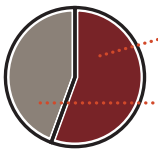
The target population was adoptive families served by the ASAP program. Families served by ASAP in the East, Northeast, Tennessee Valley, Knox, Smoky Mountain, and Upper Cumberland regions were in the intervention group. Families in the remainder of the state were assigned to the comparison group.

RESEARCH QUESTION

Will children and youth from families who have adopted and are referred (or self-refer) to ASAP's post adoption services in the East, Northeast, Tennessee Valley, Knox, Smoky Mountain and Upper Cumberland regions who receive the NMT experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health when compared to similar children and youth who receive services as usual?

Findings

386 families participated in the study

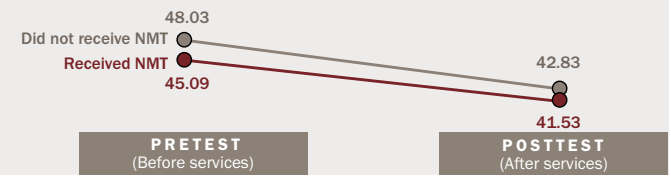


215 received the **treatment (NMT)** at Harmony Family Center.

171 received **services as usual** (comparison) at Catholic Charities.

CAREGIVER CONCERN

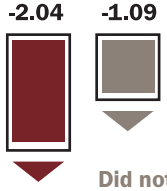
Caregivers reported less parental concern



Scores are from the Parental Feelings Form (PFF). This scale runs from 0-60. A lower score = less parental concern.

CHILD BEHAVIOR

Change in BPI Internalizing Score



Fewer internalizing behaviors

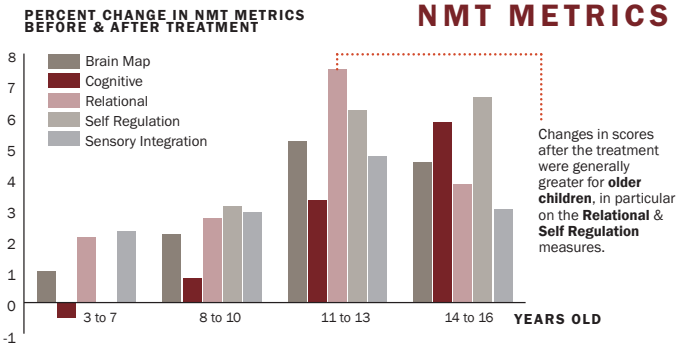
The arrows to the left represent the average reduction in BPI Internalizing Behavior Subscale scores from pretest to posttest for families who received NMT and those who did not. While behaviors improved for both groups, NMT families showed a greater improvement.

EMOTIONAL SECURITY & COMMITMENT

Caregivers reported a higher sense of belonging and stronger claim to their child.

Scores are from the Belonging and Emotional Security Tool-Adoption & Guardianships (BEST-AG). This scale runs from 13-65. a higher score = greater sense of family belonging.

NMT METRICS



RECOMMENDATION

More research using larger samples and longer observation windows are needed to examine the effects of the NMT with post-adoptive children and families. Incorporating the NMT Metric as a post-adoption intervention is a long-term investment designed to help children who have experienced significant trauma and may have a positive impact on children and families over time.

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

QIC•AG National Quality Improvement Center for Adoption & Guardianship Support and Preservation

Jack, Joseph and Morton Mandel School of Applied Social Sciences Case Western Reserve University

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

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

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

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

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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.

Executive Summary

Overview

The Tennessee Department of Children's Services (DCS) is a state-administered public child welfare agency. In 2004, DCS selected the Harmony Family Center (Harmony), a Tennessee-based private non-profit organization specializing in pre and post adoption services, to administer the state's Adoption Support and Preservation Program (ASAP). Harmony provides services to families in Eastern Tennessee and families in the Middle and Western areas of the state are served through sub-contracts with Catholic Charities. This long established history of providing post-adoption services sets Harmony apart in the National Quality Improvement Center for Adoption and Guardianship Support (QIC-AG) project. The Tennessee site of the QIC-AG implemented the Neurosequential Model of Therapeutics (NMT), a developmentally sensitive, neurobiology-informed approach, with adoptive families who request services or are referred for services in the areas of the state served by Harmony.

The study's Theory of Change suggested that once families are provided a family-centered, trauma-informed, bio-psychosocial assessment process to identify their needs and linked to specific services, they would have the knowledge and skills to effectively manage problems when they arise, which would increase placement stability and reduce the risk of discontinuity. The QIC-AG project was implemented at the Intensive Interval level of the QIC-AG Permanency Continuum Framework and the intervention was located in the **Compare and Learn** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*.

Intervention

The Neurosequential Model of Therapeutics (NMT) includes three core components:

- Training/Capacity Building - Developing the necessary materials, tools and training experiences for family counselors to use the NMT with adopted children.
- Initial Assessment – Assessing (informed through multiple sources) the timing and severity of trauma on brain development and developing the "NMT Metrics Report."
- Child Specific Recommendations – Developing and implementing individualized, comprehensive Treatment Plans based on information collected during the Initial Assessment.

Primary Research Question

The study's research question was:

Will children and youth from families who have adopted and are referred (or self-refer) to ASAP's post adoption services in the East, Northeast, Tennessee Valley, Knox, Smoky Mountain and Upper Cumberland regions who receive the Neurosequential Model of Therapeutics (NMT) experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health when compared to similar children and youth who receive services as usual?

The target population was solely adoptive families served by ASAP program who had children under the age of 18 and were adopted through the Tennessee Department of Children's Services, a public child welfare system in another state, or through private domestic or intercountry processes.

A quasi-experimental pre and posttest design were used to evaluate the NMT intervention. Children served by Harmony received the NMT, and those served by Catholic Charites received services as usual.

ASAP staff delivered pretest measures at intake and posttest measures at the end of services to the intervention and comparison groups. In addition, all ASAP staff who were providing services to the intervention and comparison groups were sent a link to an on-line satisfaction survey. The NMT staff fidelity and treatment plan adherence were also measured throughout the study.

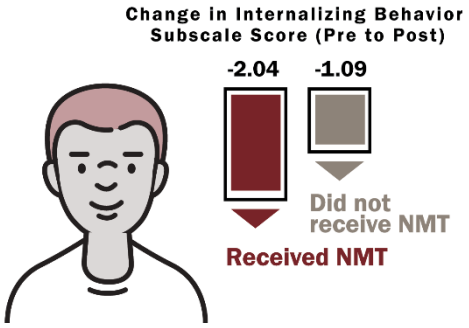
Key Findings and Discussion

A quasi-experimental design was used to examine differences between the families assigned to the intervention group (n = 215) and families who received services as usual (n = 171). In this analysis, we observed trends which suggested that positive changes were occurring for those who received NTM and that changes were generally in the direction one would expect with this intervention. Specifically:

Child behavioral issues. This was measured with the Behavioral Problem Index (BPI). On the BPI, a decrease in score suggests fewer behavioral issues:

- Both the intervention and comparison groups saw statistically significant differences between scores at PRE and POST BPI scores.
- A difference was observed between intervention and comparison groups in the overall BPI score, with slightly greater change observed for the intervention group. While not statistically significant at the .05 level, this is trending towards a statistically significant result (on average, a reduction of 1.82 points, p=.086).

- Change in the BPI-internalizing subscale among respondents in the intervention group was better than those in the comparison group (on average, a reduction of 0.96 points, p=.046), a statistically significant finding.

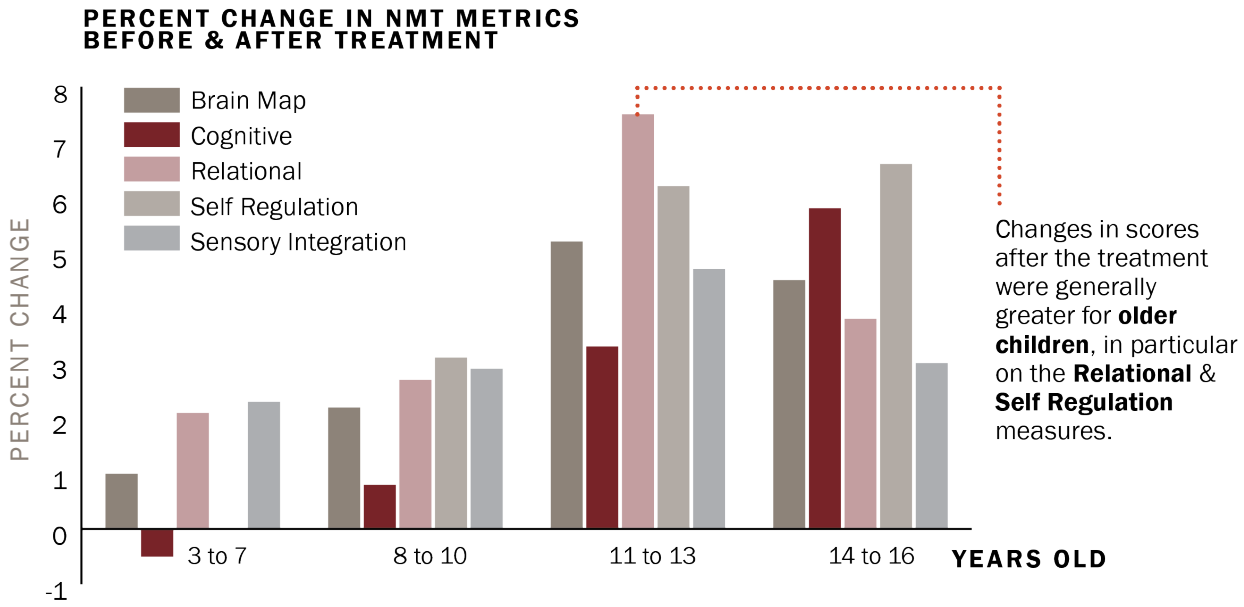


- Similarly, change in the BPI-externalizing subscale among respondents in the intervention group was better than those in the control group, on average, a reduction of 1.32 points (p=.092), trending towards statistical significance.

Caregiver commitment. This was measured with the Belonging and Emotional Security Tool – for Adoptive and Guardianship families (BEST-AG). On the BEST-AG scale, increases suggest an improved sense of belonging and emotional security. While not statistically significant, the BEST-AG shows a slightly stronger trend for the treatment group, suggesting that with additional time and more study participants, a statistically significant difference may emerge.

Familial relationships. This was measured with the Parent Feelings Form (PFF). For this measure, lower scores are preferred. Results showed an overall reduction in PFF scores from pretest to posttest. The PFF showed declindes for both groups, but not a statistically significant difference.

The NMT Metrics (for the intervention group only). Compared to neurotypical children their age, children and youth who received the intervention saw an increase, over baseline, of their functioning on key domains measured through the NMT Metrics: participants moved closer to the neuro-typical functioning on all domains. The largest percent change occurred among older children and youth, with most change observed for children over the age of 11.



Among children adopted through the child welfare system, many have had difficult experiences in addition to maltreatment, including long periods of time in foster care prior to adoption and instability in foster care. Children in families who reach out for assistance after adoption may have experienced significant trauma and could benefit from trauma-informed post adoption services and supports. Changes from pretest to posttest on the NMT measures were stronger for older children (those over 8 years old). Therefore, the NMT may be more helpful for older children. However, these results may have also been due to better reasoning capacity of older youth, different experiences with trauma or the effects of the NMT may need more time to be observed with younger children.

In summary, the trends found in this study are promising for children and youth who received NMT, but more research using larger samples and longer observation windows are needed to examine the effects of the NMT with post adoptive children and families. Addressing issues with children who have expereinced maltreatment, trauma and loss is difficult work and takes time. The observation window in this study was less than a year, and results of interventions may not be observed until more time has passed. In this relatively short period of time the intervention group saw change on key measures included in the metric (e.g., particularly for older children in the relational and self-regulation domains). Perhaps with additional time, and more families enrolled, different results regarding the intervention and comparision groups may have emerged. Incorporating the NMT Metric as a post adoption intervention is a long-term investment designed to help children who have experienced significant trauma and may have a positive impact on children and families over time.

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 9

TENNESSEE: THE NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT)

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Tables and Figures

Site Background

The Tennessee Department of Children's Services (DCS) is the public child welfare agency that investigates allegations of child abuse and neglect, administers the State's foster care system and for the children who come into care, works to find permanence through reunification, adoption, or guardianship. In 2004, DCS selected the Harmony Family Center, a Tennessee-based private non-profit organization specializing in pre and post adoption services, to administer the state's Adoption Support and Preservation Program (ASAP). This long established history of providing post-adoption services sets Harmony apart in the QIC-AG project. The Harmony Family Center provides services in eastern Tennessee and adoptive families in the middle and western areas of the state are served through sub-contracts with Catholic Charities. All adoptive families in Tennessee are eligible to receive services from ASAP. Services are available at no cost or low cost to any state resident who adopt privately, domestically or internationally (Tennessee Department of Children Services Annual Progress and Services Report, 2015).

Services provided by Tennessee's ASAP include adoption preparation training, monthly support groups located in 12 sites around the state, an annual conference focused on adoptive issues for families and clinicians, and a lending library of books on pre and post adoption information. Services, ranging from counseling to camp, are designed to support and promote the success of adoptive and guardianship families on every level and at every stage of the adoption journey.

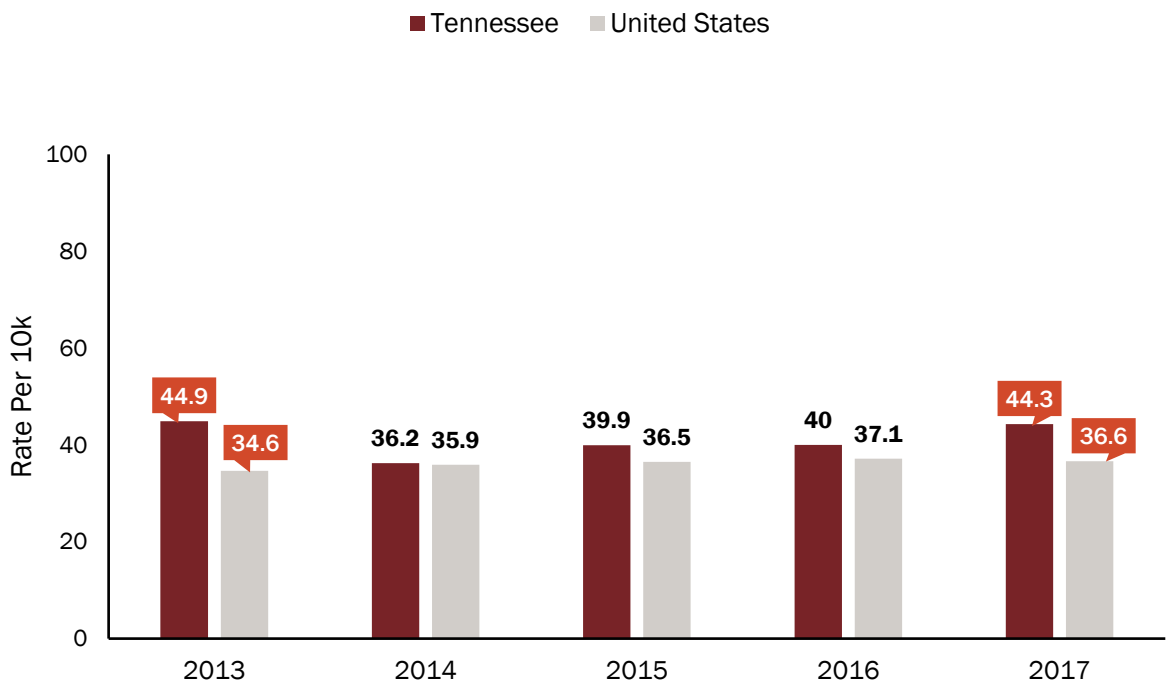
A cohesive team that included a Project Management Team (PMT), Stakeholder Advisory Team (SAT) and the Implementation Team (IT) designed and implemented the Tennessee QIC-AG project. The study's Theory of Change postulated that by using a family-centered, trauma-informed, bio-psychosocial assessment process to identify the needs of the child and family, the most appropriate type of intervention will be identified. With appropriate intervention, families will be linked to services specific to their needs. Once linked to appropriate services, families will have the knowledge and skills to effectively manage issues or problems when they arise which will increase placement stability and reduce the risk of discontinuity.

The Neurosequential Model of Therapeutics (NMT) is a developmentally sensitive, neurobiology-informed approach to clinical problem solving that has been used with children and youth who have experienced trauma or maltreatment. The NMT Metric provides a picture of a person's strengths and vulnerabilities in relation to his or her developmental history and offers a set of enrichment, therapeutic and educational activities that matches the person's assessed needs that is then used to guide how clinicians provide services to the children and youth they are serving (Perry & Dobson, 2013). Given the high level of services-as-usual provided by ASAP, the Tennessee QIC-AG site was uniquely situated to embark upon the intense training necessary to carry out the project. The NMT augmented services as usual in the intervention regions.

National Data: Putting Tennessee in Context

The data in this section is provided to put the site in context with national data. By comparing data from Tennessee to that of the nation we are able to understand if Tennessee is a site that removes children from their homes more or less than the nation, on average, and compares median lengths of stay for children in foster care. Finally, we compare the per capita rate of children receiving IV-E adoption or guardianship assistance. We provide all these comparisons over the past five years to give a sense of recent trends.

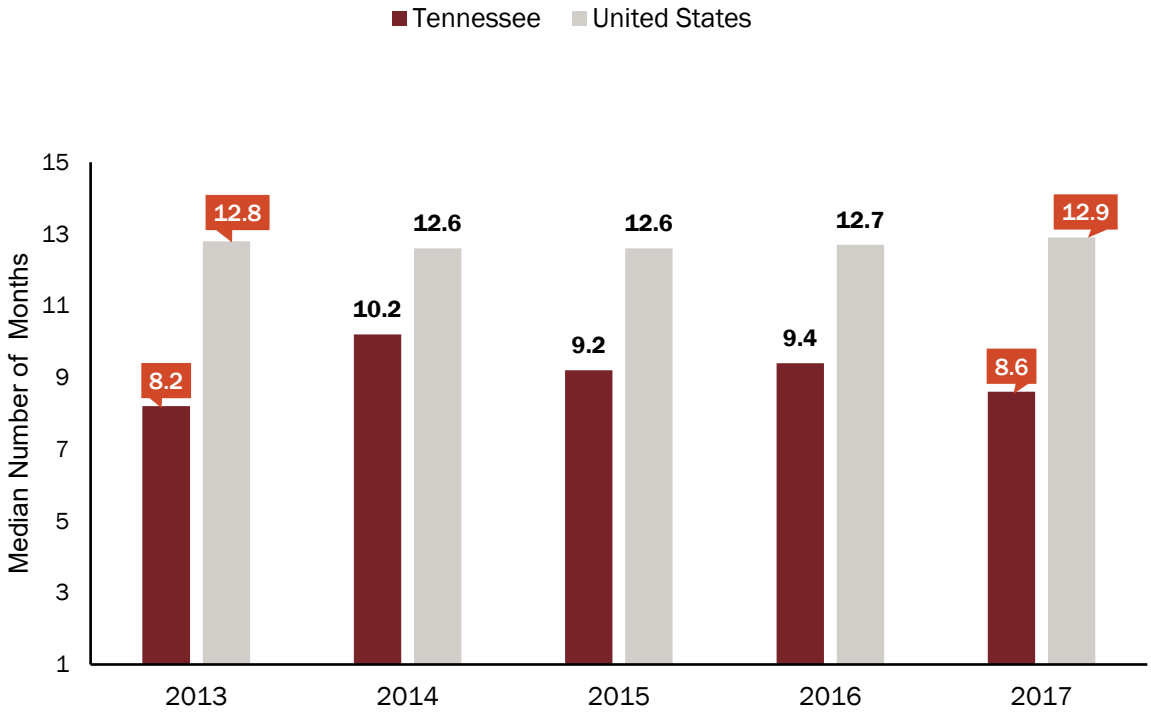
Figure 9.1. Tennessee Foster Care Entry per Capita Rate (2013 – 2017)



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/

As displayed in Figure 9.1, between Fiscal Years 2013 and 2017, the rate of children entering foster care in Tennessee was higher than the average U.S. foster care entry. Between 2013 and 2017, the state's foster care entry rate was fairly steady, decreasing only slightly from 44.9 per 10K (6,700 children) to 44.3 per 10K (6,679 children). The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. While per capita rate for Tennessee was higher than the per capita rates for the U.S., the overall rates in the state decreased slightly while overall rates in the nation increased.

Figure 9.2. Tennessee Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)

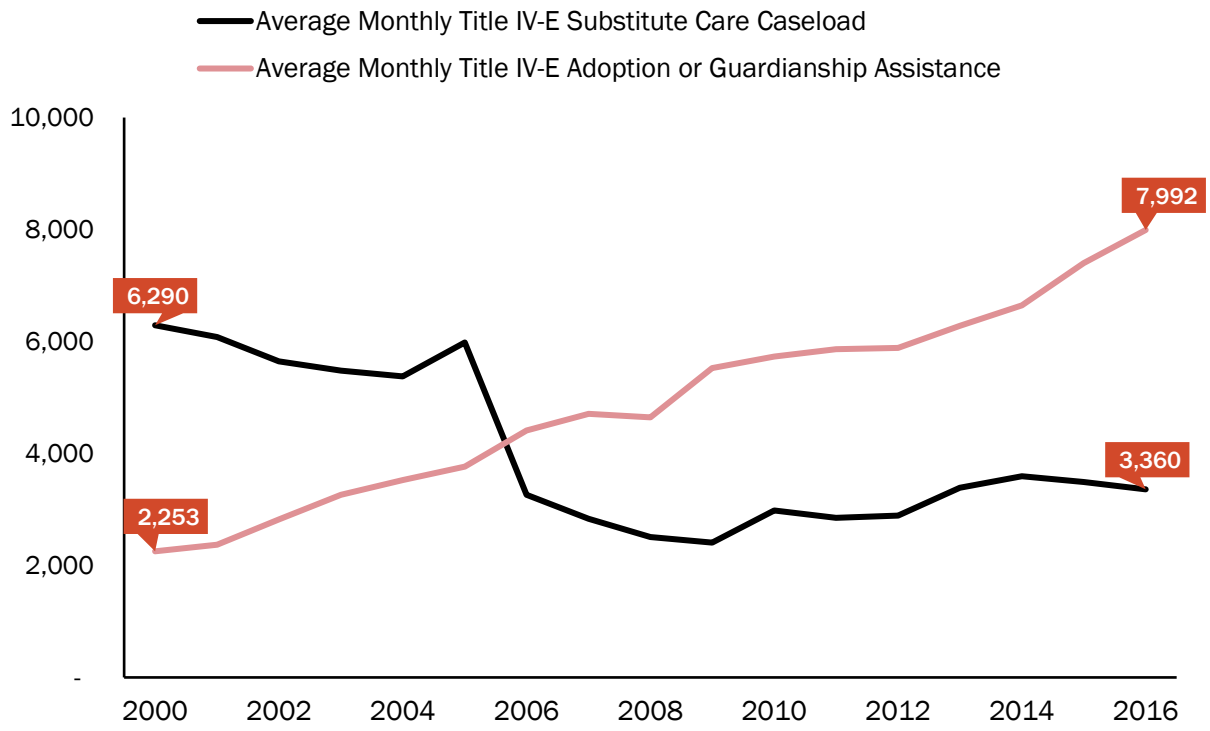


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

Between 2013 and 2017, the medium length of stay for children in foster care on at the end of each year (shown in Figure 9.2) were lower for Tennessee than the U.S. The length of stay increased a little in Tennessee from 8.2 months in 2013 to 8.6 months in 2017 while in the U.S. it increased slightly from 12.8 months in 2013 to 12.9 months in 2017.

Nationally, we have seen a shift in the number and proportion of children living in IV-E supported foster care and IV-E funded adoptive or guardianship homes. As shown in Figure 9.3, the number of children in Tennessee in IV-E funded foster care was much higher than the number of children in IV-E funded adoptive homes were approximately the same in 2000 (6,290 and 2,253 respectively), yet in 2016 these numbers have changed dramatically. In 2016 there were 3,360 children in IV-E funded substitute care and 7,992 children in IV-E funded adoptive homes.

Figure 9.3. Tennessee Caseloads (2000 – 2016)



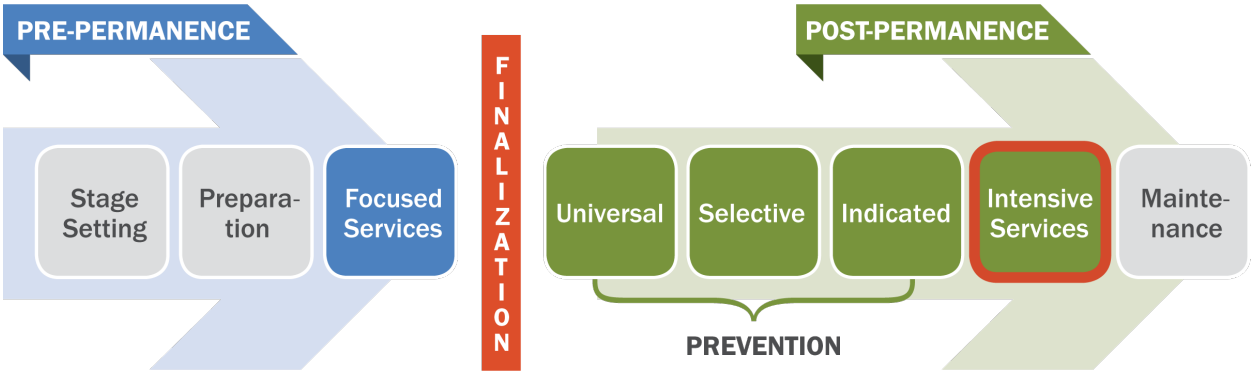
Data sources: Title IV-E numbers: U. S. Department of Health and Human Services / Administration for Children and Families, compiled data from states' Title IV-E Programs Quarterly Financial Reports, Forms IV-E-1 (for years prior to 2011) and CB-496 (for 2011 and later).

QIC-AG Permanency Continuum Interval

Tennessee implemented an intervention at the **Intensive Interval** level of the QIC-AG Permanency Continuum Framework. **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.

The existing services, or services-as-usual, provided by the ASAP program in Tennessee include intensive services for families who reached out to the agency and families who were referred to the agency for services.

Figure 9.4. Tennessee QIC-AG Permanency



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:

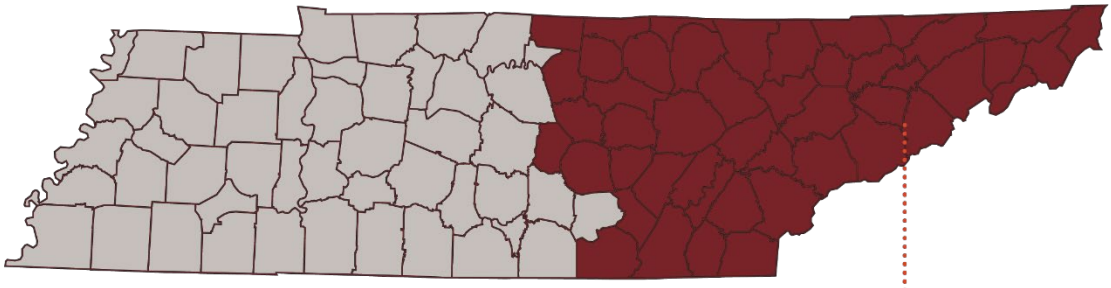
Will children and youth from families who have adopted and are referred (or self-refer) to ASAP's post adoption services in the East, Northeast, Tennessee Valley, Knox, Smoky Mountain and Upper Cumberland regions (P) who receive the Neurosequential Model of Therapeutics (NMT) (I) experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health (O) when compared to similar children and youth who receive services as usual (C)?

Each part of the PICO is described below.

Target Population

The target population was adoptive families served by ASAP program. ASAP-involved families are typically families who have high services and support needs, and therefore, may be at increased risk for post permanency discontinuity. Children under the age of 18, who were adopted, through Tennessee's Department of Children's Services, a public child welfare system in another state, or internationally, via intercountry, or private domestic adoption are eligible to receive ASAP services.

Families served by ASAP in the East, Northeast, Tennessee Valley, Knox, Smoky Mountain, and Upper Cumberland regions were assigned to the intervention group. These regions are served by Harmony Family Center. Families in the remainder of the state were assigned to the comparison group.



The target population was **adoptive families served by the ASAP program.** Families served by ASAP in the East, Northeast, Tennessee Valley, Knox, Smokey Mountain and Upper Cumberland regions were in the intervention group. Families in the remainder of the state were assigned to the comparison group.

Families who were not eligible to participate in the evaluation included:

- Adoptive families who received case management only services from ASAP. These families are provided referrals, linkages, phone, and email support, but are typically not in need of, or desire, in-home services.
- Adoptive families who begin in-home services and then stop engaging within 90 days. This includes, for instance, families with a child who is hospitalized or in residential treatment, and therefore closed for services from ASAP.
- Families who obtained permanence through Subsidized Permanent Guardianship.

Intervention

The NMT integrates the core principles from the fields of neurodevelopment and traumatology to determine how the timing and severity of trauma might influence the development of the brain. The NMT diagnostics help professionals and families apply interventions appropriately aligned with the child's needs and strengths (Perry, 2006). The NMT has been used with young children, in a therapeutic preschool setting, and in residential settings (Barfield, Dobson, Gaskill, & Perry, 2012). However, it has never been tested with an adoption population. Testing the NMT as an assessment tool aligned well with developing evidence-based models of support and interventions in Tennessee.

A key consideration for participation in the NMT intervention was the willingness of the participating agency staff to actively engage in the provision of services. There was strong interest in the project across the State. Ten of Tennessee's 12 geographic regions expressed interest in participating in the project. The QIC-AG team strategically chose four areas in the state based on their interest and commitment to seeing the project through to successful completion. Dr. Bruce Perry, the NMT purveyor, provided extensive consultation and training to the sites. No adaptations to the NMT model were made for the QIC-AG project.

According to the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare* the goal of the **Compare and Learn** phase should result in "an intervention with evidence that suggests it is more likely than one or more alternatives to improve outcomes" (Framework Workgroup, p. 4).

THE NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT)

The NMT in the Tennessee QIC-AG project had three core components: 1) Training/Capacity Building, 2) Initial Assessment and 3) Child-Specific Recommendations

1) Training/Capacity Building

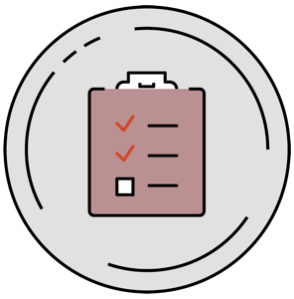
The ChildTrauma Academy developed a set of training materials, supervised training experiences and Clinical Practice Tools to help family counselors develop the capacity to use the NMT with the adopted children and youth they serve. To implement the NMT, participants in the NMT certification process needed to understand the impact of trauma and maltreatment on the developing child or youth. Participants were provided in-depth exposure to core concepts of the intervention including child development, neurobiology, traumatology, attachment theory and were trained to use the online NMT Metrics which included the Functional Brain Map.

2) Initial Assessment

The NMT assessment process included examining a child's past and current experiences and functioning. Family counselors reviewed the history of adverse experiences and relational health factors and estimated the timing and severity of developmental risk that may have influenced brain development. The NMT Metrics Report provided a semi-structure assessment of important developmental experiences and a current "picture"

of brain organization functioning (i.e., a Functional Brain Map). The report quantified the nature, timing, and severity of adverse experiences as well as relational health factors. Scoring the NMT metrics estimated relative brain-mediated strengths and weaknesses and was informed by multiple sources including previous health (or mental health) records, school records, parents, foster parents, other caregivers, clinicians and other people who had information about, or contact with, the child. When there was incomplete historical information, family counselors used clinical judgment to reconstruct histories and score maps.

3) Child-Specific Recommendations



The Family Counselor developed and implemented an individualized, comprehensive Treatment Plan for the child based on information collected during the Initial Assessment and with input from parent(s) and the child. The key to developing child-specific recommendations was ensuring that prescribed therapeutic activities matched developmental capabilities and needs indicated on the child's NMT Metrics Report. The interventions often included patterned, repetitive and rewarding experiences targeting areas of the brain impacted by adverse experiences (ChildTrauma Academy website; Perry & Dobson, 2013). Therapeutic and educational enrichment programs were provided by a "therapeutic web" or group of adults and peers (e.g., caregivers, teachers, coaches, front-line mental health workers, foster parents and parents) invested in the child's growth and development (Hambrick, Brawner, & Perry, 2018). The length and frequency of services provided were customized to meet the unique needs of the child and parent/family being served.

Comparison

Families residing in the following regions received the services as usual: East, Northeast, Tennessee Valley, Knox, Smoky Mountain, and Upper Cumberland regions. Families residing in the remainder of sites were the comparison group. These families were served by Catholic Charities.

Outcomes

The short-term outcomes for the Tennessee QIC-AG project were:

- Decreased child behavioral issues
- Increased staff satisfaction with delivery services
- Improved familial relationships
- Improved caregiver commitment

Long term outcomes, set *a priori* by the project, included:

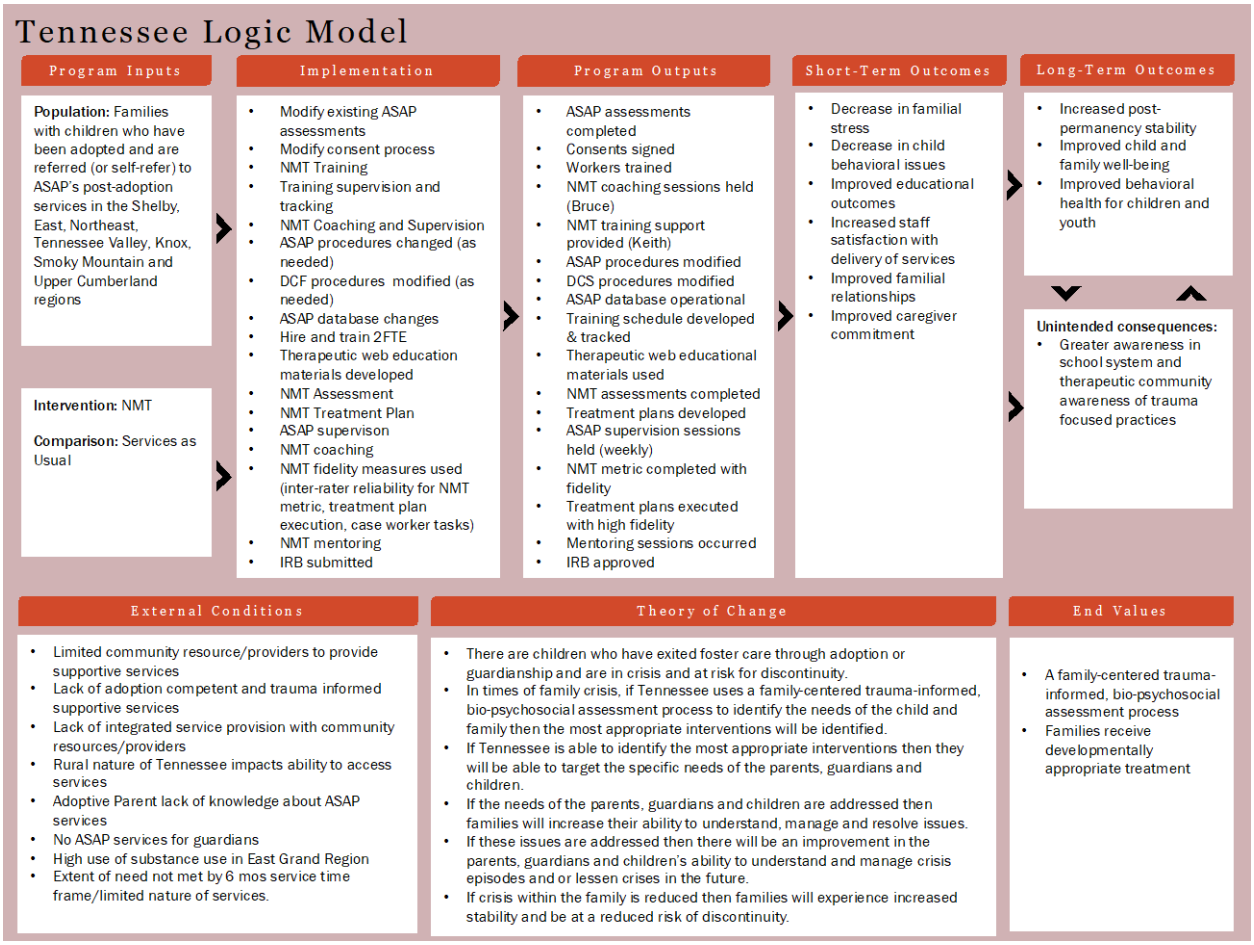
- Improved post permanency stability
- Improved child and family wellbeing
- Improved behavioral health for children and youth

The ASAP program collects assessment data at the start and end of service delivery. Most of the outcomes were assessed using measures collected by program staff from parents. In addition, a staff survey was conducted to examine staff satisfaction with the delivery of services. Originally, we had hoped to measure familial stress and educational outcomes, but we were unable to measure these outcomes with the existing data provided to the evaluation team.

Logic Model

The Logic Model (Figure 9.5) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and core developmentally informed interventions to the intended proximal and distal outcomes. The model 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 9.5. Tennessee Logic Model



Evaluation Design & Methods

A quasi-experimental group design was utilized to evaluate the QIC-AG initiative in Tennessee. The selection of the NMT as the intervention made an experimental design difficult. A key component of the NMT required a community approach, or a coordinated effort between the study participants and school systems, health providers, and recreational services. It would have been nearly impossible to gather these various community partners together for a family assigned to the intervention group, and then ask the same partners to not provide the same array of services to a family assigned to the comparison group. Thus, this study used a quasi-experimental design, with a comparison group made up of children from the regions in which families received services-as-usual. Pretest and posttest scores were analyzed to examine change for children who participated in the intervention and children who received services as usual.

It was hypothesized that the NMT would result in decreased familial stress, decreased behavioral issues, improved educational outcomes, increased staff satisfaction with the delivery of services, improved familial relationships, and improved caregiver commitment. It was further hypothesized that there would be an associated increased post permanency stability, improved child and family wellbeing and improved behavioral health. It was expected that children in the intervention regions would receive an array of services that better meet their needs when compared to similar families who received services as usual.

The evaluation design and protocol were reviewed by the Institutional Review Board (IRB) at the University of Wisconsin-Milwaukee (UWM) and the Research Review Committee at the Tennessee Department of Children Services (DCS).

Procedures

USABILITY TESTING

During usability testing, the program outputs, listed in the Logic Model, were tracked. The program successfully completed all the output measures. Minor changes were made during usability to adjust some time frames and question structure associated with the completion of assessment tools.

RECRUITMENT

The recruitment process for the QIC-AG initiative was the standard ASAP protocol, adapted only slightly to accommodate the project. Prospective adoptive families were informed about ASAP services by the DCS worker during the adoption process. In addition, during the formative evaluation phase, mailings began to all families receiving adoption assistance about the availability of ASAP services. The mailings occurred twice a year. Participants could self-refer or be referred to ASAP by professionals. Families in the regions of the state served by Harmony were assigned to the intervention group, and families served by Catholic Charities were assigned to the comparison group.

INTAKE

A request for ASAP services could be made online at www.tnasap.org or by calling the ASAP Helpline. The initial request for services was completed by the adoptive parent or could be made on the child/family's behalf by a service provider (i.e. DCS or CPS staff, therapist, residential treatment or inpatient program staff).

The Clinical Manager reviewed the referral and contacted the family within 24 hours of the initial request for services. The Clinical Manager made the final determination of crisis or non-crisis status, assigned the case to a Family Counselor in the ASAP database, and notified the Family Counselor. The Family Counselor contacted the family within 24 hours of the case assignment.

FIDELITY AND ADHERENCE

Two types of information were assessed for the NMT: Fidelity to the metrics, assessed by the purveyor and adherence to the treatment plan recommendations, assessed by the ASAP staff.

The NMT Staff Fidelity

On a bi-annual basis, all of the NMT-trained clinicians were required to score one case using the NMT Online Clinical Practice Tools. The purpose of the NMT online tool was to evaluate staff fidelity in using the NMT Metric. Each participant was provided a case abstract and a one-hour online session devoted to questions and answers about the case. Participants then submitted scored reports by a set date. Following the submission deadline, the purveyor (ChildTrauma Academy; CTA) identified obvious errors in scoring and distributed scored reports. CTA provided feedback via a 30-minute recorded discussion of common scoring areas where errors occurred.

Treatment Plan Adherence

The online NMT treatment plan contained a measure that allowed the NMT-trained clinician (or Family Counselor) to rate the adherence to the recommendations suggested in the treatment plan. For each task that appeared on the plan, the clinician determined whether the task was completed with high, medium, or low adherence. Monitoring of adherence started after the project was underway and was completed only for cases that closed in 2018 or later. The system for monitoring adherence was developed by ASAP project staff. ASAP staff determined the timing and frequency of the use of this measure.

The ASAP team at Harmony provided the following guidelines to their staff in terms of how the rating should be conducted. If the activity was carried out:

- **0 to 33%** of the time, a rating of **'low'** was assigned
- **34 to 67%** of the time, a rating of **'medium'** rating was assigned
- **68 to 100%** of the time, a rating of **'high'** was assigned

Outcomes

INTERVENTION-SPECIFIC OUTCOMES

ChildTrauma Academy (CTA), the purveyor for the NMT, has developed neuro-typical ratings on each of the constructs associated with the NMT Metrics. These ratings are used to assess how children and youth whose information is input into the NMT database compare to neuro-typical children and youth of the same age.

PRIMARY OUTCOMES

The Adoption Support and Preservation Program (ASAP) program's data collection system was used to collect information that allowed the evaluation team to examine pre and post intervention outcomes for all participants in the intervention and comparison groups. These data were gathered through questions asked by the ASAP staff and included measures of child behavior issues (as reported in the BPI); family functioning (as reported in the PFF); and caregiver commitment (as reported on the BEST-AG).

Pre and posttest measures were delivered by ASAP staff, as part of the intake procedures (pretests) and subsequently at the end of service (posttests). No incentives were paid to respondents. The same measurement procedures were used in the intervention and comparison regions.

ADMINISTRATIVE DATA

Administrative Data was obtained from Tennessee DCF. These data included information on the foster care experiences of children prior to adoption or guardianship, and data that allowed for the evaluation team to track post permanency discontinuity. Administrative data were linked to program data to examine study participants who experienced placement instability.

Measures

The outcomes were measured through the following scales or items[1] These data were collected by ASAP staff as part of their initial assessment and at the end of service:

Belonging and Emotional Security Tool – Adoption and Guardianships (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).

Illinois Post Permanency Commitment Items

Several items from the Illinois Post Permanency Surveys were used to evaluate the parent's commitment is child relationship in terms of commitment. These questions were originally collected by the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign in two studies, one initiated in 2005 and another in 2008. Both studies were funded by the Illinois Department of Children and Family Services (IDCFS) in order to understand how families formed through adoption or guardianship from foster care fared after legal permanence. Subsequent research related to these studies found that key questions from these surveys related to caregiver commitment played a role in understanding post permanency discontinuity (Liao & Testa, 2016; Liao & White, 2014; Testa, Snyder, Wu, Rolock, & Liao, 2015).

Behavior Problem Index (BPI)

The Behavior Problems Index measures the frequency, range, and type of childhood behavior problems children ages four and older may exhibit (Peterson & Zill, 1986). It is based on responses by the primary caregiver as to whether a set of 28 problem behaviors is not true, sometimes true, or often true. Scores on the BPI range from 0 to 56, where higher scores indicate a child may be exhibiting more behavior. The BPI contains two subscales: the BPI Internalizing Subscale (11 items) and the BPI Externalizing Subscale (19 items) which are used to measure a child's tendency to internalize problems or externalize behaviors.

Parent Feelings Form - PFF

The Parent Feelings Form (PFF; Angold et al., 1995) is a 16-item list of questions reported to be helpful in learning about parental attitudes and in helping parents name their concerns. Higher scores suggest a higher level of concern.

[1] Originally we expected to also measure familial stress and educational outcomes, but we were unable to measure these outcomes with the existing data provided.

Staff Satisfaction

Services were assessed through surveys with ASAP staff in the intervention and comparison regions. The ASAP survey was online and consisted of 31 items such as demographic questions about the staff, items that rated the services most likely to be requested, referred and received, and open-ended questions about the effectiveness of services.

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

In this section, we will first describe the profile of public adoptive families who came to the attention of ASAP services and then describe the profile of private or intercountry adoptive families who were part of the QIC-AG study in Tennessee.

Sample Frame and Participant Profile

Participants who sought services from an ASAP provider between October 1, 2016, and December 31, 2018, and requested services other than case management only, were included in this study. If families were served by Harmony, they were part of the intervention group. Families served by Catholic Charities were a part of the comparison group. Participant outcomes were tracked through May 2019. All adoptive families residing in Tennessee were eligible for ASAP services. This included families who have adopted through the public child welfare system and families who adopted through private domestic or intercountry adoption. A total of 518 families were served by the ASAP program during the study period, 386 were identified as public adoption cases, 132 as private or intercountry adoption.

PUBLIC ADOPTIVE FAMILIES

Of the 386 children identified as public adoptions, 243 had child welfare IDs (TFACTS IDs) that linked to the child welfare administrative data (142 with Harmony and 101 with Catholic Charities). Demographic characteristics were examined for families in the two sites who had adoptive children with matching records in administrative data (Table 9.1). On most observed characteristics, families served by the two agencies were similar. However, there were statistically significant differences between groups on the following characteristics:

- A greater proportion of children served by Catholic Charities had 3 or more moves while in foster care (55%) than those children served by Harmony (32%); X^2=12.88 (1) p=<0.001, a statistically significant difference.
- A greater proportion of children served by Harmony were identified as White (81%), as compared to children served by Catholic Charities (70%); X^2=14.22 (4) p<.007, a statistically significant difference.
- On average, children served by Harmony spent less time in foster care prior to adoption (M = 2.73; SD 1.85) compared to Catholic Charities (M = 3.23; SD 2.03); t(241)= 2.03 p<.044, a statistically significant difference.

Table 9.1. Characteristics of Public Adoptive Families Served by ASAP

TENNESSEE	HARMONY FAMILIES		CATHOLIC CHARITIES FAMILIES		DIFFERENCES BETWEEN HARMONY AND CATHOLIC CHARITIES		
NUMBER	142 of 215 (66%)++		101 of 171 (59%)++				
	%		%		χ^2	*df*	*p*
LENGTH OF TIME IN CARE					7.82	2	0.02
0-17 MONTHS	21%		10%				
18-23 MONTHS	19%		14%				
24+ MONTHS	60%		76%				
TYPE OF MALTREATMENT							
PHYSICAL ABUSE	12%		13%		0.04	1	0.834
NEGLECT	39%		34%		0.65	1	0.419
SEXUAL ABUSE	6%		4%		0.66	1	0.417
CHILD IS DISABLED	11%		13%		0.31	1	0.579
3+ MOVES IN FOSTER CARE	32%		55%		12.88	1	<0.001
CHILD RACE					14.22	4	0.007
WHITE	81%		70%				
BLACK	5%		15%				
OTHER RACE OR UNKNOWN	11%		14%				
CHILD IS HISPANIC	2%		1%				
CHILD IS FEMALE	52%		47%		0.73	1	0.391
AGE AT PERMANENCY					7.31	5	0.199
0-2	18%		15%				
3-5	29%		24%				
6-8	30%		31%				
9-11	15%		12%				
12-14	5%		11%				
15 +	3%		8%				
PARENT IS BIOLOGICALLY RELATED TO CHILD	6%		9%		1.50	1	0.220
PARENTS MARRIED OR TWO-PARENTS*	38%		23%		5.01	1	0.025
	M	**SD**	**M**	**SD**	***t***	***df***	***p***
CHILD AGE AT PERMANENCE	6.41	3.65	7.49	4.11	2.15	241	0.033
PARENT AGE AT PERMANENCE*	41.60	8.28	40.87	10.02	-0.62	240	0.536
MEAN YEARS IN FOSTER CARE	2.73	1.85	3.23	2.03	2.03	241	0.044
TIME FROM ADOPTION TO ASAP ASSESSMENT	3.77	2.70	3.76	3.06	-0.04	240	0.965

Notes:

Orange cells represent a statistically significant difference at the .05 level

Percent of non-missing data is reported.

*This is based on the data provided on foster parents. We are making the assumption that these foster parents become the legal adoptive parent or guardian.

++ Not all participants were finalized in TN, so those cases did not match to the TN AFCARS data. Also, some were finalized prior to the AFCARS submissions to QIC began. The denominator represents public cases with TFACTS IDs.

PRIVATE DOMESTIC AND INTERCOUNTRY ADOPTIVE FAMILIES

A total of 132 families who adopted children through private domestic or intercountry agencies also came to the attention of the ASAP program during the evaluation period. Of those families:

- **78** were served by Harmony
- **54** were served by Catholic Charities

Demographic characteristics were examined for families in the two sites who had adopted children with matching records in administrative data (see Table 9.2). However, 62 families did not have assessments done that collected demographic information (Comprehensive Assessments completed by the ASAP staff). Therefore, demographic information was available for 70 (53%) of private and intercountry adoptive families served by ASAP. On all observed characteristics, families served by the two agencies were similar, with no statistically significant differences between the agencies.

Table 9.2. Characteristics of Private or Intercountry Adoptive Families Served by ASAP

PRIVATE	HARMONY FAMILIES		CATHOLIC CHARITIES FAMILIES		DIFFERENCES BETWEEN HARMONY AND CATHOLIC CHARITIES		
NUMBER	47		23				
	%		%		χ^2	*df*	*p*
CHILD RACE							
WHITE	55%		48%		7.46	4	0.113
BLACK	9%		26%				
OTHER RACE OR UNKNOWN	36%		26%				
CHILD IS HISPANIC	2%		4%				
CHILD IS FEMALE	49%		65%		1.65	1	0.199
AGE AT PERMANENCY							
0-2	53%		57%		1.85	3	0.605
3-5	23%		19%				
6-8	13%		5%				
9-11	11%		19%				
PARENT IS BIOLOGICALLY RELATED TO CHILD	15%		9%		0.53	1	0.467
PARENTS MARRIED OR TWO-PARENTS	87%		82%		0.31	1	0.576
	M	**SD**	**M**	**SD**	***t***	***df***	***p***
CHILD AGE AT PERMANENCE	3.82	3.08	3.69	3.59	-0.15	66	0.884
CHILD AGE AT ASSESSMENT	11.01	3.85	10.75	3.77	-0.27	67	0.790
PARENT AGE AT ASSESSMENT	48.39	10.10	45.16	7.41	-1.33	65	0.187
TIME FROM ADOPTION TO ASSESSMENT	7.16	4.44	7.08	3.93	-0.07	65	0.944

Note: Demographic information is available for 70 (53%) of private and intercountry adoptive families served by ASAP only.

The process evaluation examined results regarding fidelity and adherence to the intervention. Results are presented below. This report focuses on children who reached out for ASAP services between December 2018 and May 2019.

FIDELITY AND ADHERENCE

Staff Fidelity to the NMT

All of the NMT-training and NMT certified clinicians completed a fidelity exercise, as described above. This is a rating specifically of staff fidelity to the use of the NMT Metric. The scores on these exercises determined the fidelity rating given to each clinician. CTA-initiated fidelity exercises occurred over the course of 2.5 years (5 exercises). However, one of the exercises was experimental, and therefore not included in this summary. Results (summarized in the table below) found that the majority of clinicians were rated as performing at an acceptable standard for research (a total of 60% across the four reporting periods). This is not an assessment of clinical skills. Rather, CTA reports that 'acceptable for research' is a higher standard than what would be an acceptable clinical rating.

Table 9.3. The NMT Fidelity by Reporting Period

	REPORT PERIOD 1		REPORT PERIOD 2		REPORT PERIOD 3		REPORT PERIOD 4		TOTAL	
ACCEPTABLE FOR RESEARCH	8	62%	6	60%	6	50%	10	67%	30	60%
NOT ACCEPTABLE FOR RESEARCH	5	38%	4	40%	6	50%	5	33%	20	40%

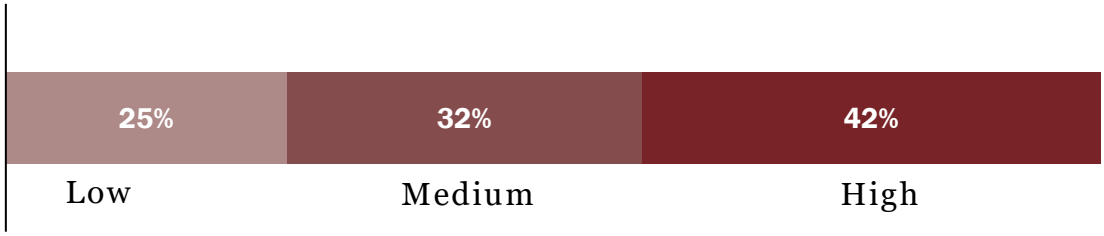
Treatment Plan Adherence

The NMT-trained clinicians were asked to assess each child-specific recommendation after it had been implemented, and report if it was completed with 'high', 'medium' or 'low' adherence. Monitoring of adherence started after the project was underway and was completed only for cases that closed in 2018 or later. The system for monitoring adherence was developed by ASAP project staff. The ASAP team at Harmony provided the following guidelines to their staff in terms of how the rating should be conducted. If the activity was carried out:

- **0 to 33%** of the time, a rating of **'low'** was assigned
- **34 to 67%** of the time, a rating of **'medium'** rating was assigned
- **68 to 100%** of the time, a rating of **'high'** was assigned

Adherence to the treatment plan recommendation was assessed by the NMT-trained clinicians for cases that closed in 2018 or later. Of the 95 cases that closed during in 2018 or the first quarter of 2019, 70 (74%) had recommendations that were assessed for adherence, and 26% were not rated. Of the 70 cases rated, there were a total of 947 recommendations. Clinicians rated:

Figure 9.6. Adherence to the Recommendation



Of the 947 recommendations that were rated by Harmony staff, the level of adherence varied by type of recommendation, as shown in the table below. Recommendations related to the family had the largest percentage of 'high' adherence.

Table 9.4. Level of Adherence to the Recommendation

	RECOMMENDATION TYPE			
LEVEL OF ADHERENCE	FAMILY	INDIVIDUAL	THERAPEUTIC WEB	TOTAL
HIGH	152	175	73	400
	50%	36%	45%	42%
MEDIUM	89	179	39	307
	30%	37%	24%	32%
LOW	60	128	52	240
	20%	27%	32%	25%

Additional information regarding the type of recommendations are included in the Appendix.

Outcome Evaluation

This section will begin with intervention-specific results. These are results related to only the participants who received the NMT metrics (the intervention group). This is followed by the primary study outcomes, where intervention and comparison study participants are reported.

Terminology Defined

Intervention group or intervention participants:
Families in this group were assigned (based on region) to the intervention group and received the NMT. Families in this group worked with the ASAP staff at Harmony.

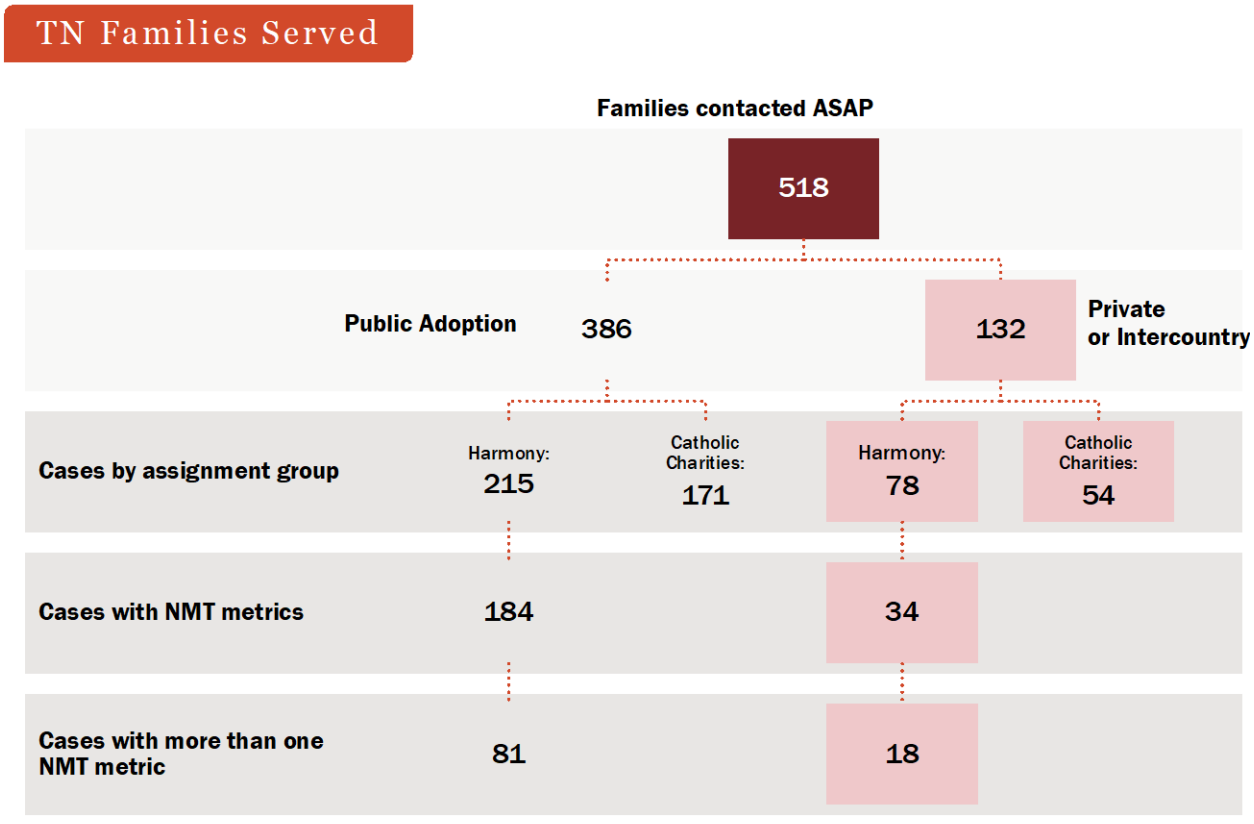
Comparison group:
Families in this group were assigned (based on region) to the comparison group. They received services as usual intervention provided by Catholic Charities.

This section will begin with reporting on intervention-specific outcomes and then report on the primary study outcomes (where results for families in the intervention and comparison groups are evaluated).

As displayed in Figure 9.7, a total of 518 families were referred or self-referred for ASAP services during the evaluation period. Of those, 386 families were public adoptions and 132 families were private domestic or intercountry adoptions. Of the public adoptions, 215 families received services from Harmony and 171 from Catholic Charities. Of the private domestic or intercountry adoptions, 78 families received services from Harmony and 54 from Catholic Charities. In total, 184 public adoptive families had an initial NMT metric completed by Harmony, and 81 had a follow-up metric also completed. In addition, 34 private domestic or intercountry adoptive families had an initial NMT metric completed by Harmony, and 18 a follow-up metric also completed.

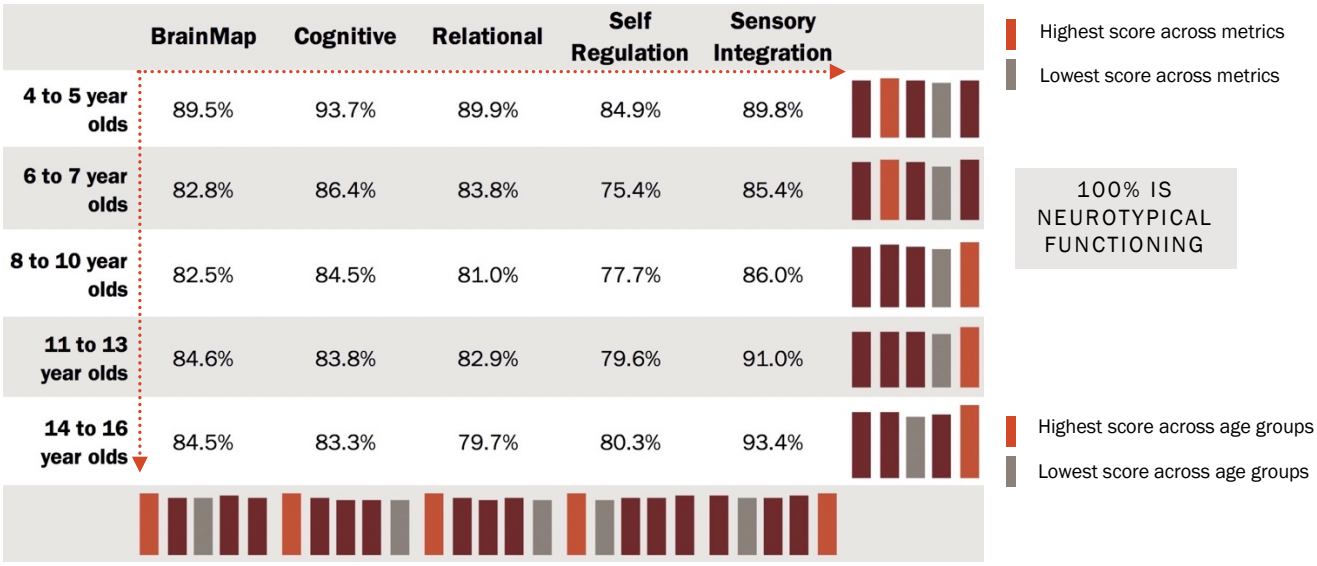
This section will begin with reporting on intervention-specific outcomes and then report on the primary study outcomes (where results for families in the intervention and comparison groups are evaluated).

Figure 9.7. Families in Contact with ASAP



The first graph (Figure 9.8) shows the baseline functioning of the children for whom the NMT metrics were completed. A total of 184 initial metrics were completed on families, however, data from children in the following age groups were not presented because there were too few assessments completed in their age group, making it difficult to draw conclusions: children under 3-years old and youth ages 17 to 19. Figure 9.8 reflects outcomes for 167 children. Additional details are included in Table 9.15 in the Appendix.

Figure 9.8. Baseline Metrics: Percent of Neuro-typical Functioning by Age



The results in Figure 9.8 show that:

- All age groups were below the 100% neuro-typical functioning standard on all measures at baseline. Scores on measures at time 1 ranged from a low of about 75% of typical functioning on self-regulation for 6 to 7-year olds to a high of almost 94% of typical functioning on the Sensory Integration measure for 14-16-year olds and Cognitive Functioning among 4-5-year-olds.
- Self-regulation was the area for which children and youth had the lowest percent of neuro-typical functioning, regardless of age.
- Sensory integration was much higher (closer to neuro-typical functioning) for youths ages 11 and older. Scores on this measure were highest for the oldest age group (14 to 16-year-olds).
- For the majority of the measures, 4 to 5-year-olds were closer to neurotypical functioning than other age groups, with the exception of Sensory Integration.
- Youth ages 14 to 16 had the lowest relational scores of all age groups.

Figure 9.9 represents the data from the final metrics completed on the child (at or near the end of service). A total of 81 time-two (or final) NMT metrics were completed. Children under 3-years-old and youth ages 17 to 19 were excluded due to the low numbers. A total of 75 Final Metrics are reported in Figure 9.9 and Table 9.16 (in the Appendix). These results indicate:

- Percent of typical for self-regulation continues to be the lowest domain among all measures at posttest and across ages. However, 4-5-years olds are approximately 88% of typical for this outcome.
- Percent of typical for sensory integration is the highest score at posttest for all but one age group (4 to 5-year-olds).
- The youngest age group (4 to 5-year-olds) had the highest percent of neurotypical functioning across four of the five measures (i.e., all except Sensory Integration). Sensory Integration was highest for the oldest age group (14 to 16-year-olds).
- An upward trend was observed from pre to posttest, with children moving closer to the neuro-typical functioning on all domains, from pre to posttest.

Figure 9.9. Final Metrics: Percent of Neuro-typical Functioning by Age

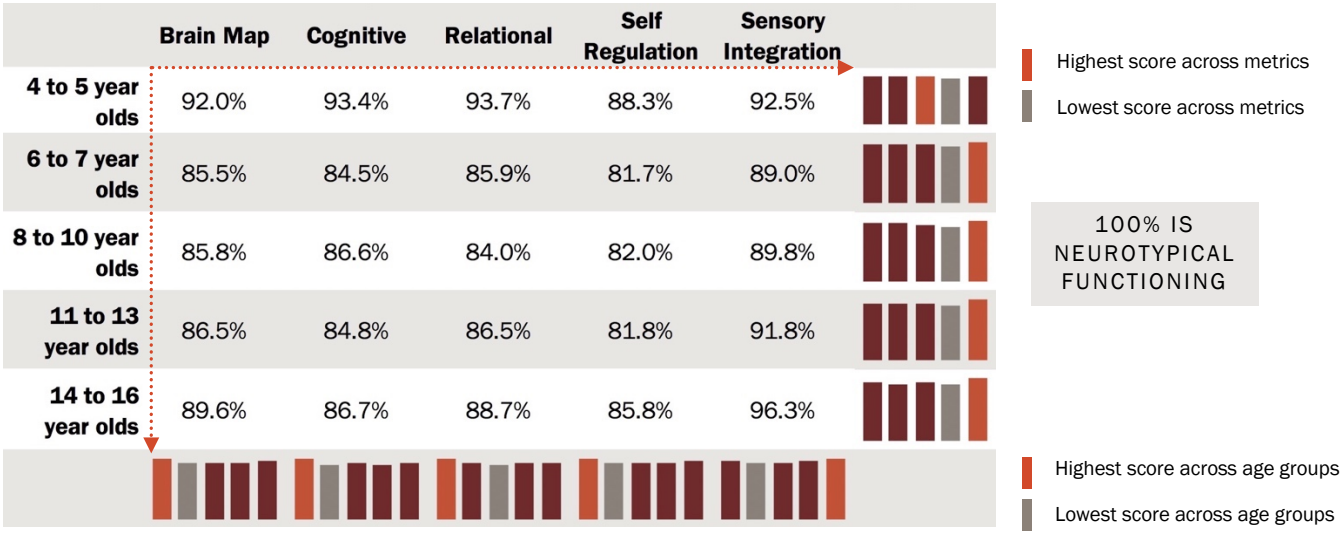
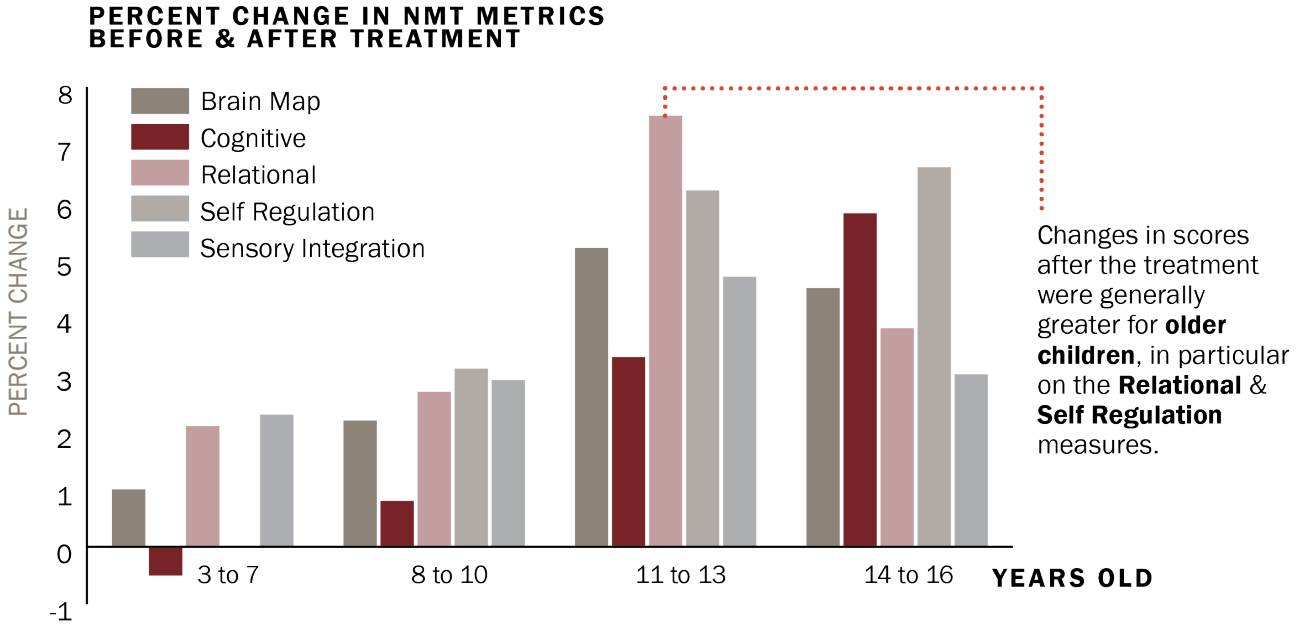


Figure 9.10 charts the percent change, from baseline (pre measures) to post intervention on the NMT Metrics for families served in the intervention group. A total of 75 Final Metrics are reported on in Figure 9.10 (and Table 9.17 in the Appendix). Key observations:

- The percent change was generally greater for older children than younger children across all domains. In particular, percent change was highest on all measures for children ages 11 and older.
- The highest percentage changes from pretest to posttest were in the relational domain for 11 to 13-year-olds (over 7%) and in the self-regulation domain for 11 to 16-year-olds (over 6%).
- In general, change (increases relative to the norm) were observed on all measures among children ages 8 and above, but very little change occurred on all measures for children ages 7 and younger.

Figure 9.10. Neuro-typical Functioning: Percent Change (Baseline to Final Metrics)



How do these results differ for children adopted via intercountry or as private domestic channels

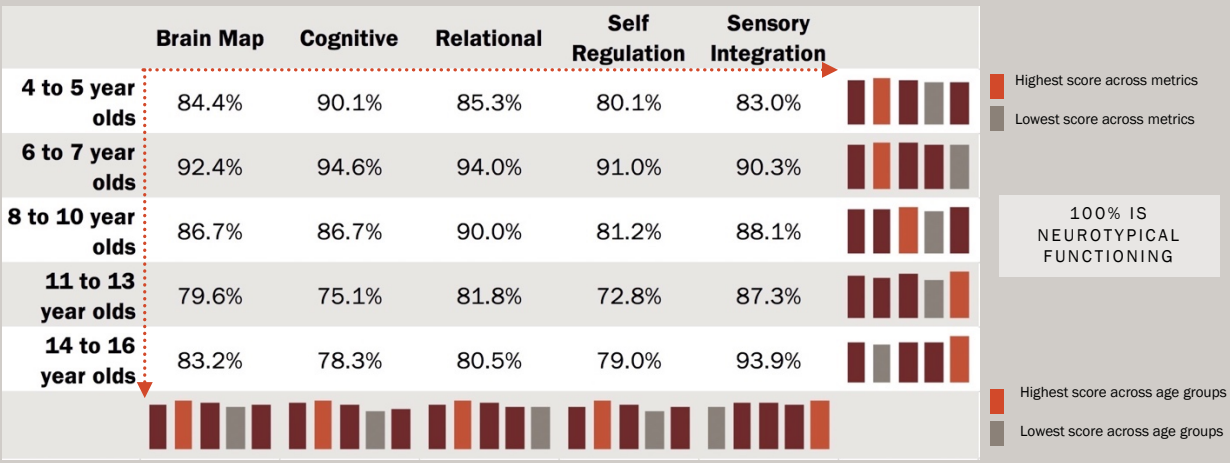
Due to the small number of private or domestic adoptive families for whom the NMT metrics were completed at two time points, the same analysis was not conducted for this sample. However, the general trends for both public and private adoptive families were similar. For instance, at the pre intervention phase (baseline):

- All age groups were below 100% neuro-typical functioning on all measures at baseline.
- Cognitive functioning was closest to neuro-typical functioning for 4 to 7-year-olds, and 11 to 16-year-olds.
- 6 to 7-year-olds were closest to neuro-typical functioning across all domains, except for sensory integration.
- 11 to 13-year-olds were furthest from neuro-typical functioning across several domains: Brain map, Cognitive and Self-regulation.
- Sensory integration was much higher (closer to neuro-typical functioning) for youths ages 14 to 16-years old.

However, caution should be used in drawing too many conclusions from this analysis as only 32 children had data available for this summary. Post measures (at the end of service completion) are not reported due to the small numbers of completed Metrics (n=18).

Figure 9.11. Private and Intercountry Adoptions: Time One Percent of Neuro-Typical Functioning

	Brain Map	Cognitive	Relational	Self Regulation	Sensory Integration
4 to 5 year olds	84.4%	90.1%	85.3%	80.1%	83.0%
6 to 7 year olds	92.4%	94.6%	94.0%	91.0%	90.3%
8 to 10 year olds	86.7%	86.7%	90.0%	81.2%	88.1%
11 to 13 year olds	79.6%	75.1%	81.8%	72.8%	87.3%
14 to 16 year olds	83.2%	78.3%	80.5%	79.0%	93.9%



Additional information on private and intercountry adoptions is available in a separate evaluation conducted by the University of Nebraska - Lincoln.

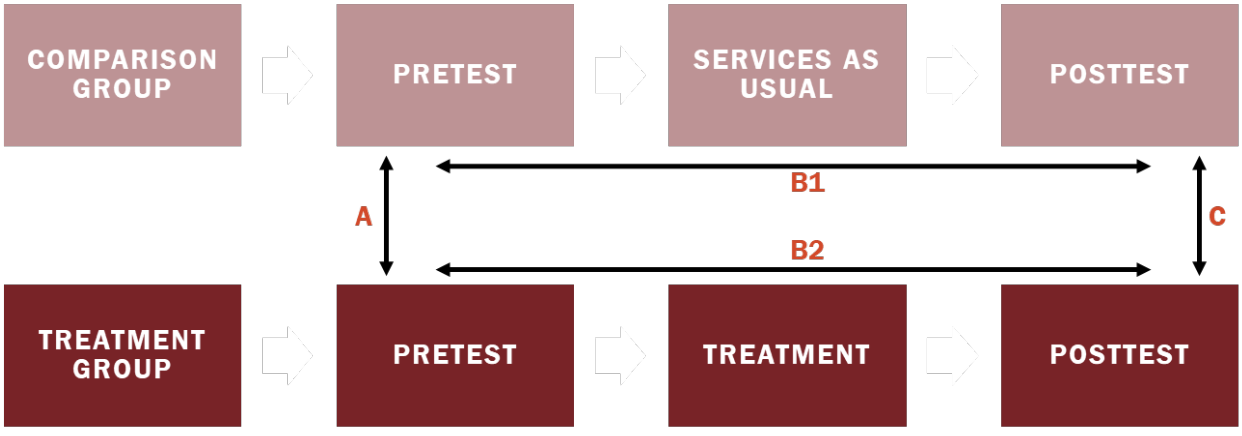
The short-term outcomes for the Tennessee QIC-AG project were:

- Improved caregiver commitment. This was measured through the Belonging and Emotional Security Tool for Adoptive Parents and Guardians (BEST-AG).
- Decreased child behavioral issues. This was measured through the Behavioral Problem Index (BPI).
- Improved familial relationships. This was measured through the Parent Feelings Form (PFF).
- Increased staff satisfaction with delivery services. This was measured through an ASAP staff survey, administered to staff in the intervention and comparison sites.

The study's quasi-experimental design employed a pre-posttest design to examine these outcomes. For these analysis, only intervention participants (those who had a NMT Metric) were included in the analysis. This process included a three-step process which is described and illustrated below:

- **A:** The first statistical tests examined differences between the treatment and comparison groups at baseline prior to the intervention (when families initially came into contact with the program).
- **B1 and B2:** The second set of statistical tests (paired t-tests) included the comparison group (B1) and the treatment group (B2) and examined the question: Was there a change in scores for individuals who completed both the pretest and posttest (i.e., a change from pretest to posttest among either B1 or B2)?
- **C:** The third statistical tests (difference in difference tests) examined the question: Did the changes observed from pre to post differ between the comparison or treatment group?

Figure 9.12. Quasi-Experimental Design



Test A

The first tests (A), compared treatment and comparison groups at baseline before the intervention was conducted. These results found no statistically significant between-group differences. These data were also examined by age and no statistically significant between-group differences were found. These findings suggest that the intervention and comparison groups were similar at baseline for the variables examined. The measures examined included: BEST-AG, BPI, and the PFF (see Table 9.18 in the appendix for specific results).

Tests B1 and B2

The second tests (B1 and B2) compared pre and posttest scores for each group. These analyses used paired t-tests, meaning the average change in scores across individuals was examined over time, and only those with a pre and posttest were included (see Table 9.5 below). The third tests (C) then examined whether these changes over time from pretest to posttest were statistically different for intervention versus comparison groups (see Table 9.20 in the appendix).

Table 9.5 shows the results of pre-post changes for the first three primary outcomes (B1 and B2 in Figure 9.12). All outcomes showed statistically significant changes between pre and post in both the intervention and comparison groups.

Table 9.5. Outcome Changes, From Baseline to Post Intervention

	COMPARISON GROUP				INTERVENTION GROUP			
	N	Mean Diff	SD	*p*	N	Mean Diff	SD	*p*
BELONGING AND EMOTIONAL SECURITY TOOL (BEST): MEAN DIFFERENCE (POST - PRE)								
BEST-AG	99	2.05	7.67	0.005	102	2.54	6.36	<0.001
BEST-AG CLAIMING	99	0.39	2.69	0.077	102	.40	2.01	0.048
BEST-AG EMOTIONAL SECURITY	99	1.66	5.76	0.003	102	2.14	5.31	<0.001
BEHAVIORAL PROBLEM INDEX (BPI): MEAN DIFFERENCE (POST - PRE)								
BPI	100	-3.28	8.01	<0.001	104	-4.84	7.71	<0.001
BPI - INTERNALIZING	100	-1.08	3.50	0.001	104	-1.82	3.62	<0.001
BPI - EXTERNALIZING	100	-2.15	5.95	<0.001	104	-3.31	5.60	<0.001
PARENT FEELINGS FORM (PFF): MEAN DIFFERENCE (POST - PRE)								
PFF	92	-5.92	16.49	<0.001	97	-3.73	12.07	0.003

Notes:
Orange cells represent a statistically significant difference at the .05 level based on one-tailed paired t-tests.
Changes (differences) were assessed by subtracting Post from Baseline scores (POST – BASELINE) within each individual.

Test C

The final – and third -- test (C) is a difference-in-differences test, which compares the rate of changes observed over time (i.e., from pretest to posttest) between the intervention and comparison groups. Results for each outcome, described below, are detailed in Table 9.20 in the Appendix.

Caregiver Commitment: BEST-AG

On the BEST-AG scale, increases suggest an improved sense of belonging and emotional security. While not statistically significant, the BEST-AG shows a stronger trend for the intervention group on the primary BEST-AG and the subscales. The BEST-AG pre and post differences are graphed in Figures 9.13, 9.14 and 9.15. The overall BEST-AG and subscale BEST scores shows increases (improvements) from pre to post, but the rate of change in the treatment group is not statistically different from the change observed in the comparison group (see Table 9.20 in the Appendix).

Figure 9.13. BEST-AG: Overall Score at Pre and Post

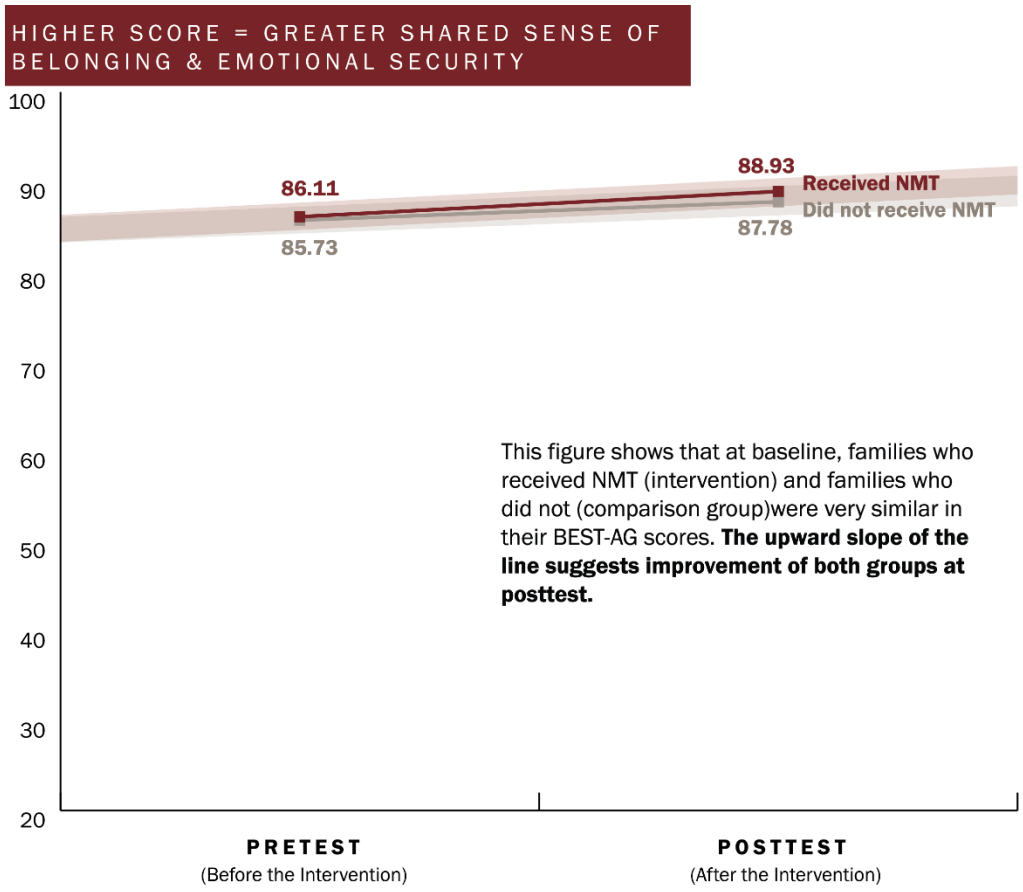


Figure 9.14. BEST-AG: Claiming Subscale Scores at Pre and Post

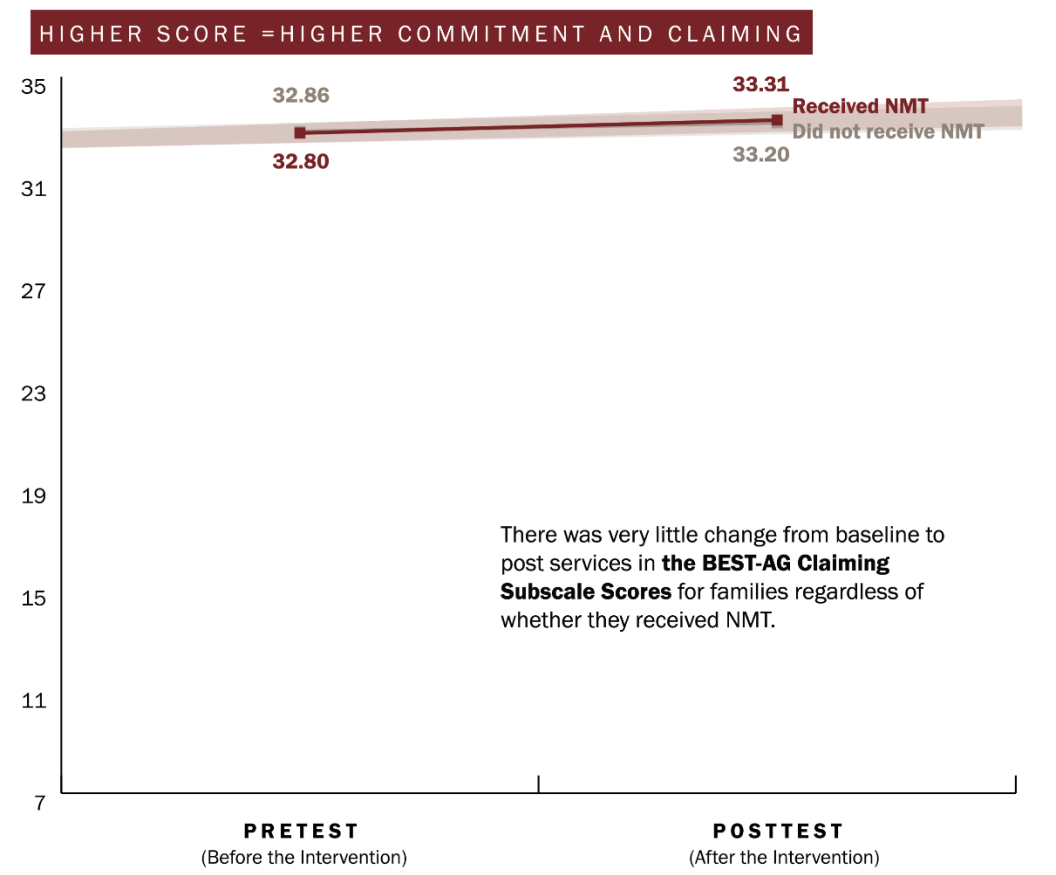


Figure 9.15. BEST-AG: Emotional Security Subscale Scores at Pre and Post

Child Behavioral Issues: BPI

On the BPI, a decrease in score suggests fewer behavioral issues. Both the intervention and comparison groups saw statistically significant differences between PRE and POST BPI scores (see Figures 9.16 – 9.18 and Table 9.20 in the Appendix). On average, children in the comparison group saw a reduction in the BPI score of 3.39 points, while children in the intervention group saw a reduction of 5.22 points. The decrease in scores from pre and post was stronger for the intervention group, as compared to the comparison group. Specifically:

- A difference was observed between intervention and comparison groups in the overall BPI score. While not statistically significant at the .05 level, this is trending towards statistically significant result (on average, a reduction of 1.82 points, p=.086).
- The change in the BPI-internalizing subscale among respondents in the intervention group was better than that in the control group (on average, a reduction of 0.96 points, p=.046), a statistically significant finding.
- The change in the BPI-Externalizing subscale were trending towards statistical significance (on average, a reduction of 1.32 points, p=.092).

Figure 9.16. Overall BPI: Scores at Pre and Post

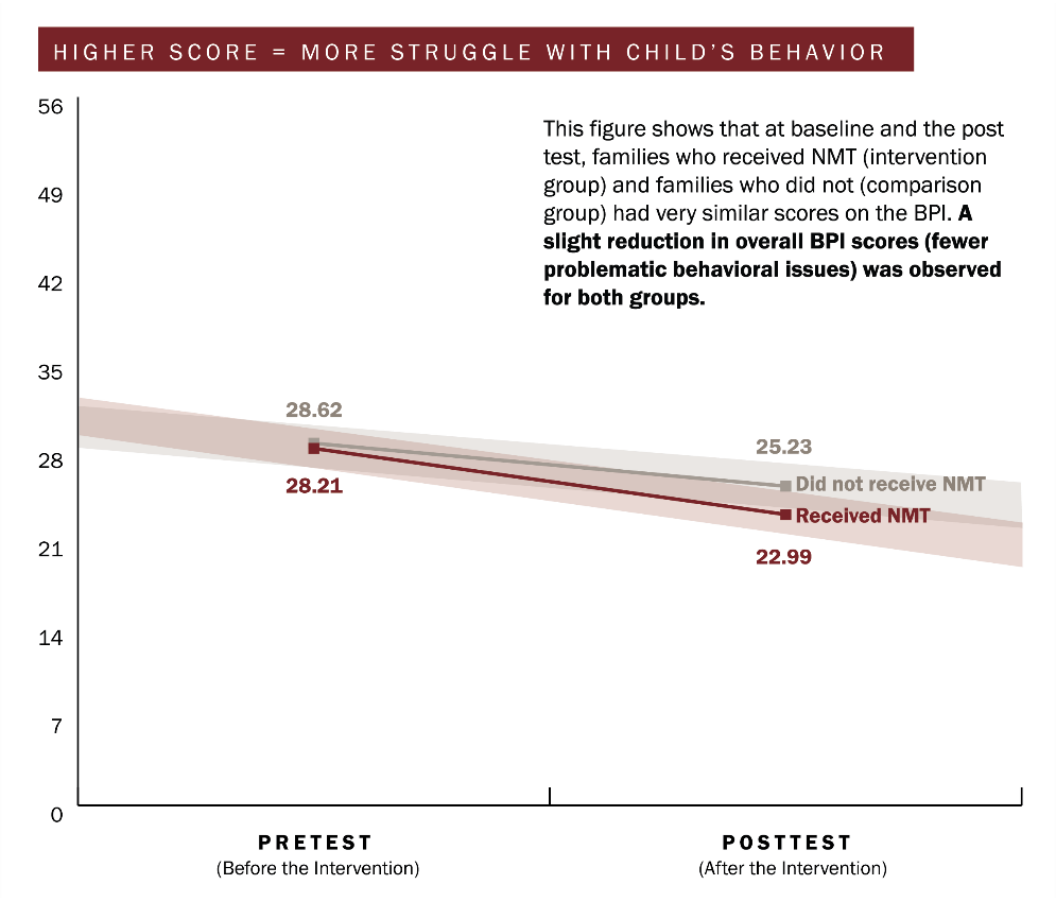


Figure 9.17. BPI – Internalizing Subscale: Scores at Pre and Post

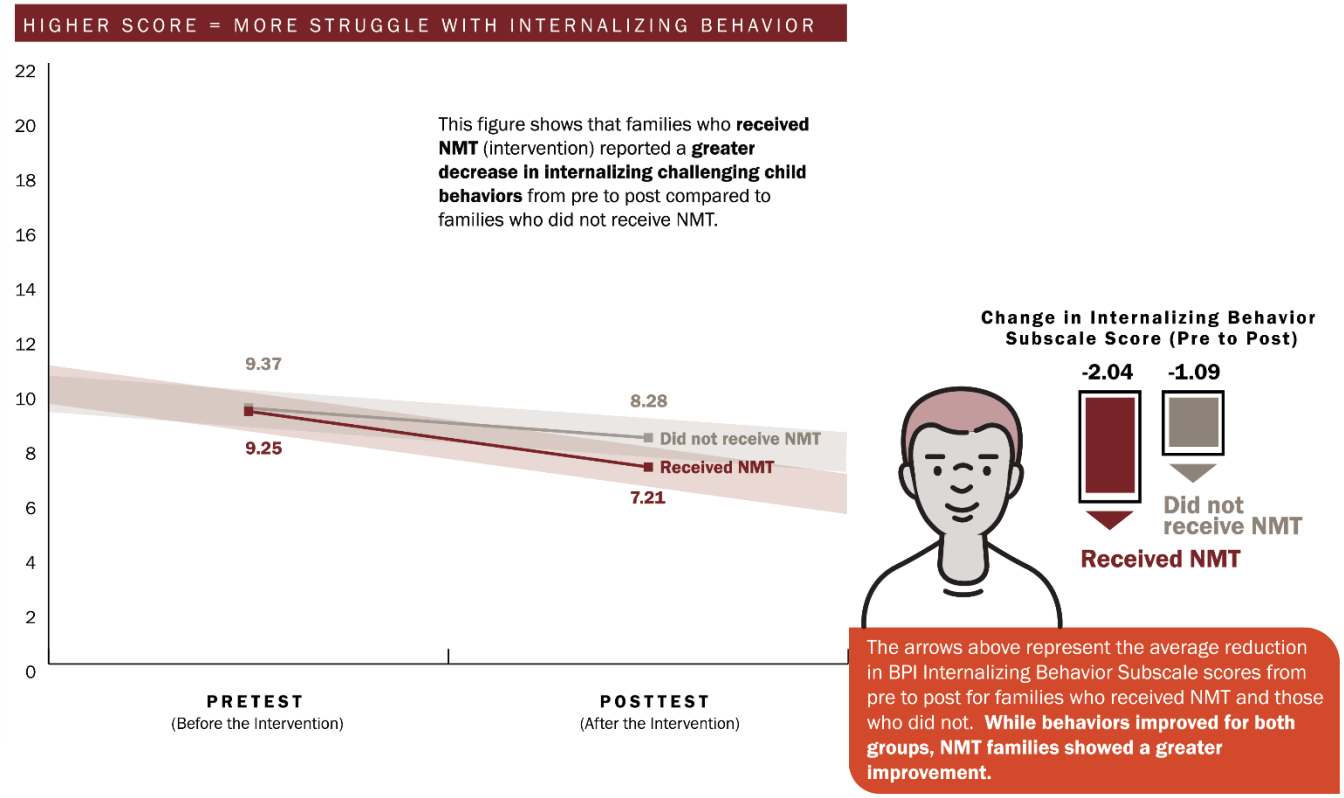
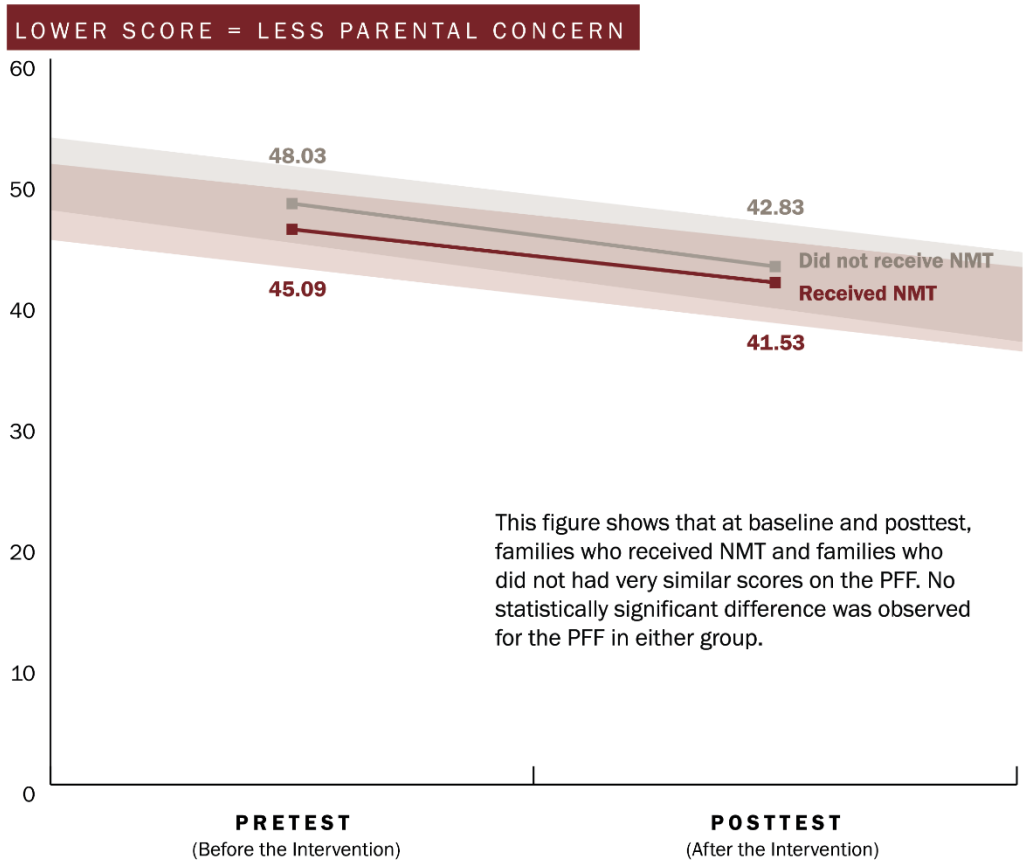


Figure 9.18. BPI – Externalizing Subscale: Scores at Pre and Post

Familial Relationships: PFF

For the PFF lower scores are preferred. While not statistically significant, the PFF shows a slighter stronger trend for the comparison group compared to the intervention group. On average, children in the intervention group saw a smaller reduction on the PFF than families in the comparison group.

Figure 9.19. PFF Scores at Pre and Post



How do these results differ for children adopted via intercountry or as private domestic channels

Differences on a number of key characteristics were examined between public and private or intercountry adoptive families served through the ASAP program (see Table 9.21 in the Appendix). The following characteristics were examined: Child age at adoption or at ASAP outreach, parental age at adoption or ASAP outreach. In addition, pre and post t-test means were compared for the BPI, BEST-AG, PFF, and caregiver commitment questions. Children adopted through the public child welfare system were, on average, older at the time of adoption than children adopted through intercountry or privately (M = 7.02 (SD=4.10) and M = 3.78 (SD=3.22), $p<.001$, respectively). In addition, the age of the children at the time the families came into contact with ASAP, was younger for children adopted through the public system compared to children adopted through private or intercountry adoptions (M = 4.05 (SD=3.57) and M = 7.14 (SD=4.25), $p<.001$, respectively). On all other characteristics or measures, the families, on average were very similar, suggesting that adoptive families, regardless of the type of adoption, are more similar than different.

Staff Satisfaction with the Delivery of Services

To examine if there was greater staff satisfaction with the delivery of services among the staff from the intervention and comparison sites, 27 ASAP staff were invited to participate in a survey. Of those staff, 21 (11 from Harmony Family Center and 10 from Catholic Charities) completed the survey for a response rate of 78%. To assess staff satisfaction, ASAP staff from both Harmony and Catholic Charities were asked questions on a 5-point Likert scale from 1 to 5 (5 being the highest):

- How satisfied are you with the services you provided?
- How satisfied are you with the level of support you are receiving?
- How manageable do you feel your current caseload is?
- To what extent do you feel you are positively influencing other people's lives through your work?

The majority of ASAP staff from Harmony and Catholic Charities were frequently or very frequently satisfied with the services they provided and level or support they received from their agency/program (Table 9.6). They also reported frequently and very frequently manageable caseloads. A majority of the respondents from both agencies frequently or very frequently reported that they felt they were a positive influence on people's lives. It is important to note that the small number of staff at each agency made it difficult to draw strong conclusions regarding the differences between the two agencies on any of these issues. The NMT training is extensive, and respondents had different amounts of experience with the NMT materials. It is possible that with additional time as trained NMT facilitators that different responses would have emerged.

Table 9.6. ASAP Staff Satisfaction

SATISFACTION LEVELS WITH STAFF BY HARMONY FAMILY CENTER AND CATHOLIC CHARITIES		
	PERCENT OF STAFF WHO REPORTED FEELING FREQUENTLY OR VERY FREQUENTLY:	
SATISFIED WITH SERVICES PROVIDED	Harmony Family Ctr.	82% (9)
	Catholic Charities	90% (9)
SATISFIED WITH LEVEL OF SUPPORT FROM AGENCY/PROGRAM	Harmony Family Ctr.	91% (10)
	Catholic Charities	80% (8)
CURRENT CASELOAD IS MANAGEABLE	Harmony Family Ctr.	82% (9)
	Catholic Charities	70% (7)
TO WHAT EXTENT DO YOU FEEL YOU ARE POSITIVELY INFLUENCING OTHER PEOPLE'S LIVES THROUGH YOUR WORK?	Harmony Family Ctr.	64% (7)
	Catholic Charities	80% (8)

Limitations

While the study had a number of strengths, it also had some limitations. First, Tennessee has a long history of providing services for families through the ASAP program, as such the results from this study may not be applicable to other jurisdictions that do not have a long history or providing post-adoption servies. Having an experimental design and larger sample size, including with the staff survey, would have strengthened the findings. In addition, extending the time period that the study was conducted would have possibly allowed more time to observe change. Personal and interpersonal change is difficult and takes time, especially given the long history of trauma that many adoptive youth have experienced due to maltreatment and previous placement moves (Jones & Schulte, 2019). The observation window in this study was less than a year, and results of interventions may not be observed until more time has passed. In this relatively short period of time the intervention group saw change on key measures included in the metric (e.g., particularly for older children in the relational and self-regulation domains). Perhaps with additional time, and more families enrolled, different results regarding the intervention and comparision groups may have emerged.

Cost Evaluation

The Tennessee QIC-AG project implemented and tested the effectiveness of a family-centered trauma-informed intervention that used a biopsychosocial assessment process to identify the needs of children and families who are referred (or self-refer) to Tennessee's ASAP program. The intervention served 293 families who have adopted children in the targeted regions of the state, including children adopted through the child welfare system, internationally, and private domestically.

Cost Evaluation Approach

The cost-effectiveness research (CER) analysis provides information for policymakers and administrators to help maximize desired outcomes based on the associated cost of achieving them (Meunnig, 2002). CER analysis was applied to the outcomes identified by Tennessee.

Assumptions, Conditions, and Constraints

The first step in this analysis was to identify issues which might impact the validity of our cost analysis findings. CER analyses typically rely on researchers making subjective decisions based on their judgments and perceptions of the available information. Thus, it is important to record assumptions, constraints, and conditions relevant to Tennessee that may impact the analysis.

ASSUMPTIONS

Assumptions are those factors which will likely impact the program and thus, the accuracy of the cost analysis (Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration, 1993). The primary assumption underlying this cost evaluation is that the time period of implementation is long enough to achieve change in the outcome measures. We are assuming that the impact of the NMT assessment and recommended intervention is achieved or not achieved within the timeframe of the project. However, it is likely that the intervention's true impact will not be seen until after the project period. Each site is implementing its intervention on a different timeline. Some sites may have a full two years to implement while others have less than a year.

We also assume multiple positive outcomes are likely impacted by the QIC-AG site programs. For pre permanency interventions, the desired impact of the programs is adoption or guardianship. However, other positive outcomes may not be necessarily captured by the intervention.

A final assumption is that the resource allocation captured in costs paid to sites is accurate. It is likely that staff time may be over or under-budgeted depending on the time constraints. For example, at the beginning of an intervention, more staff effort may be needed, but as a program continues, staff effort may be less intense because of the familiarity with the intervention.

CONSTRAINTS

Constraints are factors that have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For Tennessee, constraints include the long training period to obtain the NMT certification.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. For Tennessee, conditions include the purveyor offering his services and supports for a reduced rate, and well-established and long history of providing post adoption services in the state.

Cost Estimation

The next step in this cost analysis is to estimate the costs Tennessee incurred to implement the intervention. This cost estimation includes actual costs paid to Tennessee by Spaulding for Children on behalf of the QIC-AG.

KEY POINTS IN COST ESTIMATION

To the extent possible, the estimation of costs followed the Calculating the Costs of Child Welfare Services Workgroup's (2013) technical guide, *Cost analysis in program evaluation: A guide for child welfare researchers and services providers*, which identifies five key points to address in cost estimation. Each of these points is addressed below in relation to Tennessee.

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. Prior to implementation, Tennessee's intervention site, Harmony, and comparison site, Catholic Charities, had basic infrastructure including facilities, utilities, supplies, and other items. Infrastructure costs specific to these non-profits were not estimated for this cost evaluation. Rather, the specific charges to the project for facilities/office space are used. The sites also received substantial technical support from consultants and evaluators during implementation. Although the consultation was crucial to moving sites into implementation, the costs associated with the consultation will only be noted in the conclusion as additional costs for future programs to consider. Evaluation costs are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates.

Perspective refers to the person or group that incurred the costs. The perspective is essentially a filter that helps determine what costs are included. In this cost evaluation, the costs are determined from the perspective of the Tennessee QIC-AG site. In other words, if funds were spent by the program, they are considered costs. Participant costs, such as travel or childcare, are not included because they were not provided by the program. However, other programs would need to consider those participant costs in relation to the population they intend to serve.

Cost estimation should include the passage of time in order to account for inflation. Given that Tennessee implemented the intervention for a two-year period, costs did not change dramatically. The major cost that would be impacted in this short time frame is staff salary and this change is accounted for in the direct expenses that Tennessee incurred each year.

Both variable and fixed costs should be captured in cost estimation. For Tennessee, 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.

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 Tennessee were taken from monthly budget forms and summarized into Table 9.7.

Table 9.7. Costs for Tennessee

	IMPLEMENTATION			INSTALLATION	TOTAL
	FY 2019*	FY 2018	FY 2017	FY 2016	
PERSONNEL COSTS					
SITE IMPLEMENTATION MGR	$1,424	$13,832	$18,623		$33,879
ADMINISTRATIVE STAFF	$228	$2,308	$3,155		$5,690
PROGRAM STAFF	$28,063	$149,882	$130,335		$308,280
FRINGE	$5,600	$29,420	$27,338		$62,359
NON-PERSONNEL COSTS					
COMPUTER-IT NETWORK				$6,000	$6,000
CONTRACTED SERVICES: SMART			$7,488		$7,488
CONTRACTED SERVICES: CHILD TRAUMA ACADEMY		$600	$4,000	$90,000	$94,600
CONTRACTUAL: DOUG MCCAUGHAN				$30,000	$30,000
FACILITIES/OFFICE SPACE	$2,268	$12,474	$10,962		$25,704
GIFT CARD INCENTIVES			$339		$339
POSTAGE			$45		$45
PROGRAM SUPPLIES	$720	$1,415	$1,197		$3,332
TELEPHONE	$480	$2,799	$2,320		$5,599
TRAVEL	$1,314	$11,099	$17,450	$5,600	$35,463
INDIRECT COSTS					
IT SUPPORT		$4,000	$1,198		$5,198
OTHER: THERAPUETIC & EQUIPMENT	$7,960	$13,079	$45,439	$6,600	$73,079
TOTAL	**$48,057**	**$240,906**	**$269,889**	**$138,200**	**$697,053**

*FY2019: 10/01/2018 thru 3/31/19 only

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 9.7.

Collect Data on Resource Allocation

While resource costs are monetary values, resource allocation refers to the percent of time spent on the project. Personnel costs were billed to the project based on the percent of time employees were allocated to the project. The monthly expense reports described above also captured resources allocation.

Estimation of Direct Costs

Descriptions of all direct costs billable to Spaulding were defined by Spaulding. These same descriptions are used in this cost estimation. Multiple direct costs were billable to the project. Each of these is described below.

Personnel

Personnel costs totaled $313,970 for staff time allocated to the project during the implementation phase. Administrative personnel are those staff who are providing program support through organizing the program, processing documents, managing budgets and/or providing other administrative support. Tennessee had a portion of time from staff allocated for data collection and IT support which totaled $5,690. Program staff are those personnel who delivered services to families, parents and/or children. Tennessee included two full-time counselors who devoted 10-15 hours per month on the NMT related activities and a part-time training and implementation coordinator. Total program staff costs were $313,969.52.

Fringe

Overall fringe for all employees totaled $56,317. Fringe was calculated for 2.5 FTEs budgeted for program personnel. Fringe includes the 7.65% charged for each personnel for FICA and Medicare tax; $450 per month for health insurance; $200 annually for worker's compensation insurance; 1% of the first $9,000 salary for unemployment taxes; and $216 annually for professional liability insurance. Other categories included in fringe costs are described by sites in their cost reimbursement forms.

Contractual Expenses

Tennessee contracted for services from three entities. Even though the majority of these costs occurred during installation, they are included in the cost estimation because they are critical to utilizing the intervention. During installation, a private vendor was paid for developing a database system for the project for $30,000. The Child Trauma Academy provided training to staff for $90,000. This amount included 16 participants completing the Phase I training at $5,000 each. During implementation $4,600 was also paid to Child Trauma Academy. The final vendor was paid $7,487.50 for sensory-motor supplies needed to carry out the intervention.

Gift Cards

Gift cards were provided to participants for completing surveys. A total of $339.24 was spent on gift card incentives.

Materials and Supplies

Over the implementation period, $2,052.15 was spent on program supplies that were specific to the operation of the intervention.

Travel

Over implementation and installation, $28,406.75 was paid for travel. A large portion of these funds were used to pay for travel costs to attend the NMT trainings.

Facilities/Office Space

$25,704 was paid for facilities-related costs that are directly related to the office space for project-related staff.

Other Direct Charges

Other direct charges include all non-personnel direct costs that do not fit into the categories listed above, such as postage ($45.35), and phones ($5,598.52).

Estimation of Indirect Costs

Descriptions of all indirect costs billable to Spaulding were defined by Spaulding. These same descriptions are used in this cost estimation. Multiple indirect costs were billable to the project. Each of these is described below.

IT Support

IT support includes all expenses related to IT including computers, contract with a person for IT work, database design, and software. Computer and IT network charges include $6,000 and an additional $5,198 for IT support.

Other

$73,078.84 was spent on therapeutic supplies and equipment.

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 Tennessee site involved a private non-profit which had substantial infrastructure. Because the evaluation team assumed that other interested child welfare agencies would also have the infrastructure in place to run programs, we did not attempt to portion out the infrastructure costs that another agency would likely need. Likewise, we assumed that indirect costs will vary greatly by state due to cost of living issues influencing real estate prices and wages and thus, more detailed indirect cost calculations would not be useful to other entities. In order to run a similar program in another area, programs would need building space with heating, air, electricity and water; and some administrative support for contracting and financial management.

Summary of Costs

Implementation costs for Tennessee were $510,597 and installation costs related to project training and database set up were $138,200. In total, the costs for the Tennessee project were $697,053.

Cost Calculations

Cost calculations were made to understand the cost per participant and the cost-effectiveness of the intervention.

COST PER PARTICIPANT

Using Figure 9.7 which details families served by this project, 215 families formed by public adoption participated and 78 families formed by private or intercountry adoption participated in the intervention. To calculate the cost per participant, the evaluation team used families who were enrolled in the intervention group at Harmony (n=293). Based on the total costs of $697,053 and 199 participants, the cost per participant for this intervention was $2,379.

COST TO EFFECTIVENESS CALCULATION

For this cost-effectiveness analysis, we conceptualize effectiveness as the short-term outcomes designed to be impacted by the intervention. In Tennessee, the intervention was expected to reduce child behavioral issues, improve family relationships, increase caregiver commitment and increase staff satisfaction of delivery services. Findings suggest that intervention group participants showed greater improvement from pre to posttest on two short term outcomes: behavioral problems as measured by the Behavioral Problem Index; parent attitudes and concerns as measured by the Parent Feelings Form; and caregiver commitment as measured by the modified BEST. The cost-effectiveness ratio is calculated for each outcome below.

Cost to Achieve Improvement in Behavioral Issues

Several steps were taken to estimate the cost to achieve improved behavioral problems. First, data was gathered from the analysis of short-term outcomes to determine how many families had completed pre and posttest data related to behavioral problems. In the treatment group, 109 families had pre and posttest data.

Next, the cost of serving those families with a pre and posttest were calculated using the cost per participant of $2,379. This calculation is important because not all families in the treatment group completed a pre and posttest and thus, there is no information about whether behavior problems improved for families who did not complete a posttest. Examining the cost for this subgroup of matched pre/post families results is a more accurate cost of serving these specific families. Based on these calculations, it cost $259,313 to serve 109 families in the treatment group.

Table 9.8. Cost-Effectiveness Calculations for Behavioral Issues

	INTERVENTION
NUMBER OF FAMILIES W/ MATCHED PRE/POST	109
COST OF THOSE FAMILIES WITH MATCHED PRE/POST	$259,313
NUMBER W/IMPROVED OUTCOMES	73
COST EFFECTIVENESS RATIO	$3,552

The cost-effectiveness ratio was calculated by dividing the cost of families served by the number with improved outcomes:

Using this formula, the cost-effectiveness ratio was $3,552 for the intervention. In other words, for every $3,552 spent on the intervention, 1 family reported improved behavior problems.

$$\text{COST-EFFECTIVENESS RATIO} = \frac{\text{Cost of serving those families with matched pre/post tests}}{\text{Number of families with improved outcomes}}$$

Cost to Achieve Improvement in Parenting Attitudes

The same steps described above were used to estimate the cost to achieve improved parenting attitudes. First, data was gathered from the analysis of short-term outcomes to determine how many families had completed pre and posttest data related to behavioral problems. In the intervention group, 107 families had pre and posttest data on this measure.

Next, the cost of serving those families with a pre and posttest were calculated using the cost per participant of $2,379. This calculation is important because not all families in the intervention and comparison group completed a pre and posttest. Examining the cost for this subgroup of matched pre/post families results is a more accurate cost of serving these families. Based on these calculations, it cost $254,555 to serve 107 families in the intervention group.

In the intervention group, 60 families had improved feelings about parenting. The cost-effectiveness ratio was calculated using the same formula as behavior problems. Using this formula, the cost-effectiveness ratio was $4,243 for the intervention. In other words, for every $4,243 spent on the intervention, 1 family reported improved behavior problems.

Table 9.9. Cost-Effectiveness Calculations for Parenting Attitudes

	INTERVENTION
NUMBER OF FAMILIES W/ MATCHED PRE/POST	107
COST OF THOSE FAMILIES WITH MATCHED PRE/POST	$254,555
NUMBER W/IMPROVED OUTCOMES	60
COST EFFECTIVENESS RATIO	$4,243

Cost to Achieve Improvement in Caregiver Commitment

The same steps described above were used to estimate the cost to achieve improved parenting attitudes. First, data was gathered from the analysis of short-term outcomes to determine how many families had completed pre and posttest data related to behavioral problems. In the intervention group, 108 families had pre and posttest data on this measure.

Next, the cost of serving those families with a pre and posttest were calculated using the cost per participant of $2,379. This calculation is important because not all families in the intervention and comparison group completed a pre and posttest. Examining the cost for this subgroup of matched pre/post families results is a more accurate cost of serving these families. Based on these calculations, it cost $256,934 to serve 108 families in the intervention group.

In the intervention group, 68 families had improved feelings about parenting. The cost-effectiveness ratio was calculated using the same formula as behavior problems. Using this formula, the cost-effectiveness ratio was $3,778 for the intervention. In other words, for every $3,778 spent on the intervention, one family reported improved behavior problems.

Table 9.10. Cost-Effectiveness Calculations for Parenting Attitudes

	INTERVENTION
NUMBER OF FAMILIES W/ MATCHED PRE/POST	108
COST OF THOSE FAMILIES WITH MATCHED PRE/POST	$256,934
NUMBER W/IMPROVED OUTCOMES	68
COST EFFECTIVENESS RATIO	$3,778

Sensitivity Analysis

In a sensitivity analysis, assumptions made about various factors assumed in the cost-effectiveness calculation are allowed to vary in a recalculation of the CER. The findings are compared to the initial CER to provide additional context to understanding the real cost of obtaining a particular outcome. Because assumptions and factors will vary for other agencies wanting to implement the intervention, the information provided in the CER analysis can be used to vary budget line items.

In the case of the QIC-AG, sites were provided with a more generous amount of resources than were necessary to run the actual intervention because sites were required to participate in activities specific to the QIC-AG such as off-site meetings and capacity building activities. Additionally, sites were required to work extensively with a consultant and external evaluator which required significant staff time. Other child welfare agencies wishing to implement this intervention would not need all of the resources mentioned above.

For this sensitivity analysis, costs that are most likely not needed have been removed from the cost calculation. Inclusion or exclusion of costs in a sensitivity analysis such as this one is subjective. A decision was made based on the following question: Is this expense critical to the functioning of the intervention? Another agency would want to adjust costs specific to their program needs. The following exclusions were made for this sensitivity analysis:

1. For the purposes of running the intervention, only program staff are needed. 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. Additionally, the administrative staff costs were removed. However, administrative staff fringe costs were unable to be separated from program staff. The amount of fringe for both positions was included.
2. Gift cards were removed from the cost calculation. Gift cards were provided to thank people for their time in completing evaluation materials.
3. Program supplies not related to the NMT materials were excluded.
4. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings.
5. Costs related to office space rental were excluded. Other agencies would not need to lease additional office space to implement the intervention.
6. Costs related to office functioning were also excluded because none of them were necessary to implement the intervention. These costs include computer/IT support, postage, and telephone charges.

7. Contracted services for database construction were also removed.

Based on these exclusions, Table 9.11 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $545,805 which amounted to $1,863 per participant. Using this cost per participant, the cost-effectiveness ratios are: $2,781 for improved behavior problems; $3,322 for improved parent feelings; and $2,959 for increased caregiver commitment.

Table 9.11. Sensitivity Analysis: Adjusted Costs for Tennessee

	IMPLEMENTATION			INSTALLATION	TOTAL
	FY 2019*	FY 2018	FY 2017	FY 2016	
PERSONNEL COSTS					
PROGRAM STAFF	$28,063	$149,882	$130,335		$308,280
FRINGE	$5,600	$29,420	$27,338		$62,359
NON-PERSONNEL COSTS					
CONTRACTED SERVICES: SMART			$7,488		$7,488
CONTRACTED SERVICES: CHILD TRAUMA ACADEMY		$600	$4,000	$90,000	$94,600
INDIRECT COSTS					
OTHER: THERAPUETIC AND EQUIPMENT	$7,960	$13,079	$45,439	$6,600	$73,079
TOTAL	**$41,624**	**$192,981**	**$214,600**	**$96,600**	**$545,805**
*FY2019: 10/01/2018 thru 3/31/19 only					

Cost Evaluation Summary

The Tennessee site spent $2,379 per family to compare the impact of the NMT to services as usual. For those families who completed a pre and posttest, the intervention cost $3,522 to improve behavior problems per family; $4,243 to improve parenting attitudes per family and $3,778 to improve caregiver commitment.

However, there are multiple costs that could be reduced for other agencies interested in the intervention that would reduce the cost-effectiveness ratios and cost per participant. Reducing costs that are not needed for replication results in a cost per participant of $1,863. The intervention cost $2,781 to improve behavior problems per family; $3,322 to improve parenting attitudes per family; and $2,959.

It should be noted that this intervention has a heavy training workload and much of the costs were related to training.

Discussion

The Tennessee QIC-AG project tested the NMT in the **Compare and Learn** phase of developing an effective practice with an adoption sample. A quasi-experimental design was used to examine differences between the families who received the intervention (NMT) and families who received services as usual. In this analysis, we observed trends that suggested that changes were occurring, and that changes were generally in the direction one would expect with this intervention. Specifically,

- **Child behavioral issues.** This was measured using the Behavioral Problem Index (BPI). On the BPI, a decrease in score suggests fewer behavioral issues:
    - Both the intervention and comparison groups saw statistically significant differences between scores at PRE and POST BPI scores.
    - A difference was observed between intervention and comparison groups in the overall BPI score. While not statistically significant at the .05 level, this is trending towards statistically significant result (on average, a reduction of 1.88 points, p=.072).
    - The change in the BPI-internalizing subscale among respondents in the intervention group was better than those in the control group (a reduction of 0.93 points, p=.048), a statistically significant finding.
    - A similar finding occurred with the BPI-Externalizing subscale; these results were trending towards statistical significance (a reduction of 1.39 points, p=.069).
- **Caregiver commitment.** This was measured using the Belonging and Emotional Security Tool – for Adoptive and Guardianship families (BEST-AG). On the BEST-AG scale, increases suggest an improved sense of belonging and emotional security. While not statistically significant, the BEST-AG shows a slightly stronger trend for the intervention group, suggesting that with additional time and more study participants, a statistically significant difference may emerge.
- **Familial relationships.** This was measured using the Parent Feelings Form (PFF)**.** For this measure, lower scores are preferred. While not statistically significant, the PFF shows a slighter stronger trend for the comparison group compared to the intervention group.

There were several limitations for this study. First, the groups were not randomly assigned, so families who received the intervention may have been different than the comparison group in ways that were not captured by the information available in this study (e.g., children in the intervention group may have had more traumatic experiences, or different expererieces, than children in the comparison group).

A second significant limitation of this study was that the time period between pretest to posttest was limited. The NMT targets improvement in complex personal and interpersonal characteristics, based on neuro-biological assessments. Thus, it seems plausible that the effects of the NMT intervention may take significantly more time to develop, particularly given the complex trauma experiences of many youth adopted out of foster care and the fact that changes between pretest and posttest discussed above differed by child age, with older children tending to show more change over time than younger children.

Compared to neurotypical children their age, children and youth who received the intervention saw an increase, over baseline, of their functioning on key domains measured through the NMT metrics: participants moved closer to the neurotypical functioning on all domains. This finding is important given that children and youth who received NMT in the intervention group were a high-risk sample and families were reaching out for help. The largest percent change occurred among older children and youth, with most change observed for children over the age of 11. Research on the effects of the NMT with adoptive families should continue, but with longer study windows and more families. In summary, the trends found in this study are promising, but more research using larger samples and longer observation windows are needed to examine the effects of the NMT with post adoptive children and families. Incorporating the NMT as a post adoption intervention is a long-term investment designed to help children who have experienced significant trauma and may have a positive impact on children and families over time.

References

Angold, A., Costello, E. J., Messer, S. C., Pickles, A., Winder, F., & Silver, D. (1995) The development of a short questionnaire for use in epidemiological studies of depression in children and adolescents. *International Journal of Methods in Psychiatric Research*, 5, 237 - 249.

Barfield, S., Gaskill, R., Dobson, C., & Perry, B. D. (2012) Neurosequential model of therapeutics in a therapeutic preschool: Implications for work with children with complex neuropsychiatric problems. *International Journal of Play Therapy*, 21, 33– 44. doi:10.1037/a0025955

Calculating the Costs of Child Welfare Services Workgroup. (2013). *Cost analysis in program evaluation: A guide for child welfare researchers and service providers.* Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

ChildTrauma Academy. Retrieved at www.childtrauma.org

Children and Family Research Center (CFRC). (2008). *Illinois Post-Permanency Surveys (Round 1 - 2005 and Round 2 - 2008)*. CFRC: University of Illinois at Urbana-Champaign.

Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration. (1993). *Feasibility, Alternatives, And Cost/Benefit Analysis Guide*. Washington DC. Retrieved from http://archive.acf.hhs.gov/programs/cb/systems/sacwis/cbaguide/c1intro.htm

Framework Workgroup. *A framework to design, test, spread, and sustain effective practice in child welfare.* Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. February 2014.

Frey, L., Cushing, G., Freundlich, M., & Brenner, E. (2008). Achieving permanency for youth in foster care: Assessing and strengthening emotional security. *Child & Family Social Work, 13,* 218-226. doi: 10.1111/j.1365-2206.2007.00539.x

Hambrick, Brawner, & Perry (2018). Examining developmental adversity and connectedness in child welfare-involved children. *Children Austria, 0*(0), 1-11. doi: 10.1017/cha.2018.21.

Liao, M., & Testa, M. (2016). Post adoption and guardianship. *Research on Social Work Practice, 26*(6), 675-685. http://dx.doi.org/10.1177/1049731514564600

Liao, M., & White, K. R. (2014). Post-permanency service needs, service utilization, and placement discontinuity for kinship versus non-kinship families. *Children and Youth Services Review, 44*, 370-378. http://dx.doi.org/10.1016/j.childyouth.2014.07.007

Meunnig, P. (2002). *Designing and conducting cost-effectiveness analyses in medicine and health care*. San Francisco: Jossey-Bass.

Peterson, J. L. & Zill, N. (1986). Marital disruption, parent child relationships, and behavioral problems in children. *Journal of Marriage and the Family,* 48, 295-308.

Perry, B. D. (2006). The neurosequential model of therapeutics: Applying principles of neuroscience to clinical work with traumatized and maltreated children. In N. Boyd Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27–52). New York, NY: Guilford Press.

Perry, B. D., & Dobson, C. L. (2013). The neurosequential model of therapeutics. In J. D. Ford (Editor) *Treating complex traumatic stress disorders in children and adolescents: Scientific Foundations and Therapeutic models* (pp. 249-260). The Guilford Press; New York, NY.

Peterson, J. L. & Zill, N. (1986). Marital disruption, parent=child relationships, and behavioral problems in children. *Journal of Marriage and the Family,* 48, 295-308.

Richardson, W., Wilson, M., Nishikawa, J., & Hayward, R. (1995). The well-built clinical question: A key to evidence-based decisions. ACP Journal Club, 123(3), A12.

Tennessee Department of Children's Services (DCS). Retrieved at https://www.tn.gov/dcs.html

Tennessee Department of Children Services, Annual Progress and Services Report, 2014-2015. Retrieved from https://www.tn.gov/content/dam/tn/dcs/documents/quality_improvement/federal-initiatives/TN_DCS_APSR_FY_2015.pdf

Testa, M.F., & Poertner, J. (Eds.). (2010). Fostering accountability: Using evidence to guide and improve child welfare policy. New York, NY: Oxford University Press.

Testa, M. F., Snyder, S. M., Wu, Q., Rolock, N., & Liao, M. (2015). Adoption and guardianship: A moderated mediation analysis of predictors of post-permanency continuity. *American Journal of Orthopsychiatry, 85*(2), 107-118.

United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Bureau. (2017). *Child welfare outcomes report data.* Retrieved from https://cwoutcomes.acf.hhs.gov/cwodatasite/

United States Department of Health and Human Services, Administration for Children and Families. (2017). *Quarterly Financial Reports, Form CB-496. (Compiled data from states' Title IV-E Programs).*

Appendix

RECOMMENDATIONS TYPES

When examining the type of the NMT recommendations made, the following tables look within each broad category.

Within the family recommendation category, recommendations were explored as they related to specific family members. As detailed in the table below, 38% of the recommendations targeted at extended family were implemented with low adherence. The recommendations related to the extended family that were implemented with low adherence primarily related to efforts to engage and recruit extended family members.

Table 9.12. The NMT Adherence: Family-Centered Recommendations

FAMILY	FATHER/ MALE	MOTHER/ FEMALE	SIBLINGS	EXTENDED FAMILY	FAMILY TOTAL
HIGH	46%	59%	58%	12%	50%
MEDIUM	32%	26%	21%	50%	30%
LOW	22%	15%	21%	38%	20%

When examining adherence to individual recommendations, those related to cognitive issues were most likely to be implemented with a high or medium level of adherence, and those related to sensory integration (e.g., healing touch or massage, martial arts, primary somatosensory) were least likely to be implemented with high or medium levels of adherence.

Table 9.13. The NMT Adherence: Individual-Centered Recommendations

INDIVIDUAL	COGNITIVE	RELATIONAL	SELF-REGULATION	SENSORY INTEGRATION	INDIVIDUAL TOTAL
HIGH	39%	34%	35%	40%	36%
MEDIUM	47%	40%	39%	25%	37%
LOW	15%	25%	27%	35%	27%

Finally, when examining adherence related to the therapeutic web, those related to school or childcare were most likely to be implemented with high or medium levels of adherence, and those categorized as 'other' were rarely implemented with adherence. However, the 'other' category was also the smallest (18 recommendations), 11 of which were for mentoring, and all of the mentoring recommendations were implemented with low adherence.

Table 9.14. The NMT Adherence: Therapeutic Web Recommendations

THERAPEUTIC WEB	CULTURE/ COMMUNITY OF FAITH	EXTRA-CURRICULAR	SCHOOL/ CHILDCARE	OTHER	THERAPEUTIC WEB TOTAL
HIGH	36%	53%	51%	17%	45%
MEDIUM	31%	14%	30%	11%	24%
LOW	33%	33%	19%	72%	32%

Table 9.15. Baseline Metrics: Percent of Neuro-Typical Functioning by Age

BASELINE METRICS	BRAIN MAP	COGNITIVE	RELATIONAL	SELF - REGULATION	SENSORY INTEGRATION	N
4 TO 5 YEAR OLDS	89.5%	93.7%	89.9%	84.9%	89.8%	16
6 TO 7 YEAR OLDS	82.8%	86.4%	83.8%	75.4%	85.4%	30
8 TO 10 YEAR OLDS	82.5%	84.5%	81.0%	77.7%	86.0%	36
11 TO 13 YEAR OLDS	84.6%	83.8%	82.9%	79.6%	91.0%	45
14 TO 16 YEAR OLDS	84.5%	83.3%	79.7%	80.3%	93.4%	40

Table 9.16. Final Metrics: Percent of Neuro-Typical Functioning by Age

FINAL METRICS	BRAIN MAP	COGNITIVE	RELATIONAL	SELF - REGULATION	SENSORY INTEGRATION	N
4 TO 5 YEAR OLDS	92.0%	93.4%	93.7%	88.3%	92.5%	9
6 TO 7 YEAR OLDS	85.5%	84.5%	85.9%	81.7%	89.0%	11
8 TO 10 YEAR OLDS	85.8%	86.6%	84.0%	82.0%	89.8%	20
11 TO 13 YEAR OLDS	86.5%	84.8%	86.5%	81.8%	91.8%	17
14 TO 16 YEAR OLDS	89.6%	86.7%	88.7%	85.8%	96.3%	18

Table 9.17. Public Adoption: Percent Change between Pre and Post Metrics by Age

	BRAIN MAP	COGNITIVE	RELATIONAL	SELF- REGULATION	SENSORY INTEGRATION	N
3 TO 7 YEAR OLDS	1.0%	-0.5%	2.1%	1.0%	1.5%	22
8 TO 10 YEAR OLDS	2.2%	0.8%	2.7%	3.1%	2.9%	20
11 TO 13 YEAR OLDS	5.2%	3.3%	7.5%	6.2%	4.7%	17
14 TO 16 YEAR OLDS	4.5%	5.8%	3.8%	6.6%	3.0%	18

Table 9.18. Test A: Baseline Differences

	TOTAL			COMPARISON (CATHOLIC CHARITIES)			INTERVENTION (HARMONY)				
ALL AGES	**N**	**M**	**SD**	**N**	**M**	**SD**	**N**	**M**	**SD**	**Mean Diff**	***p***
BELONGING AND EMOTIONAL SECURITY TOOL (BEST) AT BASELINE											
BEST-AG	313	85.85	9.85	153	85.62	9.55	160	86.06	10.15	-0.433	1.115
BEST-AG CLAIMING	313	32.82	2.69	153	32.84	2.68	160	32.80	2.71	0.045	0.305
BEST-AG EMOTIONAL SECURITY	313	53.03	7.89	153	52.78	7.74	160	53.26	8.06	-0.478	0.894
BEHAVIORAL PROBLEM INDEX (BPI) AT BASELINE											
BPI	320	28.39	9.84	157	28.51	10.42	163	28.28	9.28	0.229	1.102
BPI - INTERNALIZING	320	9.30	4.13	157	9.33	4.00	163	9.28	4.27	0.057	0.463
BPI - EXTERNALIZING	320	20.41	7.23	157	20.40	7.76	163	20.42	6.71	-0.020	0.812
PARENT FEELINGS FORM (PFF) AT BASELINE											
PFF	298	46.49	19.92	145	47.35	20.00	153	45.67	19.87	1.679	2.310

Table 9.19. Change Scores, Baseline to Post Intervention by Age Group

	COMPARISON				INTERVENTION			
CHILD'S AGE AT ASSESSMENT: 0 TO 7	**N**	**MEAN DIFF**	**SD**	***p***	**N**	**MEAN DIFF**	**SD**	***p***
BEST-AG	21	-0.62	4.76	0.721	32	2.63	5.10	0.007
BEST-AG CLAIMING	21	-0.22	1.28	0.784	32	0.55	1.13	0.010
BEST-AG EMOTIONAL SECURITY	21	-0.40	3.84	0.679	32	2.08	4.60	0.016
BPI	21	-5.14	6.95	0.001	32	-4.44	7.33	0.002
BPI - INTERNALIZING	21	-2.06	3.56	0.008	32	-1.66	3.35	0.009
BPI - EXTERNALIZING	21	-3.32	5.51	0.006	32	-3.48	5.33	0.001
PFF	19	-1.58	10.46	0.260	30	-4.47	8.93	0.010
CHILD'S AGE AT ASSESSMENT: 8 TO 10	**N**	**MEAN DIFF**	**SD**	***p***	**N**	**MEAN DIFF**	**SD**	***p***
BEST-AG	21	2.43	8.08	0.092	18	3.76	3.97	0.001
BEST-AG CLAIMING	21	0.19	2.73	0.376	18	0.61	2.09	0.232
BEST-AG EMOTIONAL SECURITY	21	2.24	5.74	0.044	18	3.15	3.87	0.003
BPI	21	-3.29	7.95	0.036	18	-4.92	7.42	0.012
BPI - INTERNALIZING	21	-0.99	3.23	0.088	18	-1.92	3.27	0.023
BPI - EXTERNALIZING	21	-2.51	5.90	0.033	18	-3.00	4.89	0.019
PFF	25	-5.16	17.13	0.073	16	-3.81	10.39	0.163
CHILD'S AGE AT ASSESSMENT: 11 TO 13	**N**	**MEAN DIFF**	**SD**	***p***	**N**	**MEAN DIFF**	**SD**	***p***
BEST-AG	31	1.44	9.00	0.191	27	1.44	7.06	0.299
BEST-AG CLAIMING	31	0.10	3.31	0.432	27	0.15	1.73	0.659
BEST-AG EMOTIONAL SECURITY	31	1.33	6.94	0.147	27	1.29	5.94	0.268
BPI	32	-3.39	8.28	0.014	29	-4.45	8.13	0.006
BPI - INTERNALIZING	32	-1.13	3.66	0.045	29	-2.10	3.95	0.008
BPI - EXTERNALIZING	32	-1.83	6.02	0.048	29	-2.56	5.72	0.023
PFF	28	-10.71	20.13	0.005	27	-5.63	11.00	0.013
CHILD'S AGE AT ASSESSMENT: 14 AND OLDER	**N**	**MEAN DIFF**	**SD**	***p***	**N**	**MEAN DIFF**	**SD**	***p***
BEST-AG	26	4.64	7.03	0.001	25	2.72	8.29	0.114
BEST-AG CLAIMING	26	1.38	2.55	0.005	25	0.32	2.97	0.595
BEST-AG EMOTIONAL SECURITY	26	3.26	5.26	0.002	25	2.40	6.39	0.072
BPI	26	-1.63	8.63	0.172	25	-5.75	8.26	0.002
BPI - INTERNALIZING	26	-0.30	3.47	0.331	25	-1.64	3.97	0.050
BPI - EXTERNALIZING	26	-1.30	6.41	0.155	25	-4.19	6.44	0.003
PFF	20	-4.30	14.00	0.093	24	-0.63	16.89	0.858

Note: Orange cells represent a statistically significant difference at the .05 level

Table 9.20. Difference-in-Difference (DID) Results

RAW DATA FOR THE DID ANALYSIS				
OUTCOME	**GROUP**	**BASELINE**	**POST SERVICES**	**ABSOLUTE DIFF BETWEEN BASELINE AND POST**
BELONGING AND EMOTIONAL SECURITY TOOL (BEST-AG)				
BEST-AG	Intervention	86.107	88.932	2.824
	Comparison	85.731	87.783	2.052
BEST-AG CLAIMING	Intervention	32.805	33.313	0.508
	Comparison	32.861	33.202	0.341
BEST-AG EMOTIONAL SECURITY	Intervention	53.300	55.647	2.346
	Comparison	52.866	54.557	1.691
BEHAVIORAL PROBLEM INDEX (BPI)				
BPI	Intervention	28.211	22.994	5.217
	Comparison	28.621	25.228	3.392
BPI – INTERNALIZING	Intervention	9.251	7.209	2.042
	Comparison	9.371	8.284	1.086
BPI – EXTERNALIZING	Intervention	20.378	16.845	3.533
	Comparison	20.478	18.261	2.217
PARENT FEELINGS FORM (PFF)				
PFF	Intervention	45.897	41.529	4.367
	Comparison	48.035	42.831	5.203

DIFFERENCE IN DIFFERENCE: RESULTS						
OUTCOME	**DID***	**SE**	**Z**	**P>Z**	**95% CI**	
BELONGING AND EMOTIONAL SECURITY TOOL (BEST-AG)						
BEST-AG	0.772	0.962	0.800	0.422	-1.114	2.659
BEST-AG CLAIMING	0.167	0.322	0.520	0.604	-0.464	0.799
BEST-AG EMOTIONAL SECURITY	0.655	0.757	0.870	0.387	-0.828	2.139
BEHAVIORAL PROBLEM INDEX (BPI)						
BPI	-1.824	1.062	-1.720	0.086	-3.905	0.257
BPI - INTERNALIZING	-0.956	0.480	-1.990	0.046	-1.897	-0.016
BPI - EXTERNALIZING	-1.316	0.780	-1.690	0.092	-2.845	0.213
PARENT FEELINGS FORM (PFF)						
PFF	0.836	2.026	0.410	0.680	-3.134	4.806

*Difference in Difference Coefficients are each estimated as a Time-Treatment interaction in Mixed Effect Models
Note: Orange cells represent a statistically significant difference at the .05 level

Table 9.21. Public vs Private and Intercountry Adoptions: Comparing Characteristics

	PUBLIC			PRIVATE OR INTERCOUNTRY			PUBLIC VS. PRIVATE OR INTERCOUNTRY		
	N	M	SD	N	M	SD	*t*	*df*	*p*
CHILD'S AGE AT ADOPTION	384	11.01	3.94	69	10.92	3.80	-0.17	451	0.868
CHILD'S AGE AT ASAP ASSESSMENT	382	7.01	4.10	68	3.78	3.22	-6.16	448	<.001
PARENT'S AGE AT ASAP ASSESSMENT	361	45.96	10.01	67	47.33	9.37	1.05	426	0.297
TIME (YRS) FROM ADOPTION TO ASAP	379	4.05	3.57	67	7.14	4.25	6.33	444	<.001
BASELINE	**N**	**M**	**SD**	**N**	**M**	**SD**	***t***	***df***	***p***
BELONGING AND EMOTIONAL SECURITY TOOL - ADOPTION/GUARDIANSHIP (BEST-AG)									
BEST-AG	340	32.75	2.72	80	33.05	2.38	0.91	418	0.363
BEST-AG CLAIMING	340	85.66	9.84	80	86.31	9.29	0.54	418	0.589
BEST-AG EMOTIONAL SECURITY	340	52.90	7.86	80	53.26	7.52	0.37	418	0.715
BEHAVIORAL PROBLEM INDEX (BPI)									
BPI	347	28.74	10.06	82	28.61	9.09	-0.11	427	0.912
BPI - INTERNALIZING	347	20.69	7.37	82	20.62	6.49	-0.07	427	0.943
BPI - EXTERNALIZING	347	9.40	4.23	82	9.51	4.25	0.20	427	0.839
PARENT FEELINGS FORM (PFF)									
PFF	322	46.85	19.90	107	44.10	18.19	-1.26	427	0.207
POST INTERVENTION	**N**	**M**	**SD**	**N**	**M**	**SD**	***t***	***df***	***p***
BELONGING AND EMOTIONAL SECURITY TOOL - ADOPTION/GUARDIANSHIP (BEST-AG)									
BEST-AG	212	88.61	8.51	59	89.98	7.04	1.13	269	0.258
BEST-AG CLAIMING	212	55.32	7.05	59	56.19	6.01	1.68	269	0.094
BEST-AG EMOTIONAL SECURITY	212	33.29	2.16	59	33.8	1.61	0.86	269	0.392
BEHAVIORAL PROBLEM INDEX (BPI)									
BPI	213	23.68	9.81	61	22.66	10.55	-0.71	272	0.480
BPI - INTERNALIZING	213	17.28	7.09	61	16.31	7.35	-0.94	272	0.350
BPI - EXTERNALIZING	213	7.60	4.18	61	7.98	4.69	0.61	272	0.544
PARENT FEELINGS FORM (PFF)									
PFF	221	42.13	18.67	74	41.58	19.46	-0.22	293	0.83

Note: Orange cells represent a statistically significant difference at the .05 level

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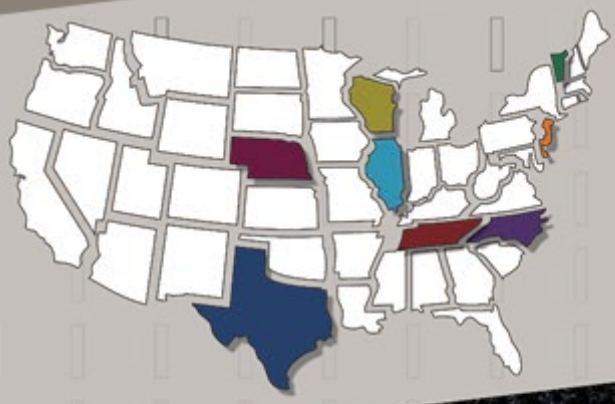
Evaluation Results from

Cross-Site Evaluation



Final Evaluation Report

September 2019

QIC•AG Quality Improvement Center for Adoption & Guardianship Support and Preservation

Authors

Nancy Rolock, PhD| Co-PI, QIC-AG | Associate Professor
Jack, Joseph and Morton Mandel School of Applied Social Sciences
Case Western Reserve University

Helen Bader School of Social Work
University of Wisconsin - Milwaukee

Rowena Fong, EdD | Co-PI, QIC-AG | Ruby Lee Piester Centennial Professor
Fellow, American Academy of Social Work and Social Welfare
The University of Texas at Austin, Steve Hicks School of Social Work

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Chapter 10

CROSS-SITE EVALUATION

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Tables and Figures

Overview

The cross-site evaluation summarizes the overarching themes and analyses found across six QIC-AG sites: Vermont, Illinois, New Jersey, Catawba County (North Carolina), Wisconsin, and Tennessee. These sites tested six different interventions (see Table 10.1) that served families after adoption or guardianship finalization (Target Group 2). We did not include findings from Texas and the Winnebago Tribe of Nebraska in this evaluation because these sites focused on interventions serving families pre-permanence (Target Group 1). This cross-site evaluation is intended to be a summary chapter that is appended to individual site-specific reports rather than a stand-alone document. For background information regarding the QIC-AG project, please refer to the Program Background chapter. For site-specific information, please refer to individual site reports.

Table 10.1. QIC-AG Target Group 2 Sites and Interventions

SITE	INTERVENTION
VERMONT	Vermont Permanency Survey
ILLINOIS	Trauma Affect Regulation: Guide for Education & Therapy (TARGET)
NEW JERSEY	Tuning in to Teens (TINT)
CATAWBA COUNTY, NC	Reach for Success
WISCONSIN	Adoption and Guardianship Enhanced Support (AGES)
TENNESSEE	Neurosequential Model of Therapeutics (NMT)

As discussed in more detail below, individual site reports found trends suggesting that, in many sites, the interventions tested may have produced stronger effects if more time was available to observe families who had received the intervention. However, during the observation period, we did not find strong intervention effects on long-term child and family wellbeing outcomes. Regarding post permanency discontinuity, based on record reviews and an examination of administrative data in these sites, only a small number of children (approximately 1% of all children involved with the project from the intervention and comparison groups) reentered foster care during the project period, not enough to draw conclusions or inferences regarding post permanency discontinuity.

Distal, or long-term, outcomes of increased post permanency stability and improved wellbeing take time to observe, more time than what the project period covered. However, research has found proximal, or short-term, outcomes, such as caregiver commitment and child behavior challenges, are predictors of these distal outcomes. Proximal outcomes were observed during the study period and are examined in this chapter. This chapter also summarizes findings related to engagement in services; survey participation; service needs and use; outcomes; and suggestions for next steps. Where applicable and relevant, results across sites are combined. In other places, results are kept separate but compared due to similarities (e.g., results of population-based surveys in Vermont and Catawba County [NC] are combined).

Cross-Site Results

This section synthesizes findings and limitations related to recruitment, intervention participation, service needs, and outcomes for families whose adoption or guardianship was finalized through the public child welfare system. Findings from the private domestic and intercountry adoptive families engaged through the project are summarized in Appendix A.

Engagement with Adoptive and Guardianships Families

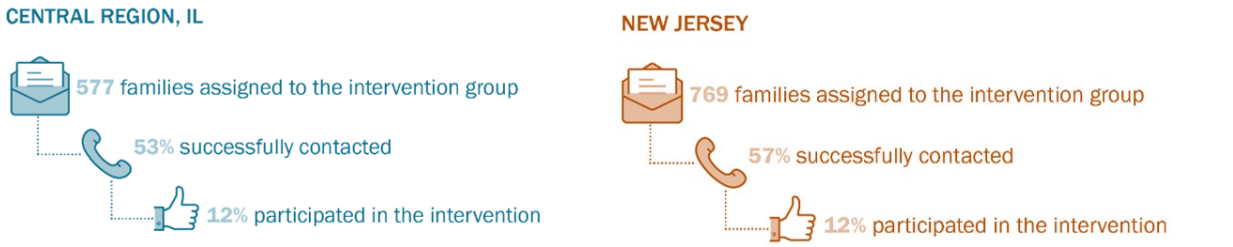
Not all child welfare jurisdictions consider outreach to families after legal finalization of adoption and guardianship as the responsibility of a child welfare system. Yet, families who have adopted or assumed guardianship of children, particularly children who have experienced trauma and maltreatment, report continuing to need support and services long after adoption or guardianship finalization (White et al., 2018). The QIC-AG project conducted a variety of outreach procedures and protocols to reach families. In some sites, a Universal approach was used where the site attempted to contact all families formed through adoption or guardianship in the jurisdiction. In other sites, a more targeted, purposeful outreach process occurred directed at families who had increased risk of post permanency discontinuity. In addition, some sites served families who self-referred or were referred for services.

This section examines engagement with the target population in each site. First, we examine families who were targeted because they had a characteristic that suggested they might be at increased risk for post permanency discontinuity (Selective prevention). We then explore engagement with families who were served in sites where families self-referred, or were referred, to a service provider (Indicated prevention). Finally, we examine service needs and usage, as reported on surveys administered to all adoptive or guardianship families (Universal prevention). A summary of engagement with families who adopted through private or intercountry processes is included in the Appendix.

SERVICE ENGAGEMENT FOR SELECTIVE PREVENTION SITES

In Illinois and New Jersey, the QIC-AG project targeted adoptive and guardianship families who had characteristics that, based on extant research, suggested they may be at increased risk for post permanency discontinuity. The primary group characteristic in these two sites was that the families had children who were pre-teens or teens. The different research designs and interventions being offered concurrently in each site make direct comparisons difficult and is the reason Cook County is excluded from the summary below. However, the Central Region of Illinois site and New Jersey used the same research design, and had similar rates of contact and participation:

- In the Central Region of Illinois, of the 557 families assigned to the intervention group, staff were able to successfully make contact with 53% of families, and ultimately 12% of those families targeted for outreach participated in the intervention.
- In New Jersey, of the 769 families assigned to the intervention group, staff were able to successfully make contact with 57% of families, and ultimately 12% of those families targeted for outreach participated in the intervention.



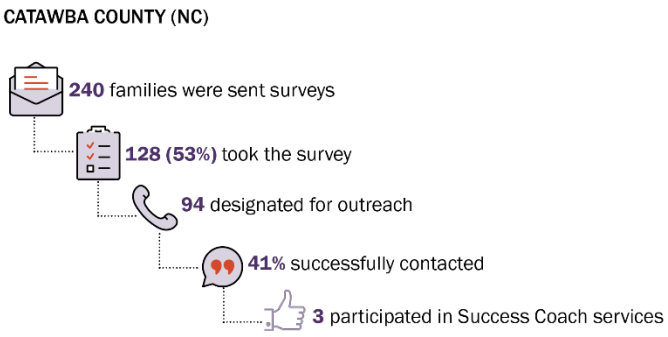
In both sites, a variety of outreach methods were used to make contact with families and increase uptake. For example, at the suggestion of the stakeholders in Illinois, the project staff made additional follow-up calls to families who initially said they wanted to participate in the project but later 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.



In Catawba County, the working hypothesis was that there were families in need of post adoption services who either did not know about the services or were unable to access the services. During the project period, 240 families in Catawba County were sent surveys. Of those 240 families, 53% (128) completed and returned surveys. Of the 128 families who returned surveys, 94 were designated for outreach. Of the 94 families designated for outreach, 41% (39) parents were subsequently successfully contacted by Catawba County staff to assess their interest in Success Coach services. A total of 3 families signed service agreements and participated in Success Coach services. Families who were contacted through outreach but declined services largely reported they did not need extra support.

In Wisconsin, at the Indicated level of prevention where services were provided to families who reached out to a contact point, there was some concern about announcing the project widely to families. In what was referred to as "the floodgates opening," the Wisconsin project staff worried they would be overwhelmed with requests for services and might not be able to serve all of the families. This concern was based on the interactions staff had with adoptive and guardianship families in the past and the difficulties the families had conveyed, and a feeling that many adoptive and guardianship families would engage in services. The program initially relied on referrals to AGES after families contacted one of the points of entry. This did not yield the number of program participants that the project expected. As a result, the agency sent letters to eligible families alerting them of the AGES program. At no point in the program did staff feel that they were flooded with requests for services.

Survey Response Rates

Surveys were sent to families in Vermont, Catawba County (NC), Illinois and New Jersey[1]. In Vermont, the survey could be completed electronically or by pen and paper. In all the other sites, the surveys were pen and paper only. In Catawba, Illinois, and New Jersey a pre-paid cash incentive was also included. A variety of methods were used to encourage participants to return the surveys: sites sent emails, made phone calls, and followed up with non-responders in a series of assertive outreach efforts. The sites also engaged a look-up service to acquire the most recent contact information for families. Surveys were sent to adoptive parents and guardians who were asked to respond to the survey focusing on one target child per family. Surveys assessed caregiver's experiences related to adoption or guardianship (for example, respondents completed standardized measures, such as the Caregiver Strain scale, the Behavior Problem Index, and questions related to caregiver commitment, familial relationships, and service needs and use).

- In Vermont, 1,470 families were sent surveys and 809 (55%) responded.

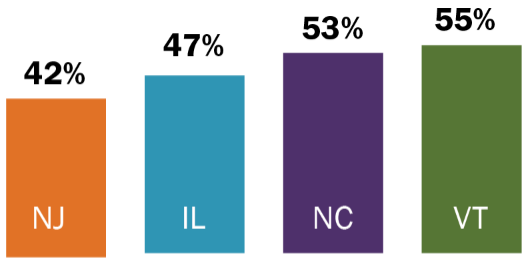
[1] The survey responses from Illinois and New Jersey discussed in this section are from the primary outcome surveys only.

In Catawba County (NC), surveys were mailed to families, with follow-up calls and mailings after the initial survey was sent. In Catawba, the survey was sent by the county agency, and contact information was the latest information the county had for families currently receiving an adoption subsidy.

- In Catawba County, 240 families were sent surveys and 128 (53%) responded.

In Illinois and New Jersey, surveys were also mailed to families, with follow-up calls and mailings after the initial survey was sent. The surveys were sent by a university-based research center based in Illinois. Prior to making contact, the research team used a look-up service to obtain the most recent contact information for families. The surveys in Illinois and New Jersey were used to collect short-term outcome data and were sent to all families assigned to the intervention and comparison groups after participants had completed the intervention. As such, response rates for intervention participants and comparison groups are also provided.

- In Illinois, 2,731 families were sent surveys and 1,293 (47%) responded.
    - Intervention participants: 105 were sent surveys, 81 (77%) responded
    - Comparison group: 596 were sent surveys, 327 (55%) responded
- In New Jersey, 1,212 families were sent surveys and 514 (42%) responded.
    - Intervention participants: 94 were sent surveys, 62 (66%) responded
    - Comparison group: 443 were sent surveys, 187 (42%) responded



Overall Response Rates

In sum, after all the various attempts to reach families who have adopted or assumed guardianship of children in foster care were completed, about half of all surveyed responded. Future projects intended to reach adoptive or guardianship families should take this into consideration. The variation in overall response rates (from 42% in New Jersey to 55% in Vermont) may be related to several factors that have nothing to do with the family's desire to provide information. For instance, it could be that families in New Jersey were hesitant to respond to a survey that came from a university that was out of state, or that there were unmeasured characteristics about families from one state or another that influenced the response rates.

The somewhat higher response rate from families in Catawba may be related to the resource-rich nature of service provision in that county (many families identified as being in need of service through the survey were already engaged in services and did not accept Success Coach services), or the state mandate to provide post adoption services. The higher overall response rate in Vermont could be related to the extra effort and assertive outreach provided by that site. Thus, differences in response rates across sites could have something to do with the specific site itself, as the jurisdictions in the QIC-AG varied widely in terms of urban-rural settings and the prior experiences families have engaging with the agency.

Finally, response rate variation may be due to the nature of the target populations in each area. Vermont and Catawba County reached out to all families, while Illinois and New Jersey focused in on families who, research suggested, had characteristics that placed them at increased risk for post permanency discontinuity. Future research should explore these differences.

SERVICE ENGAGEMENT SUMMARY

Across multiple sites, there were similar concerns that services offered post permanence would open the "floodgates" with families clamoring for services and overwhelming the public child welfare system and staff with increased demand. This was not the case in the QIC-AG sites. Other child welfare jurisdictions and other projects may run into difficulty estimating how many families to expect to serve when offering post permanency services and supports. One difficulty in estimating potential service uptake with families formed through adoption or guardianship is that many child welfare jurisdictions do not have a long history of engaging families in post permanency services. In addition, to understand how frequently services are requested by adoptive and guardianship families, a good tracking system, one that is linked to child welfare administrative data systems, is lacking in most jurisdictions. Linking to adminsitrative data would allow systems to understand the percentage of families who seek services. Our best estimates come from Illinois and New Jersey. Findings from these two sites would suggest that if service providers estimate a 12% uptake rate (both sites saw 12% of families engage in services), they should be adequately staffed to serve the families who engage in services.

Service Needs and Use

Service needs and use described in this section are summarized from the following sources:

- Surveys from Vermont and Catawba County (NC)
- Interviews with families in Wisconsin
- Surveys from New Jersey and Illinois

SURVEYS IN VERMONT AND CATAWBA COUNTY (NC)

Two QIC-AG sites, Vermont and Catawba County (NC), implemented surveys with questions that assessed post adoption service needs and use. By examining the results of these survey questions across the two sites (Tables 10.2 and 10.3), one conclusion is that the most needed and used services were those related to mental health support. In particular, individual counseling for children was a need for a significant proportion of families (e.g., almost 50% in Vermont). Thus, post permanency services should be designed to support the mental health needs of children and families.

Families in Vermont also reported high use of routine medical care (79%). Families used a wide variety of post adoption services, but service usage rates across all types of services were less than 50%. Indeed, some services received very little use. For instance, no respondents in Catawba reported using respite care or adoption support groups since their adoption was finalized. However, it is important to note that these survey results were based on populations in the state of Vermont and one county in North Carolina, and thus, they may not generalize to other locations or cultures.

Table 10.2. Vermont Service Use in Past 6 Months

OF THE 796 FAMILIES SURVEYED IN VERMONT:	NUMBER OF FAMILIES WHO USED SERVICES IN THE PAST 6 MONTHS	PERCENT OF FAMILIES WHO USED SERVICES IN THE PAST 6 MONTHS
FAMILY SUPPORT SERVICES		
FAMILY COUNSELING	213	27%
CASE MANAGEMENT SERVICE COORDINATION	99	12%
DCF SOCIAL WORK SERVICES	85	11%
SCHOOL/CHILD CARE SERVICES		
REGULAR CHILD CARE SERVICES	178	22%
AFTERSCHOOL PROGRAM	159	20%
SCHOOL-BASED CLINICIAN	152	19%
BEHAVIOR SUPPORT SERVICES	139	18%
MEDICAL SERVICES FOR CHILD		
ROUTINE MEDICAL CARE	626	79%
MEDICATION MANAGEMENT	199	25%
SPEECH OR OCCUPATIONAL THERAPY	124	16%
MENTAL HEALTH SERVICES		
INDIVIDUAL COUNSELING FOR CHILD	336	42%
INDIVIDUAL COUNSELING FOR CAREGIVER	177	22%
PSYCHOLOGICAL ASSESSMENT FOR CHILD	129	16%
PSYCHIATRIC MEDICATION FOR CHILD	126	16%
CARE COORDINATION/CASE MANAGEMENT FOR CHILD	78	10%

Table 10.3. Catawba County (NC) Service Needs and Use after Adoption Finalization

SERVICES MOST FAMILIES REPORTED NEEDING	% OF FAMILIES WHO RESPONDED TO SURVEY AND REPORTED THAT THEY NEEDED	OF THOSE FAMILIES THAT TRIED TO OBTAIN, % THAT WERE SUCCESSFUL	OF THOSE FAMILIES THAT OBTAINED SERVICES, % THAT WERE "EXTREMELY" OR "QUITE" HAPPY WITH THE SERVICES
MENTAL HEALTH SERVICES	35%	97%	74%
SPECIALIZED MEDICAL OR DENTAL CARE SERVICES	27%	89%	80%
EDUCATIONAL SUPPORT SERVICES	24%	83%	71%
CHILD DEVELOPMENTAL SERVICES	23%	100%	68%

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 legitimatized their experiences, resulting in better services for their family. Parents and guardians suggested that service providers, including school personnel, need to be better informed about the problems faced by children and youth in adoptive and guardianship families. Service providers need to be trauma-informed and familiar with issues related to families formed through adoption and guardianship.

Outcomes

Distal (long-term) project outcomes were: increased post permanency stability, improved behavioral health for children, and improved child and family wellbeing. As detailed in the site-specific reports, sites did not have enough time to see the effects of the intervention. This is a common quandary for intervention research, where follow-up periods in research studies can be insufficient. The QIC-AG Permanency Continuum highlights the importance of prevention, but long-term, complex behaviors (e.g., child externalizing behaviors) are hard to address in a single intervention and over a relatively short period. As many participants in this study reported, having continuous, long-term supports and services are important. Coupled with lessons learned in other sites, each site has a firmer foundation for understanding the experiences, characteristics, needs, and strengths of families who have experienced adoption or guardianship. While this report provides a rich set of information learned in each site, a few key messages or lessons from each site are highlighted below. This is not a comprehensive list, rather highlights of key findings by site. Additional details are provided in the site-specific reports.

- In Vermont, the project was able to provide a robust assessment of the needs, characteristics, and strengths of families formed through adoption and guardianship. The Vermont site developed an understanding of families who are struggling and those who seem to be doing well. Caregivers who would definitely adopt or assume guardianship of their child again had higher levels of resilience, open communication, perseverance in times of crisis, and more positive parent-child interaction compared to caregivers who indicated they were uncertain or definitely would not adopt or assume guardianship again. The "definitely adopt or assume guardianship again" group had less strain attributed to parenting their child and more confidence in knowing how to meet their child's needs. Additionally, they felt more prepared at the time of their child's finalization and used fewer services in the past six months than those who expressed hesitancy to adopt or assume guardianship again.

- In Illinois, intervention participants were struggling more than families who did not participate in the intervention. Yet, this study did not find that TARGET participants fared better than children in the comparison group on the outcomes measured (e.g., child behavioral issues and wellbeing measures). It is possible that no intervention effects were observed due to the limited observation window of about 6 months post intervention. With additional time, perhaps differences between the intervention participants and families assigned to the comparison group will emerge. It is also possible that families in Illinois needed something different than TARGET. Additional research is needed to develop next steps in Illinois.

- In New Jersey, no statistically significant differences were found between the TINT intervention participants and the overall comparison group and between the TINT participants and a sample of the matched comparison group on the key measures of child and family wellbeing. However, promising trends suggest that with additional time, statistically significant differences may emerge. Specifically, caregivers who participated in the intervention tended to feel better able to manage their child's behavior, which is a key factor related to post permanency stability and family wellbeing. An extended observation period in New Jersey would enhance our understanding of these issues.

- In Wisconsin, parents and guardians reported that service providers often did not listen to them or believe how bad it could be at home. Results indicated that families felt supported when the AGES workers made home visits, listened to families' concerns, and provided support and advocacy with other service providers or systems. The AGES workers were

flexible, which was critical to supporting families in need. The workers served as family advocates, amplifying the family's voice so that professionals would both listen and hear. Bringing AGES to scale, with a larger number of families and longer observation period would be a good next step.

- In Catawba County (NC), families who needed post adoption services and supports were largely already engaged in services through the existing outreach methods and service delivery systems. Few additional families requested Success Coach services as a result of Reach for Success. However, through the outreach survey sent to adoptive families, a profile of family characteristics, services sought and received, and responses to key measures related to post adoption stability provided valuable information to the child welfare agency to design future post adoption and guardianship interventions and supports.

- In Tennessee, compared to neuro-typical children their age, children and youth who participated in the intervention saw an increase, over baseline, of their functioning on key domains measured through the NMT Metrics. Importantly, a decrease in BPI scores from pretest to posttest, stronger for the intervention group compared to the comparison group, was observed. Trends found in this study are promising, but more research using a larger sample and a longer observation window is needed. Post adoption services should be designed to help children and families cope with prior experiences of trauma and placement instability.

Based on record reviews and an examination of administrative data in these sites, only a small number of children reentered foster care during the project period. Specifically, approximately 1% of all children involved with the project (from the intervention and comparison groups) reentered foster care during the project period. This is not enough to draw conclusions or inferences regarding the outcome of post permanency discontinuity.

Limitations

The interventions tested in the QIC-AG sites varied in several ways that preclude the use of a uniform multi-site design. First, the interventions selected in different sites had varying levels of evidence-support. Thus, a variety of evaluation designs were used, based on how well-supported the intervention was, results of usability testing, and the number of study participants. For example, some sites used an experimental design, yet the randomization methods varied (i.e., a traditional Randomized Control Trial or a randomized consent design [Zelen, 1979, 1990]). In other sites, a quasi-experimental design was used, and some sites used descriptive analyses. Furthermore, each site tested a different intervention, and thus, had different definitions for subject inclusion, different short-term outcomes, and a variety of external conditions that impacted implementation.

Another cross-site limitation is that previous research suggests the primary long-term outcome of interest (post-permanence stability) in the QIC-AG research study requires an extended observation period. For example, as noted above, research from Illinois has found that approximately 2% of adoptions or guardianships have experienced instability two years after finalization; 6% after five years; and 12% ten years after achieving legal permanence (Rolock & White, 2016). This is problematic for effective evaluations that have a shorter follow-up period. Given the low rate of instability and short window for follow-up, the evaluation focused on more proximal indicators that are predictive of long-term permanency outcomes (e.g., BPI scores and caregiver commitment scale). However, even the ability to observe a significant change in the relatively short follow-up period was limited.

Examining Post Permanency Discontinuity

The QIC-AG was designed to promote permanence when reunification is no longer a goal and improve adoption and guardianship preservation and support. Promoting permanence often requires the examination of factors that would jeopardize that goal and might lead to discontinuity. This section examined mechanisms for assessing risk for post permanency discontinuity, using existing administrative data and through the collection of primary data (e.g., surveys or questionnaires). Post permanency discontinuity, defined as foster care reentry after an adoption or guardianship finalization, was examined using data from four sites (Vermont, New Jersey, Tennessee, and Illinois). These data were not available from Catawba County or Wisconsin. Several Multivariate Cox survival models were estimated with administrative data to examine predictors of time-to-foster care reentry.

Separate models were run for each state and one with all four sites combined. Children were tracked using administrative data starting in the year 2000 and then ending in years 2015, 2016, or 2017 (depending on data available for each state), and the dependent variable was the time-to-reentry, with several predictor variables included in models. Multivariate Cox regression is a useful statistical model to examine the impact that several predictors have on a time-to-event outcome, such as post permanency discontinuity, while also accounting for information provided by censored cases or those cases that do not experience post permanency discontinuity by the end of the study period (Guo & Fraser 2010).

Prior research found strong evidence for using two predictors of post permanency discontinuity: 1) the caregiver's assessment of the child problem behaviors using the Behavior Problem Index (BPI); and 2) caregiver commitment to the adoption or guardianship, e.g., a caregiver's self-report of the frequency with which they think of ending the permanency relationship (Testa, Snyder, Wu, Rolock, & Liao, 2015). Based on these findings, the evaluation team used these and other measures and constructs from prior studies, conducted with families formed through adoption and guardianship, in the site-specific evaluations.

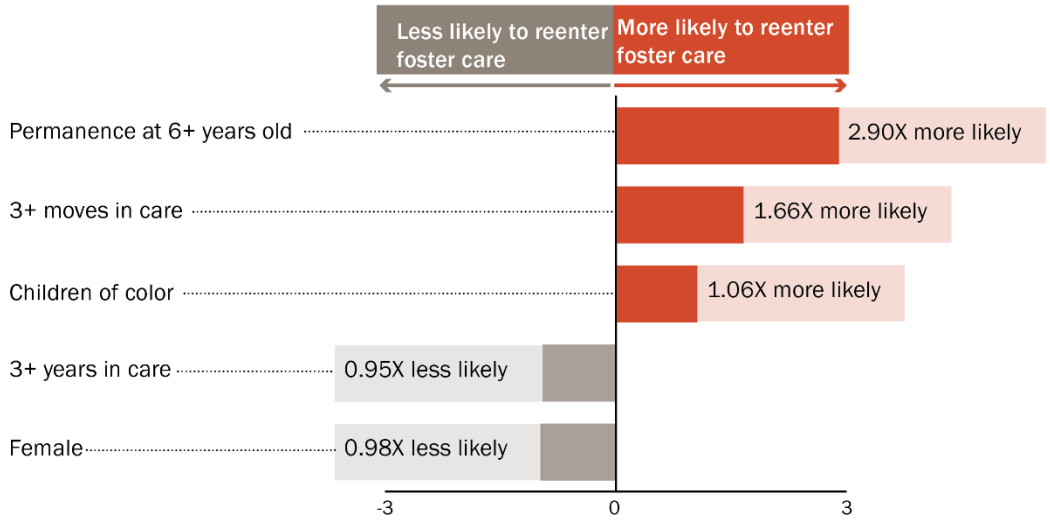
In sites that used BPI and caregiver commitment measures, families were compared across the continuum to see if there were differences in the families targeted for outreach. Specifically, it was hypothesized that families targeted for outreach at the Universal level would, on average, have low-risk scores on the key measures. In contrast, families targeted for outreach at the Selective or Intensive intervals would be expected to exhibit higher risk scores, and those where the intervention was at the Intensive level would have the highest risk scores (because Intensive interventions are designed to support those who have the highest needs).

Post Permanency Discontinuity

In this section, available administrative data was used to help understand what characteristics, known at the time of adoption or guardianship finalization, were associated with post permanency discontinuity. Prior research has established that the following experiences of children while in foster care were helpful in understanding who was most at risk for post permanency discontinuity: a child's age at the time of adoption or guardianship, the number of moves the child had in foster care prior to adoption or guardianship, and the length of time the child spent in foster care prior to permanence (Rolock, & White, 2016; Rolock, & White, 2017; White, 2016; White et al., 2018). Using data from Vermont, New Jersey, Tennessee, and Illinois, we ran multivariate survival analyses to examine these relationships. Detailed results by state are in the Appendix (Table 10.6) and summarized in Figure 10.1. In sum, this analysis found that:

- Children aged six or older at the time of finalization were 2.9 times more likely to reenter foster care compared to children whose adoption or guardianship was finalized prior to the age of six.
- Children who had three or more moves in foster care were 66% more likely to reenter foster care, compared to children who had less than three moves while in foster care.
- Children of color (compared to White children) were 6% more likely to reenter foster care.

Figure 10.1. Characteristics of Children Most Likely to Reenter Foster Care after Adoption or Guardianship



Note: The graph above shows hazard ratios. They are plotted on a logarithmic scale for ease of interpretation. Hazard ratios less than 1.0 represent decreased odds relative to the comparison group, while values greater than 1.0 represent increased odds relative to the comparison group. In this graph, for instance, the strongest predictor of foster care reentry after adoption of guardianship is the child's age at the time of permanence. The interpretation is: children aged six or older at the time of finalization are 2.9 times more likely to reenter foster care, compared to children whose adoption or guardianship is finalized prior to the age of six.

These findings largely support by prior research in that the age of the child at the time of finalization and the experience of instability while in foster care are strong predictors of post permanency discontinuity.

Analysis Along the Prevention Continuum

The QIC-AG developed the *QIC-AG Permanency Continuum of Service* to guide its work with the different sites (described in Chapter 1, Figure 1.3). The Continuum serves as an organizing framework that helps guide child welfare systems in moving children to adoption or guardianship while supporting families to maintain stability and wellbeing after adoption or guardianship has been achieved. The analysis in this section focuses on the post permanency portion of the Continuum where prevention services were offered.

Based on previous research that established associations between caregiver commitment and caregiver assessment of child behavior difficulties to post permanency discontinuity, the QIC-AG evaluation team examined these constructs across different sites. Prior research suggests these constructs are proximal outcomes associated with post permanency discontinuity. The QIC-AG targeted different groups of families formed through adoption or guardianship along the QIC-AG continuum based on the level of risk for post permanency discontinuity, theorizing that as the average risk for post permanency discontinuity increased, so would the intensity of the intervention needed. The purpose of the following analysis is to provide a preliminary test of possible screening questions that could be used to identify families who may be at risk of experiencing post permanency discontinuity.

In their QIC-AG survey responses and through initial assessments, families responded to questions and completed measures related to child and family wellbeing and behavioral health. This analysis asks the question: do family responses provide us with information that helps us differentiate between families at risk for post permanency discontinuity and those who are unlikely to experience discontinuity? Some caveats about the data analyses presented below:

- For this section of the report, Vermont and Catawba County (NC) are classified as Universal outreach. Although the Catawba intervention (Reach for Success) was an Indicated intervention, the initial survey sent to all adoptive families in the county who had not been previously engaged in post adoption services was a Universal outreach effort. This section grouped Vermont and Catawba results to examine Universal outreach data.

- For the analysis of data from Illinois and New Jersey, intervention participants were removed because we did not want to confound these findings with the effect of the intervention. In other words, for this section we are analyzing the characteristics of families identified in the Selective interval, not describing the impact of the intervention.

- In Wisconsin data were collected at **intake**, prior to participation in the intervention. This baseline data was used to understand the profile of families who indicate that they may be having some difficulty, and to compare their outcomes to families who responded to surveys in the other sites.

- The number of respondents varied by site. There is greater confidence in the results of sites where there are more respondents. In particular, caution should be exercised in the interpretation of the Wisconsin findings, given the lower number of respondents and the wide variety of types of adoptions or guardianships served in that site (please see the Wisconsin report for additional information).

- Not all sites collected the same information; therefore, some sites will not be represented in the graphs showing site-specific results.

Table 10.4. Number of Survey Respondents by Site, by Measure

MEASURES	PREVENTION: UNIVERSAL		PREVENTION: SELECTIVE		PREVENTION: INDICATED
	VT	NC	IL	NJ	WI
BPI	722	122	1,186	449	71
STRAIN	802	128	1,173	450	71
BEST-AG	N/A	126	1,209	448	71

The analysis in this section that shows data across sites does not compare how well each site did, or the outcomes for each site. Rather this analysis is intended to show how at-risk the population was in each site before contact with child welfare agencies. For example, it would be expected that participants in Wisconsin would have worse scores on scales of wellbeing at the point of contact because Wisconsin was an indicated site, and it would be expected that Catawba County would have better scores on scales of wellbeing at the point of contact because the Catawba County survey was a universal intervention.

Behavioral Problem Index (BPI)

The overall hypothesis was that the higher the sites were along the continuum from Universal to Intensive levels of intervention, the overall BPI scores would increase, suggesting more difficult child behaviors. For example, Universal sites (Vermont and Catawba County [NC][2]) gathered BPI scores for all children and youth adopted, and Vermont also included youth placed into guardianship (North Carolina did not have a guardianship assistance program until 2017; guardianship cases were not included in the Catawba study). It would be reasonable to assume that average BPI scores would be lower in these sites than BPI scores in the indicated site (Wisconsin) where the scores were gathered for children who were at higher risk for post permanency discontinuity. As shown in Figure 10.2, that trend did not hold true for all of the QIC-AG sites. Specifically, results from Vermont did not follow the expected trend.

While the average score in Vermont was lower than the scores of families who were at the Indicated level (Wisconsin), they were higher than the scores of respondents in the Selective prevention sites (Illinois and New Jersey). Aside from Vermont, the mean BPI scores in the remainder of the sites followed the expected pattern. An important message to note from this analysis is that, while BPI scores may be helpful in identifying families in need of additional support and services, having a high BPI score is not in and of itself an indicator that a family is at

[2] Note that the overall intervention in Catawba County (NC) was at the indicated level. The Universal component was the fact that the project surveyed all adoptive families in the county who had not engaged with Success Coach services.

risk. For example, Testa, et al., (2015) found that the relationship between elevated BPI scores and post permanency discontinuity was mediated by the level of caregiver commitment. Familial relationships are a complex and nuanced area that needs further understanding, particularly for families formed through adoption or guardianship.

Figure 10.2. Overall Behavioral Problem Index (BPI) Scores by Site

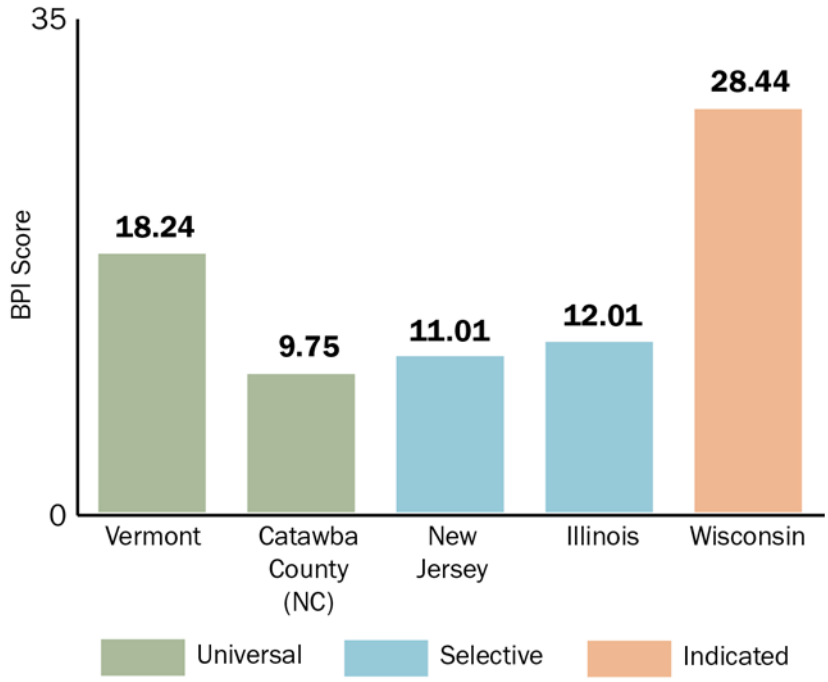


Figure 10.2 note: It should be noted that we expect to see higher levels of behavior problems in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are experiencing difficulties that result in them being in contact with a service provider, and thus, these two sites were serving families that were at higher risk for post permanency difficulties than families in the other QIC-AG sites.

Caregiver Strain

Similar to the hypothesis for BPI, the hypothesis regarding Caregiver Strain was that as sites were placed higher along the continuum, the overall Strain scores would also increase, suggesting more caregiver strain. With the exception of Wisconsin, similar mean scores were observed in most sites (Figure 10.3) that collected this information. However, the Wisconsin mean was based on only 71 children, and the other sites had between 1,173 respondents in Illinois and 128 in Catawba County. In addition, there was less overall variation in this measure than others, such as the BPI, because the total score was an average of individual scores on questions.

Figure 10.3. Mean Caregiver Strain Scores by Site

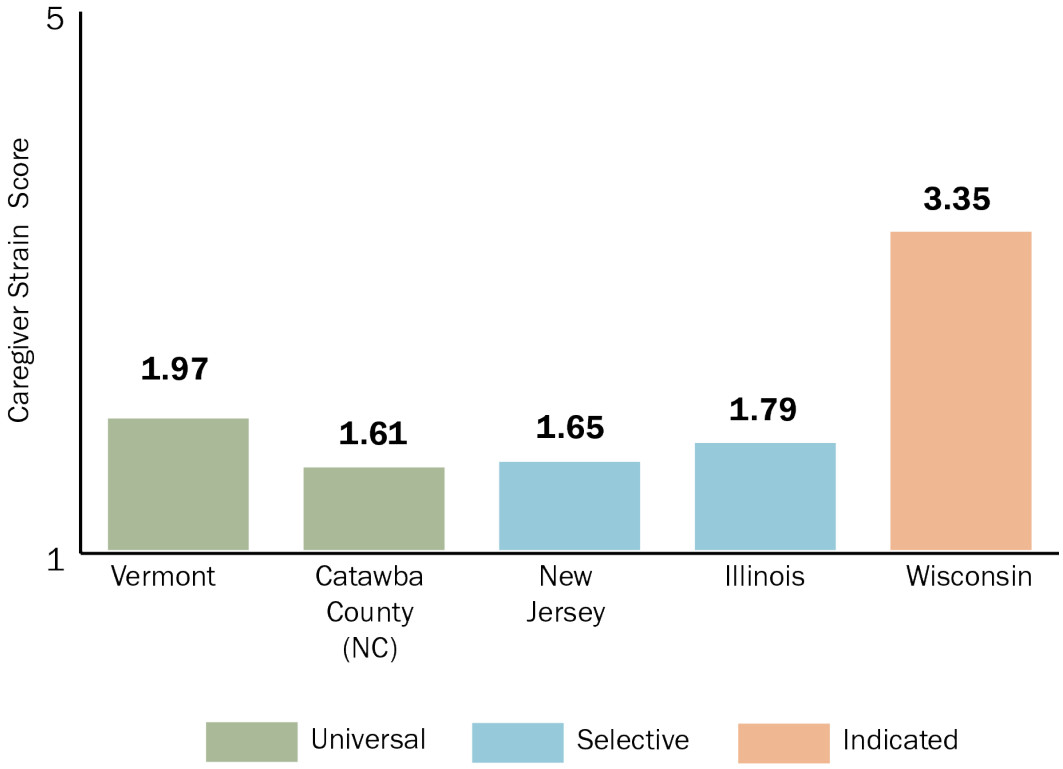


Figure 10.3 note: It should be noted that we expect to see higher levels of caregvier strain in the site that is serving families who reach out to request assistance (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are experiencing difficulties that result in them being in contact with a service provider, and thus, this site was serving families that were at higher risk for post permanency difficulties than families in the other QIC-AG sites.

Belonging and Emotional Security Tool – Adoption and Guardianship (BEST-AG)

The hypothesis associated with the BEST-AG was the opposite of the prior two measures. We hypothesized that as sites were placed higher along the QIC-AG Permanency Continuum, there would be a decrease in the level of belonging and emotional security that the caregiver had for the child or youth. Results (Figure 10.4) found similar mean scores in Catawba County (NC) (Universal), Illinois and New Jersey (Selective). The average BEST-AG scores in Wisconsin were lower; this site was also where families made contact with the system, rather than the project proactively reaching out to the family. In other words, the families in Wisconsin were experiencing some level of difficulty that resulted in their contact with the project.

Figure 10.4. Overall Belonging and Emotional Security Tool – Adoption and Guardianship (BEST-AG) Scores by Site

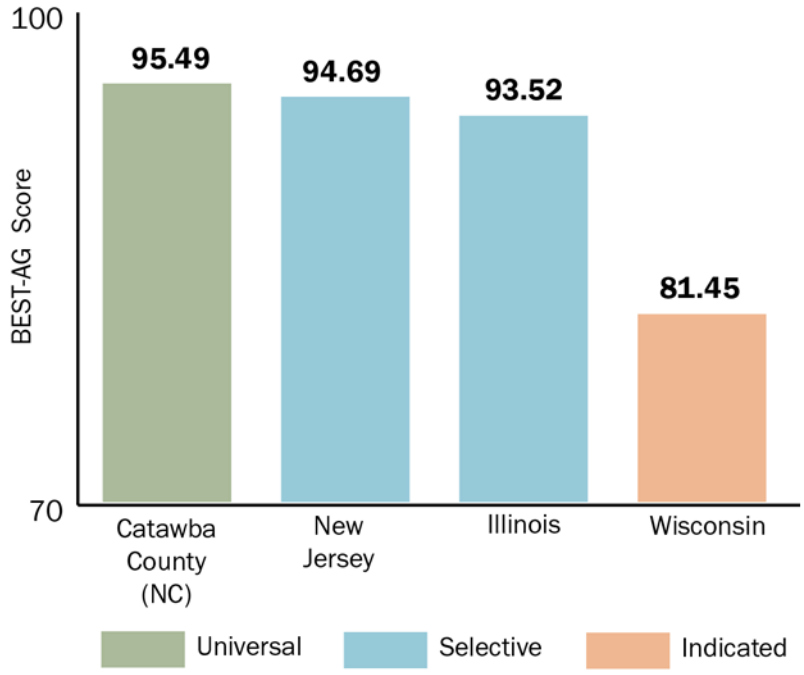


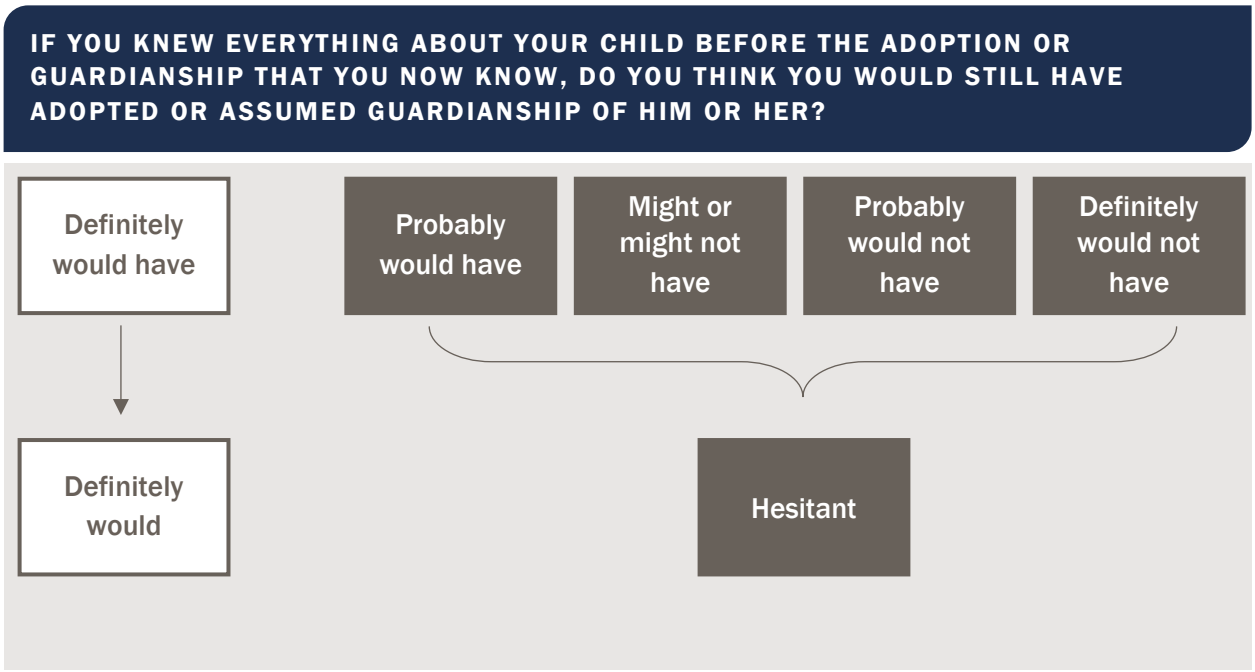
Figure 10.4 note: It should be noted that we expect to see lower levels of belonging and emotional security in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are experiencing difficulties that result in them being in contact with a service provider, and thus, thissite was serving families that were at higher risk for post permanency difficulties than families in the other QIC-AG sites.

Impact of Caregiver Commitment on Key Measures

Caregiver commitment is the extent to which adoptive parents or guardians intend to maintain children in their homes and provide long-term care for them, no matter what challenges, stressors, or negative behaviors may occur (Liao & Testa, 2016; White, Rolock, Testa, Ringeisen, Childs, Johnson, & Diamant-Wilson, 2018). Previous research studies have conceptualized caregiver commitment in two ways. First, caregiver commitment has been examined as a potential indicator, or predictor, of other long-term post permanency outcomes of interest, such as placement instability (Mariscal, Akin, Lieberman, & Washington, 2015; White et al., 2018). Second, caregiver commitment has been investigated as an intermediate or "proximal" adoption or guardianship outcome that results from the characteristics, relationships, and actions of children, caregivers, family members, social supports, and service systems (Nalavany, Ryan, Howard, & Smith, 2008; White, 2016; White et al., 2018). For example, researchers have examined how negative child behaviors, child-caregiver kinship, and even the availability of services may be associated with caregiver commitment to adoptions and guardianships (Mariscal et al., 2015; Rolock & Pérez, 2015; Testa et al., 2015; White et al., 2018).

The relationships between caregiver commitment and other post permanency variables, such as placement instability, can be quite complex. As one example, Testa and colleagues (2015) surveyed adoptive parents and guardians and assessed child behavior problems using the Behavior Problems Index (BPI) and caregiver commitment by asking caregivers about their thoughts of ending the adoption or guardianship. They found that the relationship between negative child behaviors and placement instability was mediated by caregiver commitment. Further, this mediated the relationship between child behaviors and instability and was moderated by other characteristics, such as the degree of kinship between caregiver and child.

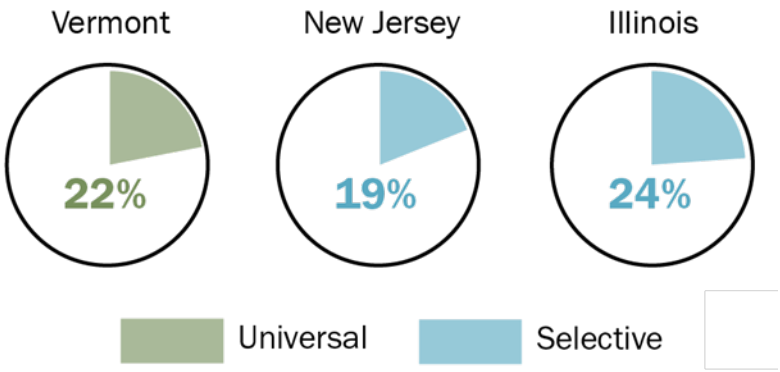
Keeping in mind the significant role caregiver commitment has played in understanding post permanency discontinuity and other challenges in prior studies (Liao & Testa, 2016; Testa et al., 2015; White et al., 2018), a series of commitment questions were asked of parents and guardians involved with this study. One of the commitment questions asked parents and guardians to think about what they know now and respond to a question that asked if they would adopt or assume guardianship again. (*If you knew everything about your child before the adoption or guardianship that you now know, do you think you would still have adopted or assumed guardianship of him or her?*) Responses were on a 5-point scale, from 'definitely would have' to 'definitely would not have'. To analyze this, first, a dichotomous variable was created, where 'definitely would have' was coded as 'definitely would,' and 'probably would have', 'might or might not have', 'probably would not have' and 'definitely would not have' were coded as 'hesitant'.



Results (depicted in Figure 10.5), show that between 19% and 24% of respondents from the prevention-related sites (Vermont, New Jersey and Illinois) expressed some level of hesitancy to adopt or assume guardianship again[3]:

- In Vermont, where outreach was Universal, 22% of families expressed hesitancy to adopt or assume guardianship again.
- In New Jersey, 19% of families expressed hesitancy to adopt or assume guardianship again.
- In Illinois, 24% of families expressed hesitancy to adopt or assume guardianship again.

Figure 10.5. Percent of Caregivers who Expressed Hesitancy to Adopt or Assume Guardianship Again



These results do not align exactly with the theory behind the continuum. Through this theory, one would expect a lower proportion of families to express hesitancy in Vermont (Universal) than in New Jersey or Illinois (Selective). It is possible that external factors (e.g., level and type of post permanency services available) play a role, or that some unmeasured factors are at play.

Keeping in mind the proportion of families in each category (hesitant to adopt or assume guardianship again, or not hesitant), the next step in this analysis examined responses **within each of these two groups.** Results (summarized in Table 10.4 in the Appendix, and in Figures 10.6 – 10.8).

[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):**

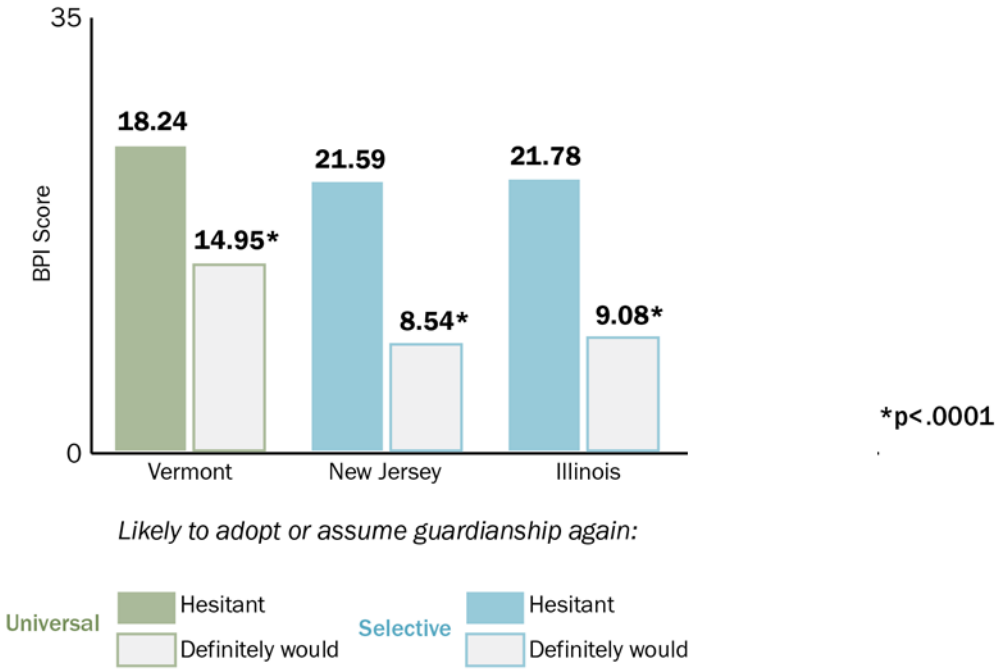
- Families who were hesitant to adopt or assume guardianship again.
- Families who expressed no hesitancy (definitely would adopt or assume guardianship again).

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.

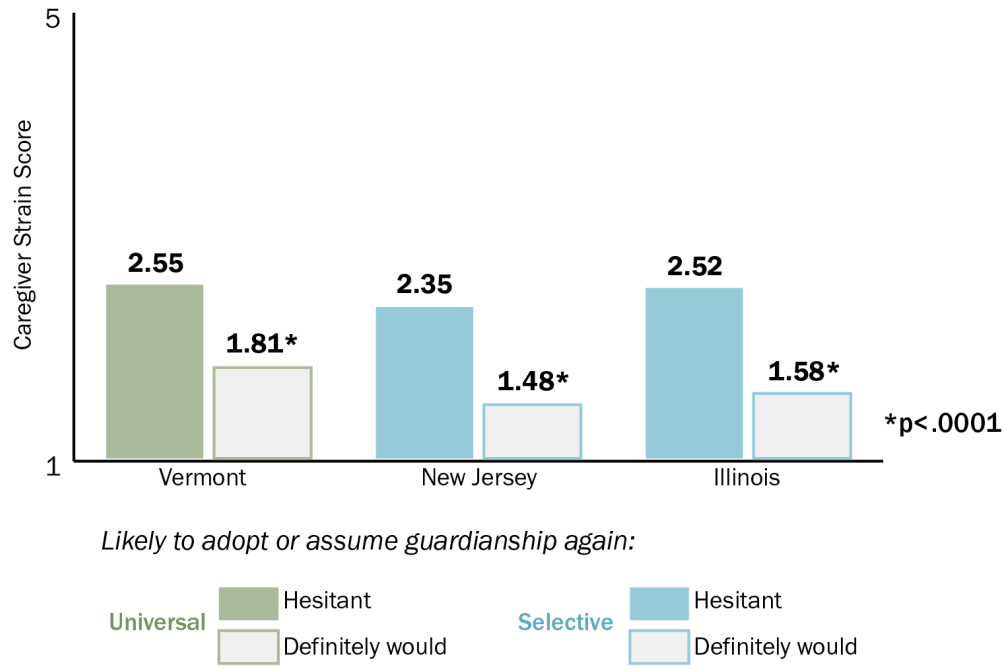
This analysis revealed some interesting trends that are examined along the continuum and across three key measures: The Behavioral Problem Index (BPI), Caregiver Strain (CS), and the Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG).

Figure 10.6. Behavior Problem Index (BPI) by Inclination to Adopt or Assume Guardianship Again



The BPI was selected as a standardized measure of child behavior problems based on previous research with adoptive and guardianship families (Liao & Testa, 2016; Testa et al., 2015; White, 2016). Higher scores on the BPI mean more behavioral issues. As shown in Figure 10.6, there is a statistically significant difference in the BPI for children whose parents or guardians expressed hesitancy to adopt or assume guardianship again and parents or guardians who *do not* express hesitancy to adopt or assume guardianship again, with those who expressed hesitancy scoring higher on the BPI.

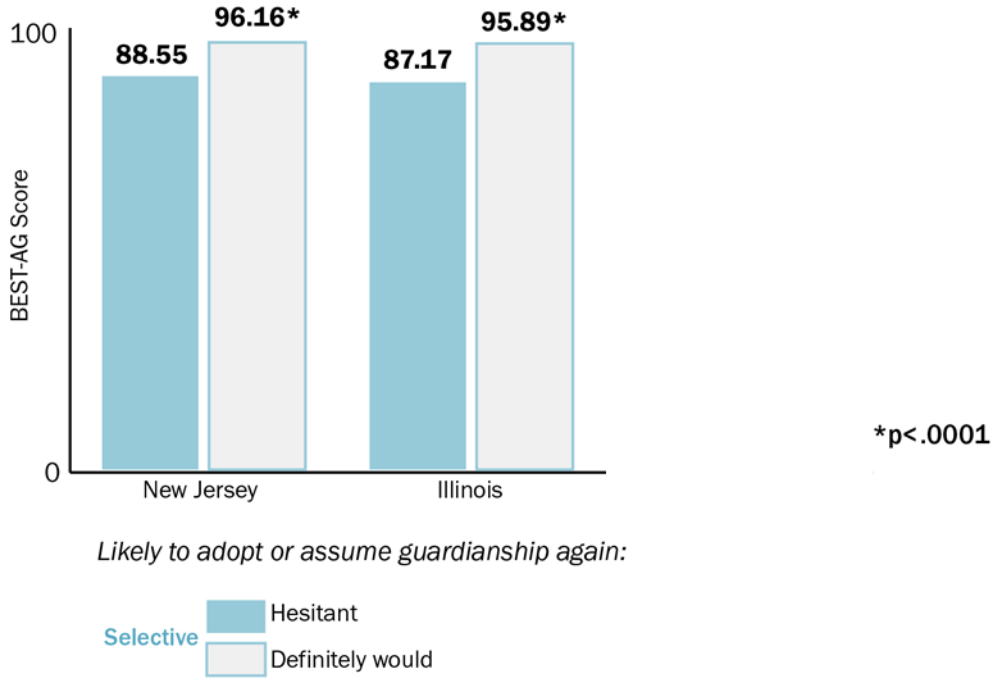
Figure 10.7. Caregiver Strain by Inclination to Adopt or Assume Guardianship Again



The Caregiver Strain Questionnaire-Adoption/Guardianship (CGSQ-AG) used in this project is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger, & Brickman, 1997), a measure to assesses the extent to which caregivers experience additional demands, responsibilities, and difficulties as a result of caring for a specific child. Caregiver strain, similar to parenting stress or burden, has been found in the previous literature to be associated with lower child and family satisfaction and wellbeing after adoption or guardianship (White et al., 2018). The same analysis was conducted with the caregiver strain measure (see Figure 10.7), and similar patterns emerged. Again, keeping in mind that this analysis focused on the differences highlighted in Figure 10.5 (that 22% of families in Vermont, 19% in New Jersey, 24% in Illinois expressed hesitancy to adopt or assume guardianship again).

With the Caregiver Strain measure, higher scores mean higher levels of strain. Results found a statistically significant difference in the level of strain reported by caregivers who expressed hesitancy to adopt or assume guardianship again in all three sites where data was available. These families also reported much higher rates on caregiver strain than families who were not hesitant to adopt or assume guardianship again.

Figure 10.8. Belongingand Emotional Security Tool (BEST-AG) by Inclination to Adopt or Assume Guardianship Again



The BEST-AG, developed by Casey Family Services (Frey, Cushing, Freundlich, & Brenner, 2008), was originally designed to help social workers frame conversations about emotional and legal commitment with foster parent and youth who are unable to reunify with their family of origin. For this study, the BEST-AG was adapted and used with families formed through adoption and guardianship because previous research has shown that lower caregiver commitment is related to increased levels of post permanency discontinuity (Testa et al., 2015; White et al., 2018).

This analysis was repeated with the BEST-AG. However, note that with the BEST-AG, higher scores mean *an increased level of belonging and emotional security*. Results (depicted in Figure 10.8) found a statistically significant difference in the BEST-AG for children whose parents or guardians expressed hesitancy to adopt or assume guardianship again. Specifically, families who express hesitancy to adopt or assume guardianship again are not doing as well as families who do not express hesitancy. There is a statistically significant difference between the two groups.

Taken together, these findings suggest that the target populations along the continuum varied in interesting and unexpected ways. For instance, in Vermont, Universal outreach would be expected to find a population with less risk for post permanency discontinuity than a population that was targeted based on specific risk factors (New Jersey and Illinois), but this was not the case. In all three prevention sites (Vermont, New Jersey, and Illinois), approximately 20% (19% to 24%) of the families who responded to surveys had much higher BPI scores, more strain, and less of a sense of belonging and emotional security. In addition, Universal and Selective prevention sites were much more similar than expected.

These findings suggest that in addition to the administrative data that can be used to assess risk for post permanency discontinuity, the question related to hesitancy to adopt or assume guardianship provides an opportunity for a more nuanced assessment of risk for post permanency discontinuity. In addition to this one question, there are other questions related to caregiver commitment and familial relationships that should be examined related to assessment for risk for post permanency discontinuity. Child welfare jurisdictions interested in targeted outreach to families formed through adoption or guardianship may consider periodically checking in with families to assess their level of caregiver commitment and familial relationship (e.g., the parent or guardian's assessment of how well they can manage their child's behavior). Based on the responses received from this check-in, jurisdictions could consider targeting limited resources to families who express hesitancy to adopt or assume guardianship again or results from additional caregiver commitment or familial relationship questions piloted with the QIC-AG project. Additional analysis of other questions related to familial relationships and caregiver commitment may also be worth exploring.

Discussion

This section summarizes several takeaways from the QIC-AG project when looking at the results of the studies across sites working with families formed through adoption or guardianship. It is important to note that discussing key themes in this way risks glossing over substantive differences across sites and the importance of site-specific considerations in service needs and intervention design. However, despite the considerable variation among these sites in populations, outreach methods, and interventions implemented, some crosscutting themes emerged across sites and may be helpful to those who plan outreach and services to families formed through adoption and guardianship.

FAMILIES KNOW WHAT THEY NEED; FAMILIES WHO WANT SERVICES ENGAGE IN SERVICES

There was a significant amount of effort by the QIC-AG aimed at understanding how to reach families, and anticipating how families would respond to outreach from the project. These findings suggest that families are quite capable of self-assessment. In short, families know what they need. This is evident in the data collected; families who participated in services had more intense struggles than those who did not engage in services. Families who engaged in services tended to be families who reported that they were struggling to effectively manage their child's behavior or respond appropriately to their child. Conversely, families who did not engage in services tended to be families who reported they were adjusting fine. In other words, future projects can worry less about the specific type of outreach (e.g., mailings addressed with a specific color of ink or pictures) and more about offering services and supports to families formed through adoption or guardianship.

SERVICE UPTAKE DID NOT OVERWHELM POST PERMANENCY SERVICE PROVIDERS

There was a concern in several sites that if post adoption or guardianship services were made available to families, too many caregivers would want them and then overwhelm the capacity of the child welfare system to respond. It was difficult to plan for group sessions or numbers of facilitators because project staff did not know how many families to anticipate participating. Jurisdictions concerned about their capacity to offer post permanency supports and services should not expect being overwhelmed with requests. Most families do well with the supports and services currently in place, and will not be interested in additional services, if offered. Furthermore, for those families who need additional services or support, they are often desperate for assistance, and the offer of additional support can be life-changing for the families involved.

ONGOING SERVICE NEEDS

Similar to other research with families formed through adoption and guardianship, families involved in this study reported that they were doing well with the supports and services they currently have in place. However, just because the level of need did not overwhelm the system does not mean that services are not needed. Families suggested that the child welfare system may want to focus on making a wider variety of post permanency services available and accessible. A primary task for child welfare service providers is to ensure that families who are struggling can easily access the services they need. In the survey responses and in interviews with families formed through adoption or guardianship, parents and guardians reported not knowing where or

how to access services, or reported trying to access services but finding them inadequate. In other words, project findings suggest that families know when they are struggling, yet helpful services remain elusive. This is further complicated by the fact that many child welfare agencies do not have a robust system of services targeted at families formed through adoption or guardianship.

Some parents and guardians reported that the supports and services available to them as foster parents disappear after finalization, yet they were still in need of those services. In addition, for adoptive parents and guardians whose needs change after finalization, services and supports can become more difficult to access. Finally, being connected with providers who understand the unique circumstances of families formed through adoption and guardianship is important to families in need. Parents and guardians reported struggling to be heard and believed. Service providers did not always believe that the situation at home was as bad as it was. For instance, Wisconsin caregivers reported that when they told a provider that they had already tried an idea, they were not believed, but when they said the same thing to an AGES worker, they were heard and believed.

Finally, the use of the word *support* is important. Families in Wisconsin reported that it is not always another intervention that is needed. Sometimes what is most needed is just a friendly voice on the other end of the phone, who can listen to struggles regarding birth family contact or provide support for older caregivers. Other times it is helping to get intensive residential treatment services for their child without relinquishing custody. TINT participants in New Jersey reflected on the important social connections (informal social support) made by attending TINT sessions. Survey respondents in New Jersey and Illinois reported that they needed formal support from the child welfare and school systems, as well as support in accessing services for their child post-permanence. It is important to understand what *support* means to the family and to find a way to offer it in a timely manner.

In sum, some suggestions moving forward:

- Maintain connections with families after adoption and guardianship. Connections to services, supports, and resources should begin prior to adoption or guardianship finalization and continue to be maintained after finalization.

- Reduce barriers to post adoption service use and empower families to seek services and supports. This process may be made easier by maintaining connections through universal outreach, which includes providing information about availability and eligibility for services after adoption or guardianship finalization so that families know how and where to access supports and services.

- Offer support through periodic, targeted outreach to families who exhibit characteristics that suggest they may be at an increased risk for post permanency discontinuity. This could be, for instance, annual check-ins with families to see how they are doing.

- Encourage child welfare jurisdictions to develop systems to track and update families' addresses and contact information so that families receive the information that agencies send.

- Increase the availability of service providers experienced in working with families formed through adoption or guardianship, particularly for child and family mental health support.

Caregivers shared additional thoughts through surveys, and the majority of those responses included something positive about the adoption or guardianship experience. In many comments,

the caregivers described a deep love and appreciation for the children they had adopted or assumed guardianship of. However, for some parents and guardians, their child also presented unanticipated challenges, including attachment issues from past trauma experienced, problems at school, and identity concerns. Additionally, challenges often did not occur until children were older, years after legal finalization of the adoption or guradianship. Difficulties interacting with birth families were problematic for some families, suggesting the need for support navigating a child's other relationships. Therefore, culturally sensitive, developmentally-appropriate, trauma-informed services that take into consideration the unique experiences of adoptive and guardianhsip families, and are requested and delivered in a timely fashion have the potential to help avert difficulties that adoptive families experience after legal permanence.

POST PERMANENCY CONTACT BY A CHILD WELFARE AGENCY IS WELCOME AND APPRECIATED

The project successfully contacted a large percentage of the families they attempted to reach. It is important to note that response rates close to, or even well below, 50% are not unusual for post adoption surveys described in the previous literature, and that response rates in previous studies vary widely (White, 2016). Furthermore, families appreciated being contacted. It is noteworthy that the project heard from many families who expressed gratitude for the opportunity to tell their story. In work with families who have exited the foster care system to adoption or guardianship, there is sometimes a question about whether and how families experience a request for engagement by the formal child welfare system. The responses provided by families suggest that they both appreciate and need outreach from the system and are interested in the results:

> **"If you ever need me to answer any questions again please let us know. We adopted three kids all [with] special needs and one that is dual diagnosis mental health and developmental disabilities and she has been the challenge! I most certainly could tell the good, the bad, the ugly, of all of it! I still would do it all over again."**

In summary, agencies should assume that families would welcome outreach post permanency. This may be contrary to the perception that adoptive and guardianship families wanted to be left alone by state agencies. Adoptive parents and guardians are often parenting children that have experienced significant trauma and struggle to receive the appropriate services without public agency support.

IDENTIFYING FAMILIES AT RISK FOR POST PERMANENCY DISCONTINUITY

Results from previous studies of post permanency discontinuity indicate that a small proportion of children who exit foster care to adoption or guardianship experience post permanency discontinuity, or reentry into foster care after finalization, as captured by administrative child welfare data systems (White et al., 2018). Yet, for families who experience discontinuity, the process can be very difficult, and result in additional trauma, loss and diminished wellbeing for all involved.

Research from other studies (extant research) has found that caregiver commitment, while strong at the time of finalization, may diminish over time and that a diminished level of caregiver commitment is associated with increased risk of post permanency discontinuity (Testa et al., 2015; White et al., 2018). However, this extant research, and the relationships they examine, are complicated. One key finding from the extant research is that child behavior problems and caregiver strain have been identified as a risk factors for post permanency discontinuity (Newton, Litrownik, & Landsverk, 2000; Liao & White, 2014). In other words, children with elevated BPI scores, and caregivers with elevated levels of strain, are at greater risk for post permanency discontinuity.

Results from this project found that there are statistically significant differences on key measures (BPI, BEST-AG, Caregiver Strain) between parents and guardians who express hesitancy to adopt or assume guardianship again and families who do not express hesitancy to adopt or assume guardianship again (one measure of caregiver commitment). Results from this project also found that families who report that they are less confident that they can meet the needs of their child, or were more likely to report that they struggle to effectively manage their child's behavior (familial relationship measures), were more likely to engage in services.

An important aspect of prevention work with adoptive and guardianship families is to be able to identify families who may be the most likely to experience post permanency discontinuity and diminished wellbeing. Through the research conducted with the QIC-AG, we asked key questions to better understand the relationship between caregiver commitment, familial relationship, and post permanency discontinuity. We found the responses show promise for use as a tool to distinguish families who were struggling and those who seemed to be doing alright. Next steps for this line of research would be to test these questions as a tool to identify families most at risk for post permanency discontinuity. These questions could be administered yearly to all adoptive and guardianship families, with targeted outreach directed at families whose responses suggest they may be at an elevated risk for post permanency discontinuity.

MULTI-PRONG APPROACH TO OFFERING SUPPORT AND SERVICES

These results found that families are capable of self-assessment for engagement in post permanency services. Universal, broad outreach efforts should occur with families formed through adoption or guardianship on a regular basis, to remind them of available services and how to access services and supports. From the experiences of this project, this should not overwhelm systems, and the relatively small proportion of families who are interested in engaging in services are likely to participate.

In addition, child welfare agencies interested in understanding which families are at increased risk for post permanency discontinuity may want to consider asking some key questions related to caregiver commitment and familial relationships at regular intervals post-finalization. Results can then be used to let families who may be struggling and at-risk for post permanency discontinuity to know more about available services. Agencies can also deliberately ask families most at risk for post permanency discontinuity about what services and supports are needed so that a robust array of supports and services can be delivered. Families experiencing stressful events are not always capable of unraveling the complex public and private service and educational systems. Families involved in this study reported that the support they received to navigate and advocate for services made all the difference in their family's wellbeing.

Finally, agencies should offer services and supports that address immediate concerns as part of their service array. In at least one of the sites, families who engaged in the intervention later engaged in services-as-usual. This suggests that they had additional needs that were not addressed through the specific intervention. A wider array of services may be needed by the adoptive parents and guardians. In addition, through the relatively small number of families who participated in the AGES program, the project has learned that some families will have issues where they are in urgent need of services. Other families will have long-term issues. These are issues that were concerning to the families and they wanted to address or better understand, but were generally not overwhelming them at that moment. Service providers need to be prepared to offer an array of services and supports to families who contact an agency or provider looking for assistance. Adoptive and guardianship families struggle like other families, but there is a uniqueness to their struggles. Services and supports need to be put into place to address these unique needs.

ADOPTIVE PARENTS AND GUARDIANS REPORT ON THEIR POST PERMANENCY EXPERIENCES

Throughout the project, the teams have listened to families formed through adoption and guardianship. Site-specific Theories of Change, membership on Stakeholder Advisory Groups (SAT) and insight from parents and guardians guided the project development and implementation. We conclude with some thoughts from parents and guardians. Several of the QIC-AG sites asked parents and guardians for additional thoughts about their experiences with adoption or guardianship. Some common themes emerged from caregiver responses across sites. First, most comments from caregivers expressed their deep love and concern for their children and showed that they were committed to their children for life. Caregivers' comments also expressed joy and delight over being able to bring their adopted or guardianship child into the home. For example:

> **"It has been a life-changing experience. It has been harder than I thought it would be, but I am always thankful that we adopted our daughter, I love her with all my heart, and I can't imagine our family without her."**

> **"It's been a great experience watching my child grow into a young respectful young man. I wouldn't trade him for the world. Had him since he was three weeks old now he is 18 years old. Best 18 years."**

> **"My adoption has given me fulfillment and purpose and an opportunity to pour into the life of my granddaughter. As we are going through her teen years we have run into many challenges, as she is developing, maturing and finding her own way. Yet this has been rewarding."**

Second, despite their commitment to children, some caregivers noted frustrations, especially regarding inconsistency and availability of services and supports. For example, caregivers reported difficulties with school-related issues, interactions with birth families, accessing mental health services, and finding help from social workers when needed. For example:

> **"Sometimes [he] can be a joy to have but when the school calls and say he's acting up at school it reflects back to me. Is there something different I can do to change his perspective on learning? He is a smart little boy but when he gets around some of his friends at school he seems to act up."**

> **"We were not aware of the depth of our daughter's disabilities. Schooling is hard for her, there is really no place she fits in, regardless of all the IEPs in place and all the hard work that has been put into it. She has many disabilities, so it is hard to get all disabilities taken care of at the same time. We knew she was delayed. We didn't know she had 5 or more diagnoses and would never graduate from high school or ever be able to go to college or live on her own."**

> **"Our biggest challenge is the close proximity of the birth family, specifically birth dad. He does not respect the boundaries of adoption and is a constant threat and worry.**
>
> **"We spent many years trying to find appropriate providers who understood our son. We were often given misinformation & guidance about our son's needs. For years, professionals looked only at behaviors rather than brain functioning & disabilities. Both he & us as parents were blamed."**
>
> **"Attachment disorder has severely impacted my daughter…She has struggled with attachment and reciprocity. I, too, have struggled with attachment to her, given her lack of reciprocity. Having worked with a therapist years ago who purportedly understood attachment disorder, my daughter and I received very little helpful guidance…The fact that she is still alive is testament to my husband's and my determination to support her and find resources for her--mostly out of state."**

These reflections show that adoptive parents and guardians are largely committed to children for life. They are satisfied with some of the supports they receive, but more could be done to help families navigate educational and mental health systems, particularly when children exhibit behavioral and/or mental health difficulties. In drafting the Theory of Change in the proposal to establish the QIC-AG, the project postulated:

Interventions that target families on the brink of disruption and dissolution do not adequately serve the interests of children, youth and families. Evidence-supported, post permanency services and support should be provided at the earliest signs of trouble rather than at later stages of weakened family commitment (Koh & Testa, 2008; Testa, Bruhn & Helton, 2010). Ideally, preparation for the occasion when post permanency stability is threatened should begin prior to finalization through the delivery of evidence-supported services that prepare and equip families with the capacity to weather unexpected difficulties and seek needed services. The best way to ensure families will seek needed services and supports is to prepare them in advance of permanence for the potential need for services and supports, and to check-in with them periodically after adoption or guardianship finalization.

Through surveys and interviews (see site-specific reports in Wisconsin, Illinois, and New Jersey), adoptive parents and guardians told this project that they need support in managing relationships with birth parents and families after finalization, as well as figuring out how much contact with the birth family is beneficial to the child. They also mentioned needing advocacy and other types of support. They need mental health services that are specific to the needs of families formed through adoption and guardianship. The QIC-AG Theory of Change is confirmed in their responses. Adjustment after adoption and guardianship is a long process, and the needs of caregivers and children do not disappear after finalization. Indeed, some issues, such as mental health, identity, and educational challenges may not appear until many years after the adoption or guardianship is finalized.

Furthermore, adoptive parents and guardians have found various ways to tell the QIC-AG project that they welcome outreach from the child welfare system after finalization. Some reported this in interviews, others in responses written in surveys, and others when they called a member of the research team to thank them for reaching out. Finally, the project has tested various measures that can help child welfare systems identify families who might welcome additional support or services. Future projects should build upon these findings in creating a 21st-century child welfare system that meets the needs of families formed through adoption or guardianship, from the pre-finalization phase, through the maintenance of stable, strong families who are prepared to access evidence-supported services and supports when they need them.

References

Brannan, A. M., Helfinger, C.A. & Bickman, L. (1997). The caregiver strain questionnaire: Measuring the impact of the family living with the child with a serious emotional disturbance. *Journal of Emotional and Behavioral Disorders,* 5(4), 212-222.

Frey, L., Cushing, G., Freundlich., M., & Brenner, E. (2008). Achieving permanency for youth in foster care: Assessing and strengthening emotional security. *Child and Family Social Work*, 13, 281-226.doi: 10.1111/j.1365-2206.2007.00539.x

Guo, S. & Fraser, M. W. (2010). Advanced quantitative techniques in the social sciences: Vol. 11. Propensity score analysis: Statistical methods and applications. Thousand Oaks, CA, US: Sage Publications, Inc.

Koh, E., & Testa, M. F. (2008). Propensity score matching of children in kinship and nonkinship foster care: Do permanency outcomes still differ? *Social Work Research*, 32(2), 105-116.doi:10.1093/swr/32.2.105

Liao, M., & Testa, M. (2016). Post adoption and guardianship. *Research on Social Work Practice, 26*(6), 675-685. doi:10.1177/1049731514564600

Liao, M., & White, K. R. (2014). Post-permanency service needs, service utilization, and placement discontinuity for kinship versus non-kinship families. *Children and Youth Services Review, 44*, 370-378. http://dx.doi.org/10.1016/j.childyouth.2014.07.007

Mariscal, E. S., Akin, B. A., Lieberman, A. A., & Washington, D. (2015). Exploring the path from foster care to stable and lasting adoption: perceptions of foster care alumni. *Children and Youth Services Review, 55*, 111-120. doi:10.1016/j.childyouth.2015.05.017

Nalavany, B. A., Ryan, S. D., Howard, J. A., & Smith, S. L. (2008, Dec). Preadoptive child sexual abuse as a predictor of moves in care, adoption disruptions, and inconsistent adoptive parent commitment. *Child Abuse & Neglect, 32*(12), 1084-1088. doi:10.1016/j.chiabu.2008.07.001

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: disentangling the relationship between problem behaviors and number of placements. *Child Abuse Negl, 24*(10), 1363-1374. http://dx.doi.org/10.1016/s0145-2134(00)00189-7

Rolock, N., & Pérez, A. G. (2016). Three sides to a foster care story: an examination of the lived experiences of young adults, their foster care case record, and the space in between. *Qualitative Social Work: Research and Practice, 17*(2), 195-215. doi:10.1177/1473325016666410

Rolock, N., & White, K. R. (2016). Post-permanency discontinuity: A longitudinal examination of outcomes for foster youth after adoption or guardianship. *Children and Youth Services Review, 70*, 419-427. http://dx.doi.org/10.1016/j.childyouth.2016.10.025

Rolock, N., & White, K. R. (2017). Continuity for children after guardianship versus adoption with kin: Approximating the right counterfactual. *Child Abuse Negl, 72*, 32-44. http://dx.doi.org/10.1016/j.chiabu.2017.07.001

Testa, M. F., Bruhn, C., Helton, J. (2010). Comparative safety, stability, and continuity of children's placements in formal and informal substitute care. In M. B. Webb, K. Dowd, B. Jones Harden, J. Landsverk, & M. F. Testa (Eds.), *Child welfare and child well-being: New perspectives from the National Survey of Child and Adolescent Well-Being* (pp. 159 – 191). New York: Oxford.

Testa, M. F., Snyder, S. M., Wu, Q., Rolock, N., & Liao, M. (2015). Adoption and guardianship: A moderated mediation analysis of predictors of post-permanency continuity. *American Journal of Orthopsychiatry, 85*(2), 107-118. doi:10.1037/ort0000019

White, K. R. (2016). Placement discontinuity for older children and adolescents who exit foster care through adoption or guardianship: A systematic review. *Child and Adolescent Social Work Journal,* 33(4), 377-394. doi:10.1007/s10560-015-0425-1

White, K. R., Rolock, N., Testa, M. F., Ringeisen, H., Childs, S., Johnson, S., & Diamant-Wilson, R. (2018). Understanding Post Adoption and Guardianship Instability for Children and Youth Who Exit Foster Care: Literature Review and Conceptual Framework (report submitted to the Office of Planning, Research, & Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services).

Zelen, M. (1979). A new design for randomized clinical trials. *New England Journal of Medicine*, 300, 1242–1245.

Zelen, M. (1990). Randomized consent designs for clinical trials: An update. *Statistics in Medicine*, 9, 645–656.

Appendices

Appendix A. Engagement with Adoptive Families Finalized through Private Domestic and Intercountry Processes

The QIC-AG project involved outreach to private domestic and intercountry adoptive families in multiple locations, including New Jersey, Illinois, Catawba County (NC), Vermont, Wisconsin, and Tennessee. Additional information on the private and intercountry adoptive families survey in Vermont is available as an appendix to the Vermont site report. In addition, a separate report completed by the University of Nebraska – Lincoln on private domestic and intercountry adoptive families has also been completed.

Across these sites, contact with private and intercountry adoptive families was somewhat limited. There is no central registry of families who adopt via private domestic or intercountry processes, making broad outreach challenging. Recruitment efforts were different for these families than for public adoptive families. At the start of the QIC-AG, project staff met with the U.S. State Department to identify a list of Adoption Service Providers (ASPs) or professionals who help families through the private/intercountry adoption process, and sites reached out to agencies providing adoption services. Only a small number of these families responded to outreach and intervention efforts. However, findings across sites generally indicated that private domestic and intercountry adoptive families were similar to public adoptive families on many characteristics examined, with some notable differences found in individual QIC-AG sites.

In New Jersey, seven private domestic and intercountry families participated in the intervention. The private domestic and intercountry and public adoptive families were similar enough in that site that the project team decided separate TINT classes for different types of adoptive families were not needed. However, some differences were also noted between groups. Specifically, all the private domestic and intercountry adoptive families who responded to the TINT pre-survey were two-parent households, employed full-time, and had a college degree or higher. In contrast, just over half of public adoptive or guardianship families in New Jersey were in a two-parent family, 43% were employed full-time, and 63% had less than a college degree. End-of-service surveys were not sent to private/intercountry adoptive families in New Jersey, thus no intervention outcomes for these families were available.

Illinois engaged 32 private and intercountry adoptive families (i.e., 14 private domestic and 18 intercountry) who all expressed interest in the TARGET intervention. Participating families were from both sites within Illinois, with 14 in Cook County and 18 in the Central Region. The mean age of adoption for those who expressed interest was less than one year old in Cook County and almost four years old in Central Region, and the mean age of intervention was about 12 years old in both regions. Finally, 84% of the private domestic and intercountry adoptive families received the full intervention (at least four sessions). However, similar to New Jersey, end-of-service surveys were not sent to private domestic and intercountry adoptive families in Illinois, thus no information on intervention outcomes for these families was available.

Outreach efforts to private domestic or intercountry adoptive families in Catawba County started with agency staff attending community events (e.g., ball games). Catawba County staff distributed information about Success Coach services at these events. Catawba County staff also met with agencies identified by the U.S. State Department who were likely to work with families in Catawba's eight-county post permanency service region. Catawba set up trainings with these ASPs to raise awareness about adoption issues, specifically raising awareness that families who adopt through a private domestic or intercountry process were eligible for post permanency services in Catawba County. Catawba also provided the ASPs who attended training with materials about Success Coach services, which the ASPs could then disseminate to the families they work with through the private adoption process. As a result of these outreach efforts to ASPs, Catawba County had one intercountry family call the child welfare agency to ask for information about post-adoptive services, but the family did not enter into a service plan with a Success Coach.

Families who adopted a child through a private agency, either domestically or internationally, were included as a sub-population of the survey study in Vermont. Initially, the Vermont site team reached out to agencies and organizations who served families formed through private or intercountry adoption. Agencies sent a letter to families in this population to inform them about the study and requested they provide their contact information to the child welfare agency if they were interested in participation. There were 117 families throughout the state who opted into the survey, 47 (40%) intercountry adoptions, 65 (56%) private adoptions, and for 5 (4%) this information was not available. Two reports, one on private domestic adoptive families and a second on intercountry adoptive families, in Vermont are attached as an appendix to the QIC-AG final evaluation report for Vermont.

In Wisconsin, 26 of the 71 children (37%) who received the AGES intervention were private domestic or intercountry adoptions or private guardianships. Specifically, 12 were private (family court) guardianships, 9 intercountry adoptions and 6 private adoptions. Qualitative results, consisting of feedback from adoptive parents, indicated that AGES benefited caregivers in both private and intercountry and public adoptions because it helped them build a support network within their families, communities, and/or friends. In addition, AGES seemed to provide all adoptive parents and guardians with someone they could talk to when feeling isolated or frustrated.

The Tennessee QIC-AG study tested whether the NMT could promote permanency and stability in adoptive families who were referred or self-referred to Adoption Support and Preservation Program (ASAP) for services, including private domestic and international adoptive families. Of the 518 families served by the post adoption program in Tennessee during the study period, 132 (25%) were private domestic or intercountry adoption, with 78 of these families served by Harmony (who received NMT) and 54 served by Catholic Charities (who received post adoption services-as-usual). Specifically, of the 132 private and intercountry adopted children served by ASAP, 32 (24%) were intercountry adoptions, 38 (29%) were private adoptions, and for 62 (47%) this information was not available. Differences between private domestic and intercountry and public adoptions were examined in statistical tests, including child age at adoption or post adoption outreach, parental age at adoption or post adoption outreach, and averages on the BPI, BEST-AG, PFF, and caregiver commitment measures. Children adopted through the public child welfare system were, on average, older than children adopted through private domestic or intercountry means. However, on most other characteristics or measures, the families on average were very similar (e.g., age of the children at the time the families came into contact with ASAP). In regard to NMT outcomes, a small number of private domestic or intercountry adoptive families completed NMT metrics, so analyses involving private domestic or intercountry adoptive families were limited. Specifically, only 37 children had NMT metrics completed, and just 15 children had NMT post-measures. Based on this limited data, the general trends for both private domestic or intercountry and public adoptive families were similar.

Appendix B. Data Tables

Table 10.5. Key Measures by Inclination to Adopt or Assume Guardianship Again

WOULD YOU ADOPT OR ASSUME GUARDIANSHIP OF YOUR CHILD AGAIN?			
VERMONT	**HESITANT**	**DEFINITELY WOULD**	**% HESITANT**
PARTICIPANTS	176	618	22%
	MEAN	**MEAN**	***p***
BEHAVIORAL PROBLEM INDEX (BPI)	26.45	14.95	<.0001
CAREGIVER STRAIN (CS)	2.55	1.81	<.0001
NEW JERSEY	**HESITANT**	**DEFINITELY WOULD**	**% HESITANT**
PARTICIPANTS	86	364	19%
	MEAN	**MEAN**	***p***
BELONGING AND EMOTIONAL SECURITY TOOL-AG (BEST-AG)	88.55	96.16	<.0001
BEHAVIORAL PROBLEM INDEX (BPI)	21.59	8.54	<.0001
CAREGIVER STRAIN (CS)	2.35	1.48	<.0001
ILLINOIS	**HESITANT**	**DEFINITELY WOULD**	**% HESITANT**
PARTICIPANTS	284	913	24%
	MEAN	**MEAN**	***p***
BELONGING AND EMOTIONAL SECURITY TOOL-AG (BEST-AG)	85.03	95.92	<.0001
BEHAVIORAL PROBLEM INDEX (BPI)	22.15	9.17	<.0001
CAREGIVER STRAIN (CS)	2.56	1.57	<.0001

Note: Orange cells represent a statistically significant difference at the .05 level

Table 10.6. Survival Analysis Predicting Foster Care Reentry after Adoption or Guardianship

	VERMONT			NEW JERSEY			TENNESSEE			ILLINOIS			ALL FOUR SITES TOGETHER		
	HR*	95% HR CONFIDENCE		HR	95% HR CONFIDENCE		HR	95% HR CONFIDENCE		HR	95% HR CONFIDENCE		HR	95% HR CONFIDENCE	
FEMALE	0.89	0.67	1.19	1.08	0.94	1.24	0.95	0.80	1.13	0.95	0.86	1.04	0.98	0.92	1.05
CHILD OF COLOR	0.81	0.30	2.19	1.20	1.03	1.39	0.94	0.78	1.13	1.29	1.09	1.54	1.06	0.98	1.15
CHILD ACHIEVED PERMANENCY AT THE AGE OF 6 OR OLDER	3.90	2.76	5.52	2.08	1.79	2.42	15.67	11.66	21.06	2.73	2.41	3.09	2.90	2.67	3.16
CHILD SPENT THREE OR MORE YEARS IN FOSTER CARE	1.05	0.77	1.44	0.70	0.60	0.82	1.13	0.94	1.35	1.04	0.91	1.19	0.95	0.88	1.03
CHILD HAD 3 OR MORE MOVES WHILE IN FOSTER CARE	1.37	1.02	1.83	3.01	2.58	3.50	1.63	1.37	1.94	1.41	1.26	1.57	1.66	1.54	1.78
NUMBER OF OBSERVATIONS USED IN MODELS			2,779			19,493			12,012			25,532			59,816

Note: HR stands for Hazard Ratio.

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