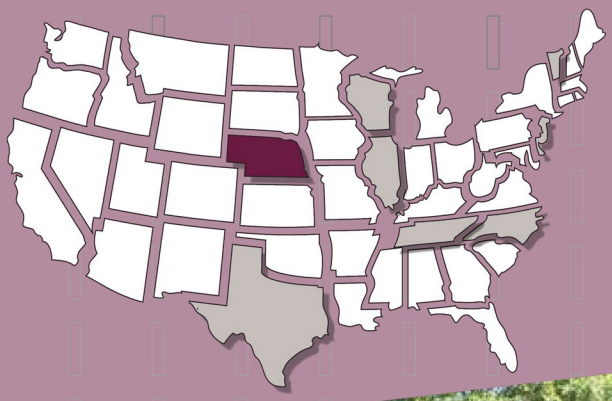
Evaluation Results from

# Winnebago Tribe of Nebraska



## Final Evaluation Report

September 2019

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

# Chapter 2: Winnebago Tribe of Nebraska

## Note to the reader of this report

The QIC-AG evaluation involved eight sites and eight evaluation reports. The full evaluation report has one chapter per site. For site-specific reports (what you are reading here), we have included a background section (Chapter 1), the individual site report (Winnebago Tribe of Nebraska is Chapter 2), and a cross-site evaluation (Chapter 10). The chapter numbers reflect the chapters designated in the full report.

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


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.

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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.

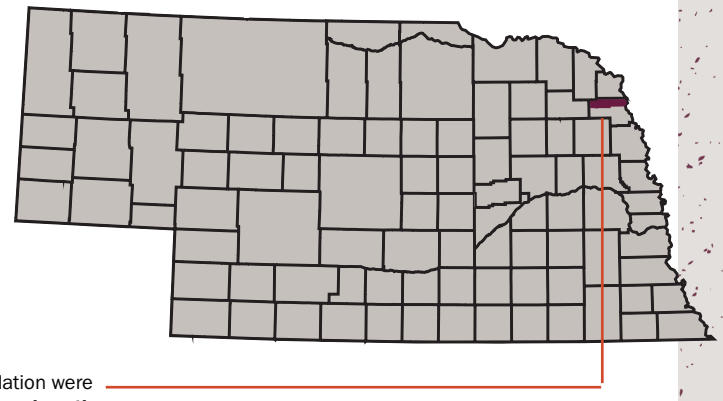
We also thank the many stakeholders on the QIC-AG site specific Project Management Team (PMT), Stakeholder Advisory Team (SAT) and Implementation Team (IT) who were invaluable in providing the support and direction needed to implement the study. The participants on these three teams included community 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.

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**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 1

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# QIC-AG Overview

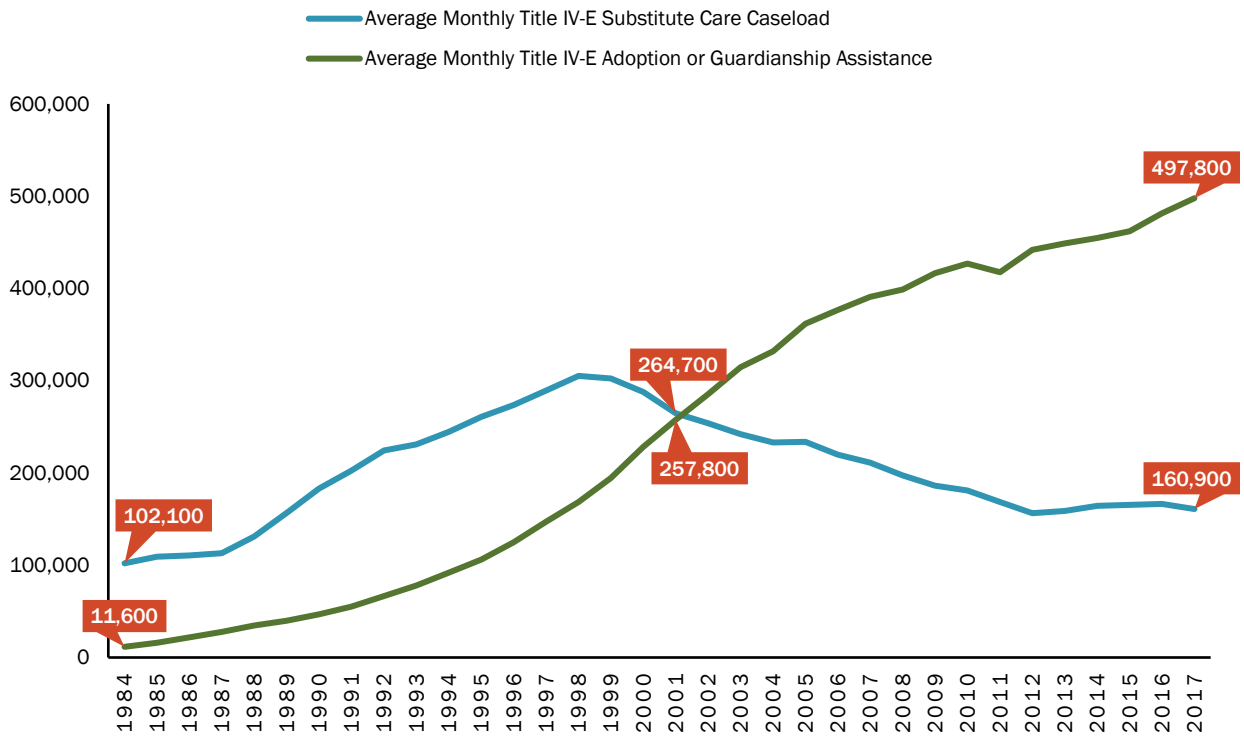
The Children's Bureau, Administration for Children and Families, and Department of Health and Human Service established the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG). In October 2014, the QIC-AG was awarded to Spaulding for Children in partnership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

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

## Background

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

Figure 1.1. National Average Monthly IV-E Funded Caseloads




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

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

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

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

# QIC-AG Target Populations

## Target Group 1

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

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

### PICO RESEARCH QUESTION

The PICO question for Target Group 1 was:

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

### THEORY OF CHANGE

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

## Target Group 2

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

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

### RESEARCH QUESTION

The PICO question for Target Group 2 was:

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

### THEORY OF CHANGE

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

## Private Domestic and Intercountry Adoptive Families

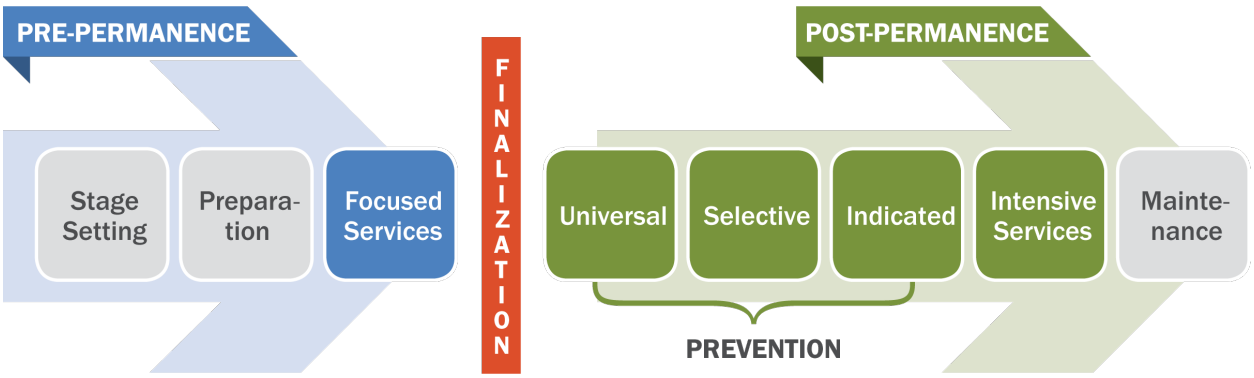
The challenges associated with providing a stable, long-term and permanent home are not consigned to adoptions and guardianships that occur through the child welfare system. Private domestic and intercountry adoptive families can also encounter post permanency disruptions and discontinuity. Children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

# QIC-AG Continuum of Services

## Pre Permanence

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

Figure 1.2. QIC-AG Permanency Continuum




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

## Stage Setting

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

## Preparation

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

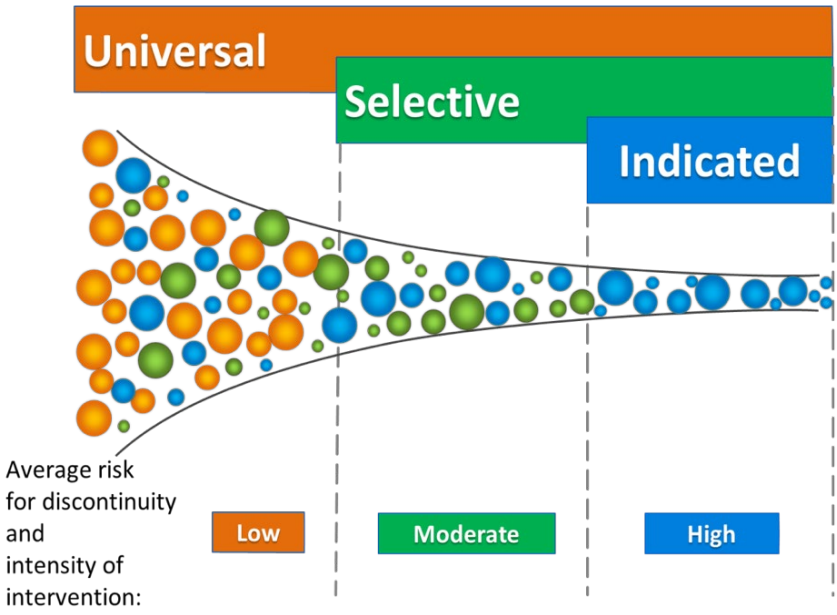
## Focused Services

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

## Post Permanence

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

Figure 1.3. Prevention Framework




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

## Universal

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

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

## Selective

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

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

## Indicated Services

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

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

## Intensive

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

## Maintenance

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

# Site Selection

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

## Pre Assessment

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

## Initial Assessment

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

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

## Full Assessment

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

## Tribal Selection Process

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

# Implementation & Evaluation

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

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

## Evaluation

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

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

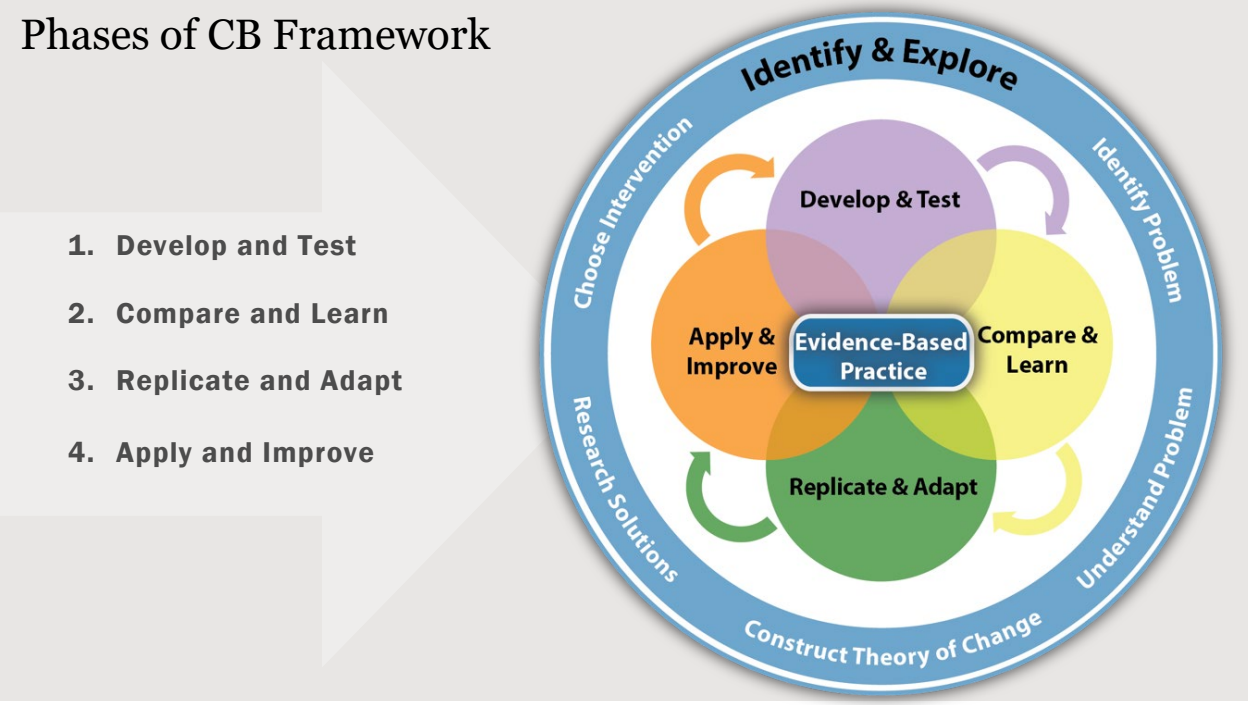
## Guiding Frameworks

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

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

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

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



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

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

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

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

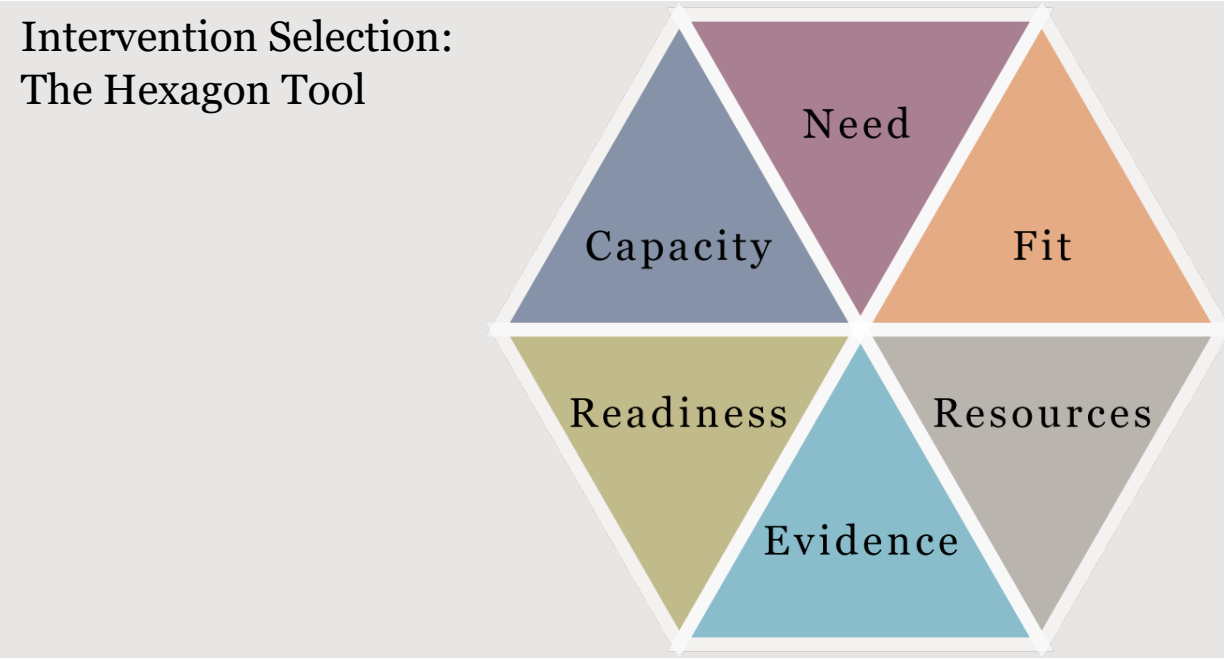


Table 1.1. Site, Target Population, Intervention and Study Design

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

**Process Evaluations** included the following types of information:

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

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

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

# Summary

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

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

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# Chapter 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.

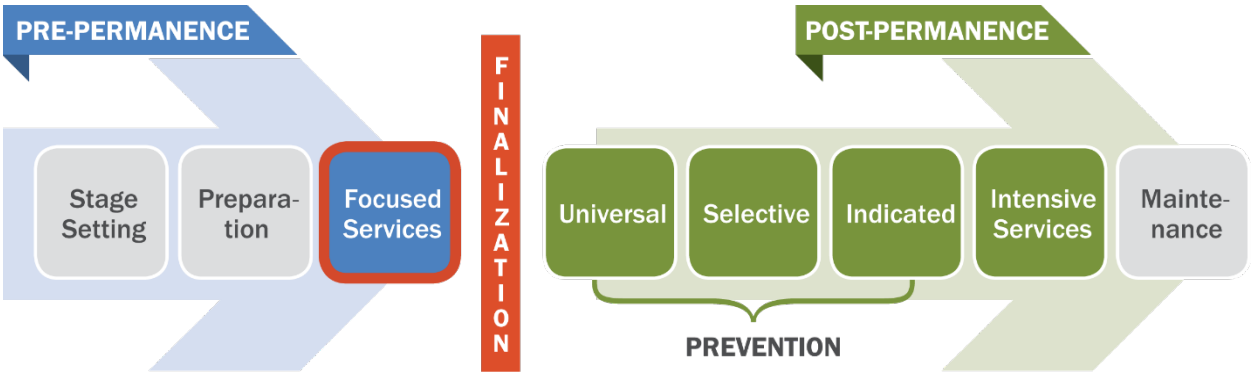
This is made more difficult because state service providers are limited in their knowledge of tribal sovereignty, tribal courts, and tribal practices. For example, current child welfare assessments and placements do not identify issues with multi-generational trauma nor do they recognize the strengths 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

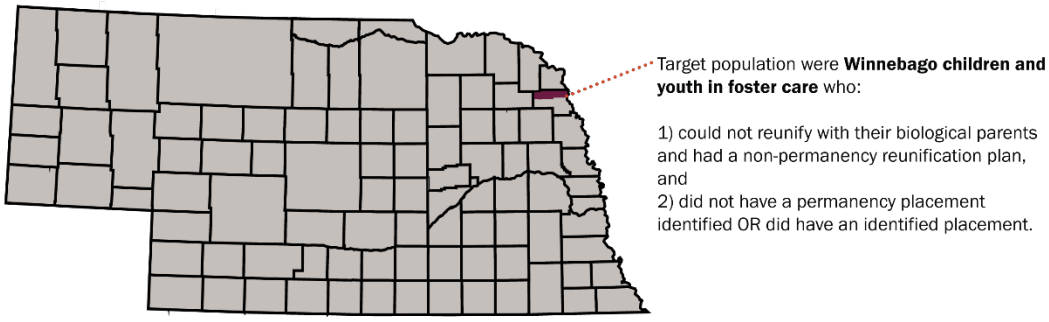
The Winnebago Tribe adapted, implemented, and evaluated the FGDM model. The evaluation of the model was focused on answering the research question using the Population, Intervention, Comparison Group, Outcome (PICO) framework (Richardson, Wilson, Nishikawa, & Hayward, 1995; Testa & Poertner, 2010). For 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.

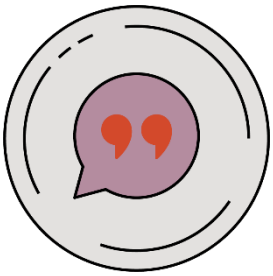
4. When agency concerns are adequately addressed, preference is given to the family group's plan over any other possible plan. In accepting the family group's lead, an agency signifies its confidence in and commitment to working with and supporting family groups in caring for and protecting their children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

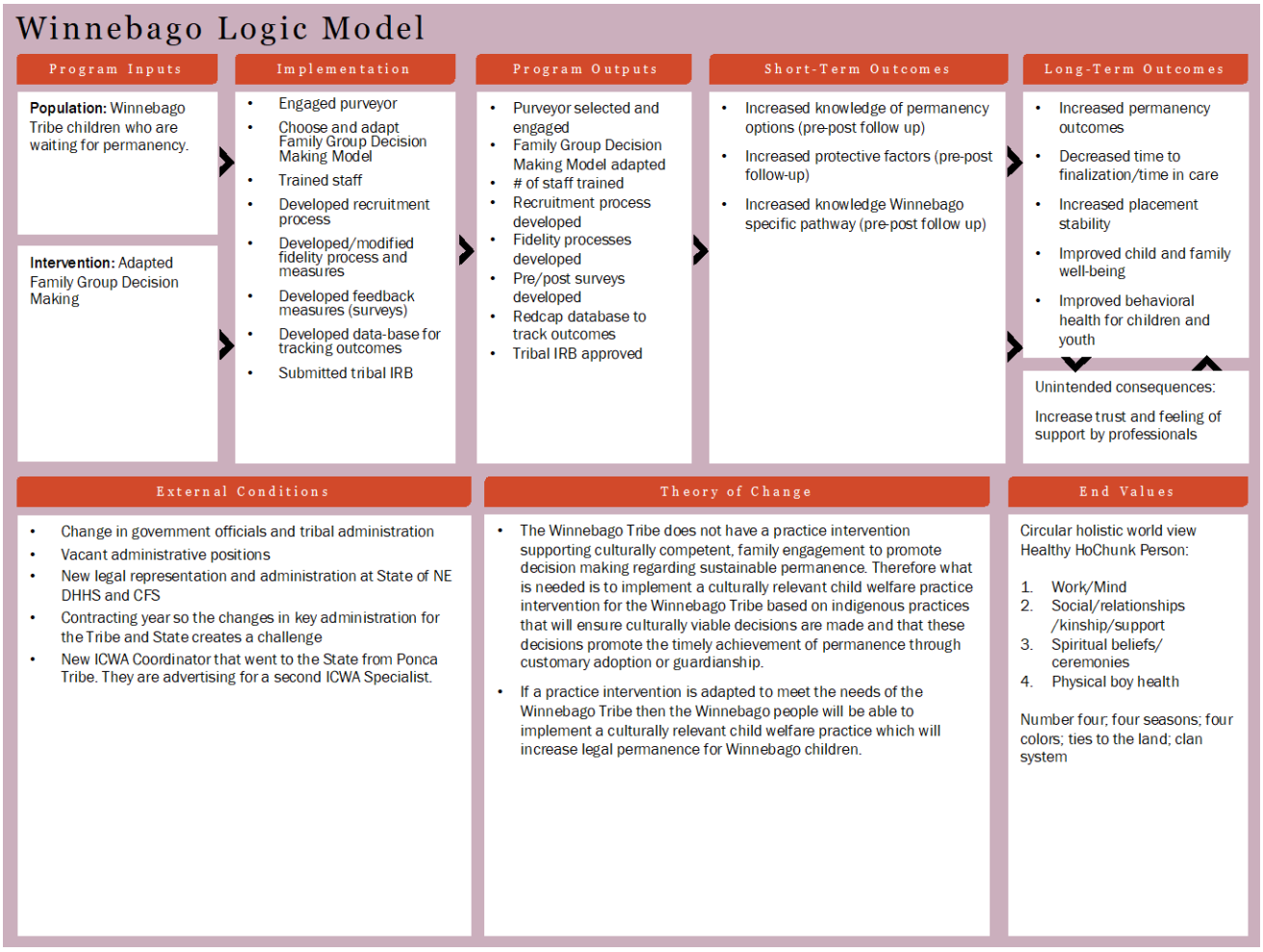
The long term outcomes for the Važokį Wošgą Gicą Wo'ųpį intervention were:

- 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

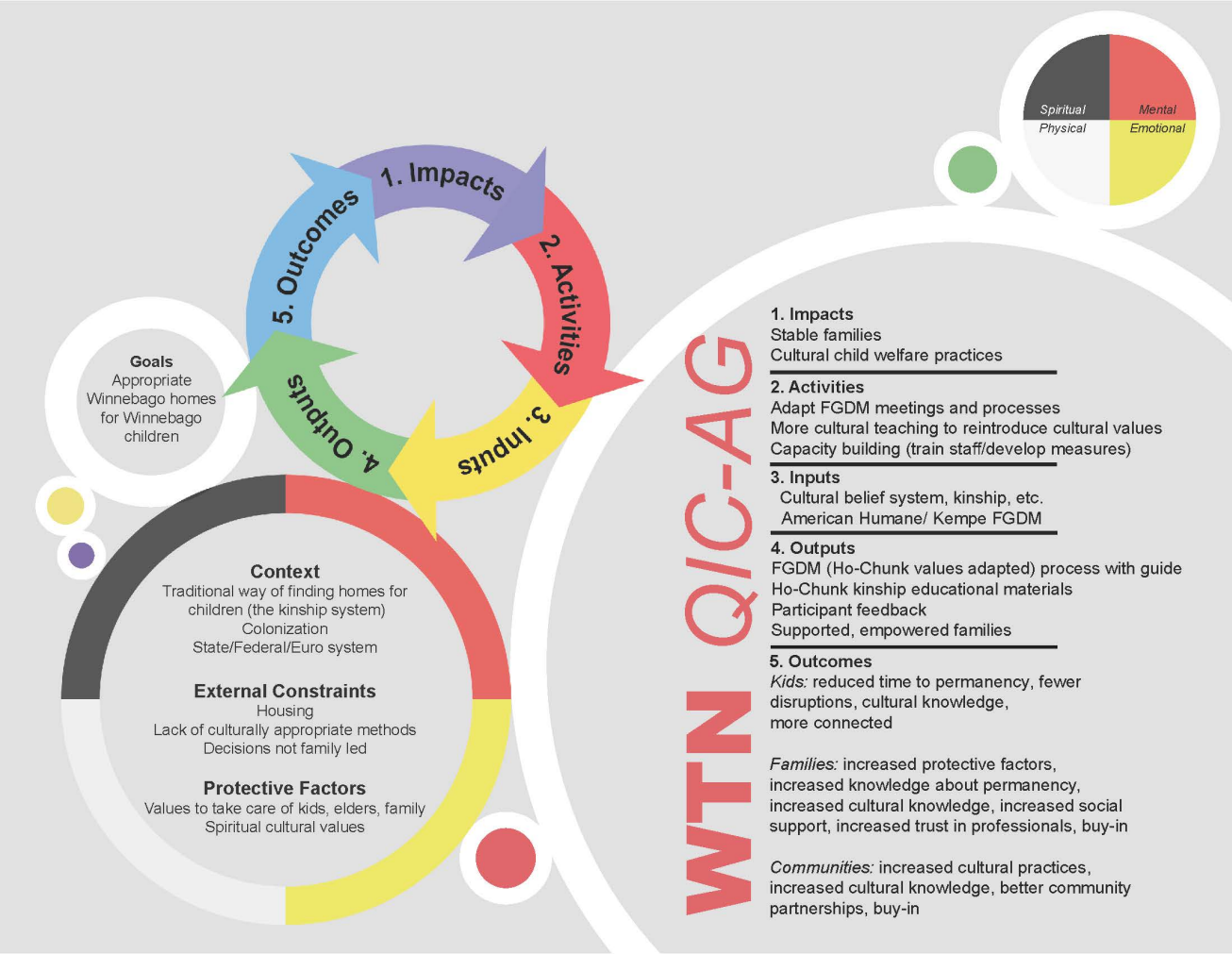
The Logic Model (Figure 2.2) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and core developmentally informed interventions to the intended proximal and distal outcomes. The model identifies the core programs, services, 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

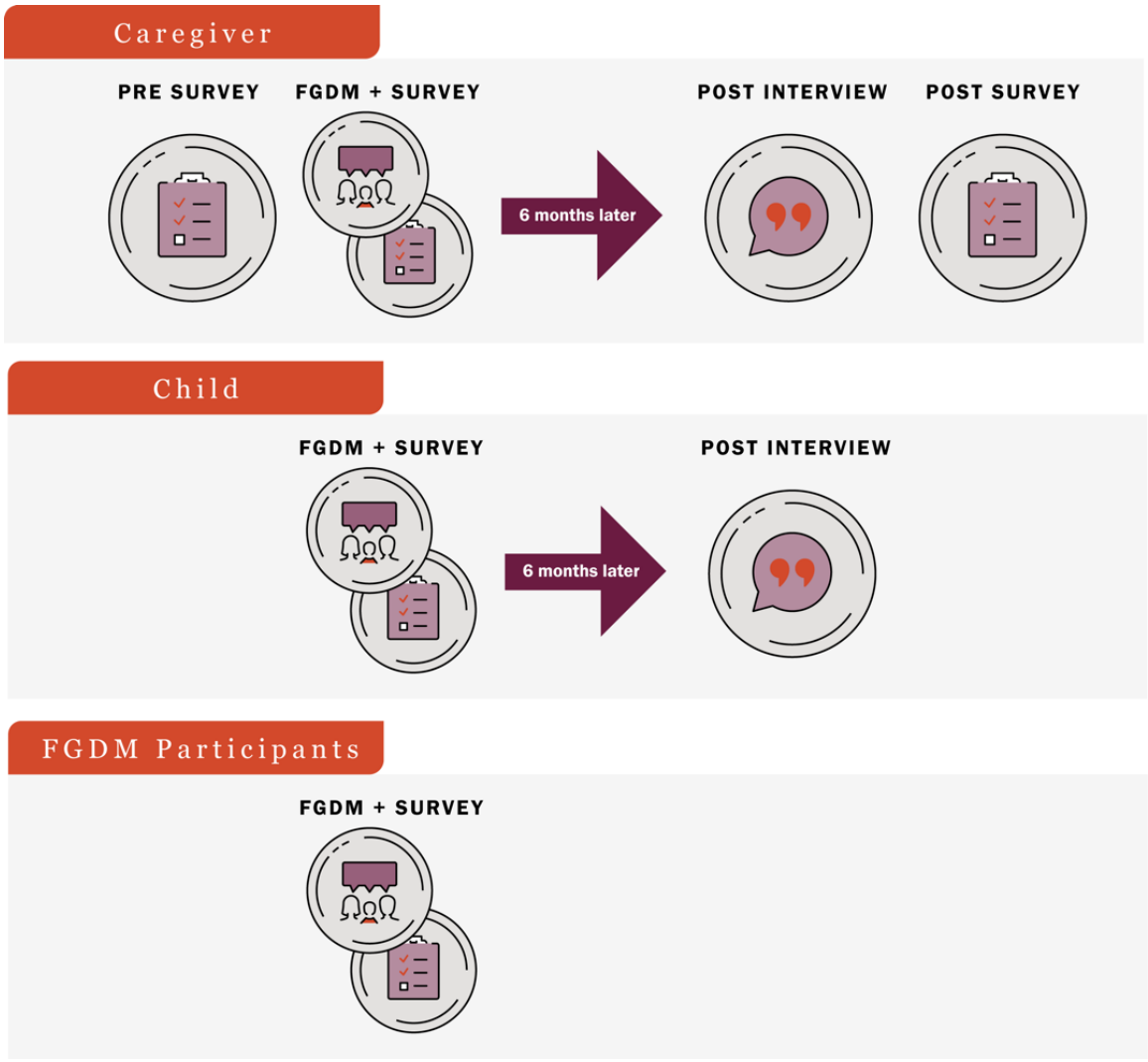
The original evaluation of Ważokį Wošgą Gicą Wo'ųpį included a mixed-method outcome evaluation using a non-experimental pre-posttest design. However, based on the low sample size, the research study design shifted to a descriptive study with a greater focus on process evaluation. There was limited data 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.

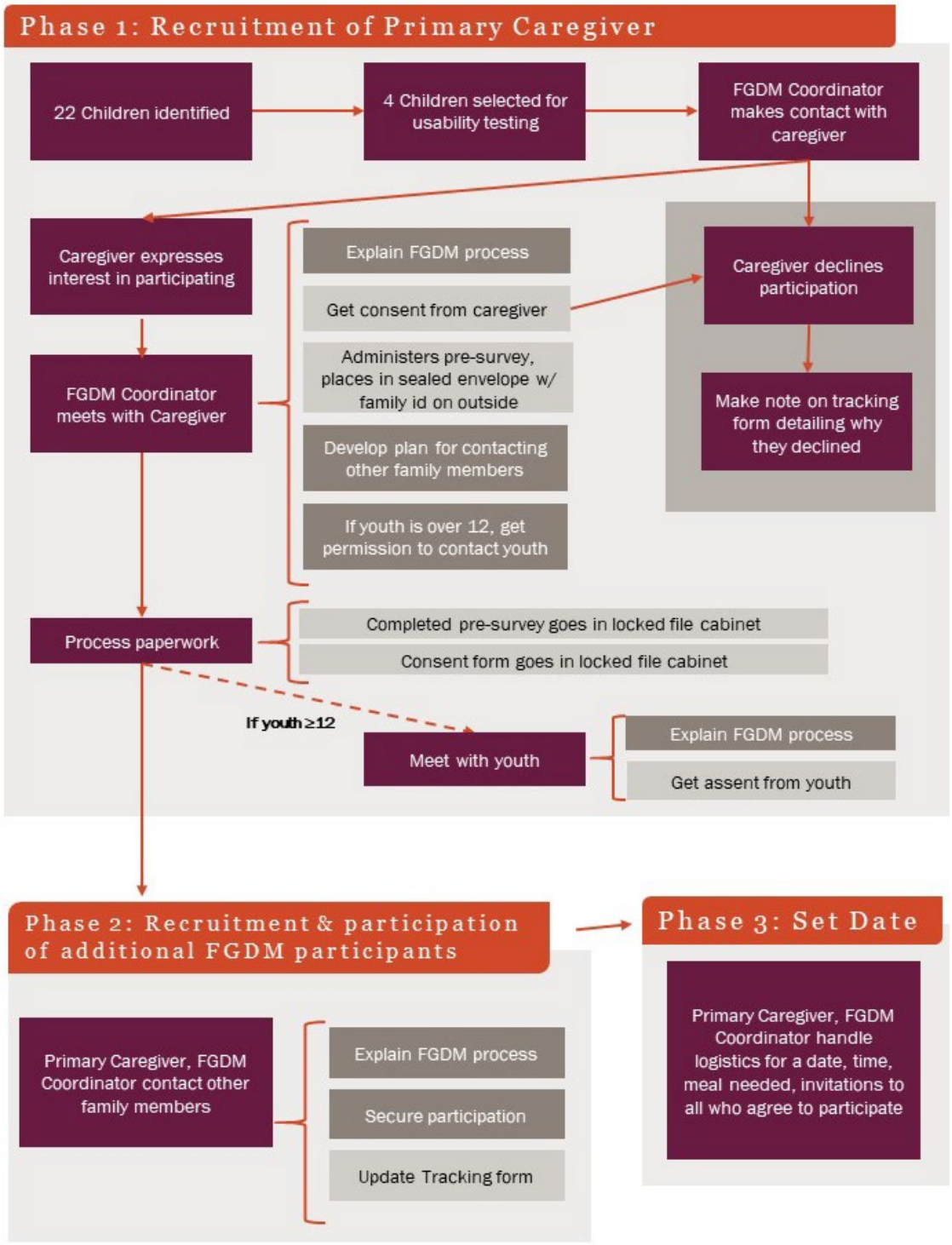
## RECRUITMENT

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.

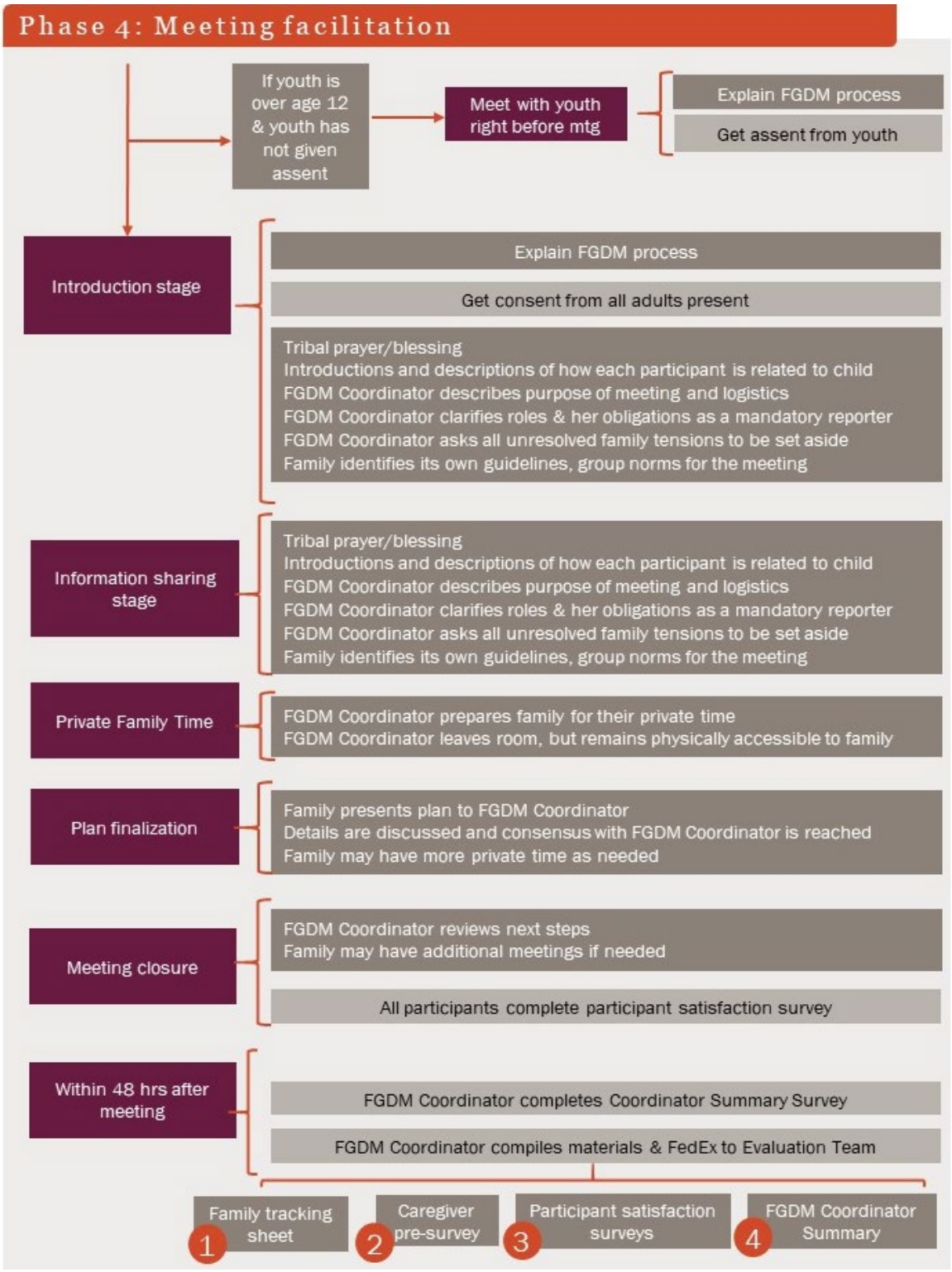
Figure 2.5. Evaluation of Recruitment Protocols




## ADHERENCE

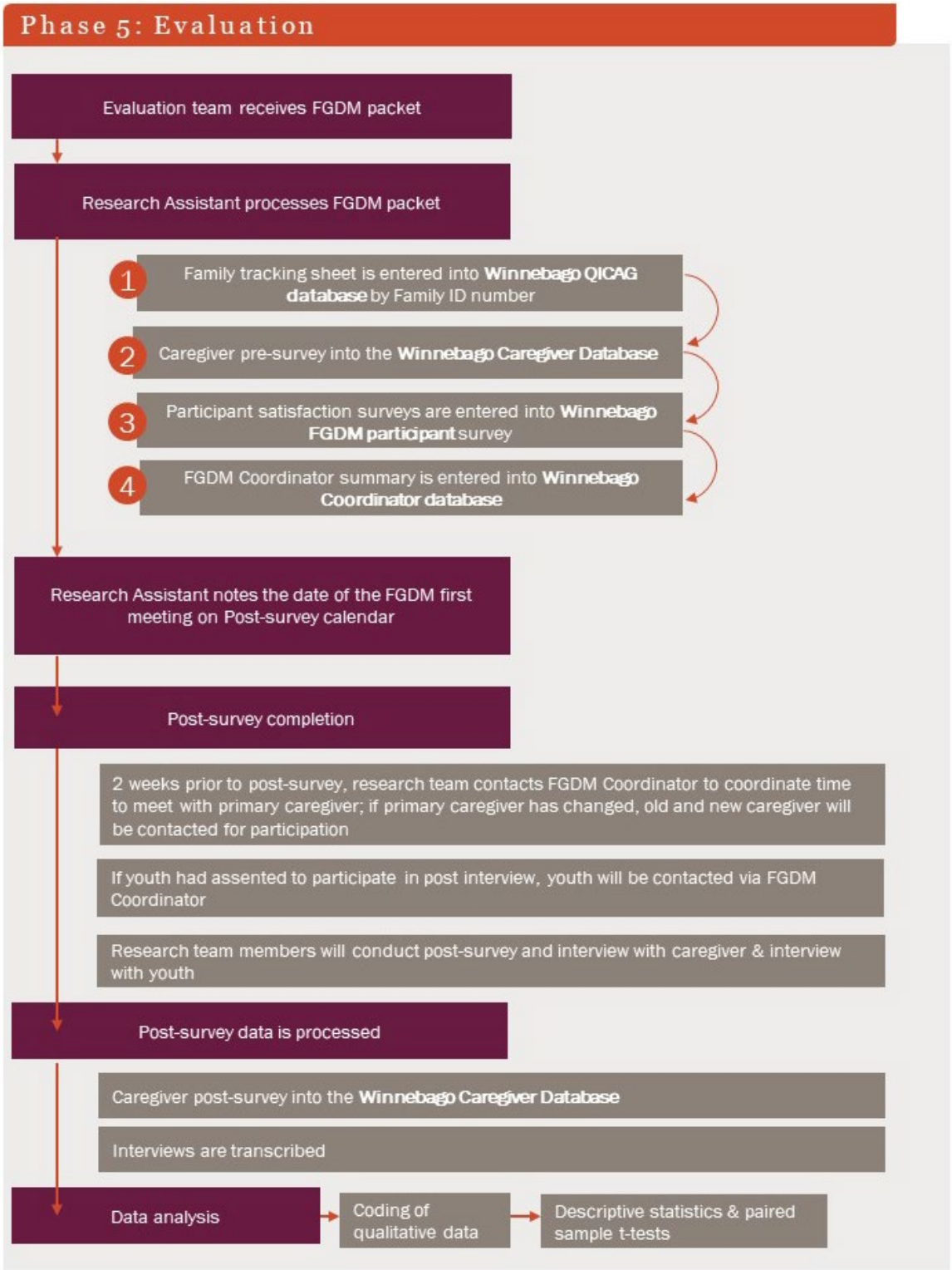
In addition to the evaluation recruitment protocols, the Winnebago site team and evaluation team worked to develop detailed procedures for collecting and storing data. Figure 2.6 details the study protocol that the site followed when holding meetings.

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.

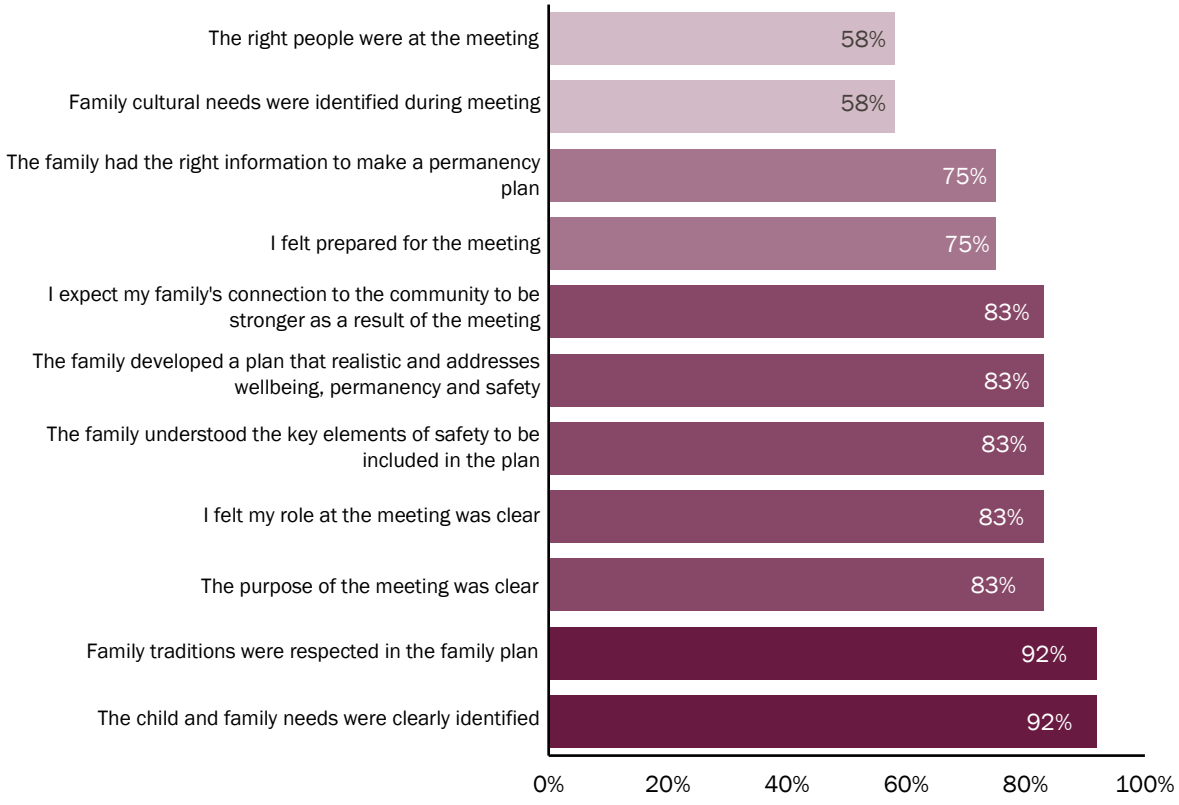
# Process Evaluation

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 |
| 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

## 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.

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# Chapter 10

CROSS-SITE EVALUATION

## Table of Contents

## 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

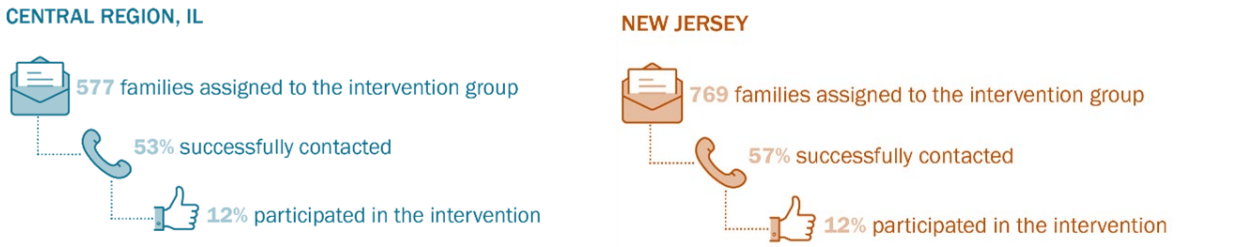
Not all child welfare jurisdictions consider outreach to families after legal finalization of adoption and guardianship as the responsibility of a child welfare system. Yet, families who have adopted or assumed guardianship of children, particularly children who have experienced trauma and maltreatment, 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.



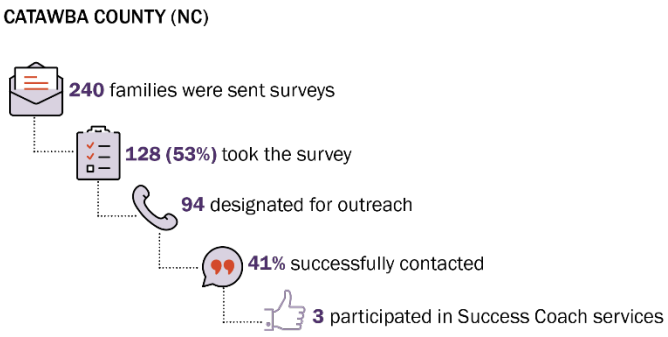

In both sites, a variety of outreach methods were used to make contact with families and increase uptake. For example, at the suggestion of the stakeholders in Illinois, the project staff made additional follow-up calls to families who initially said they wanted to participate in the project but later 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.

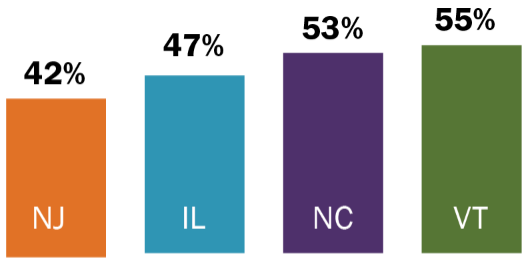
[1] The survey responses from Illinois and New Jersey discussed in this section are from the primary outcome surveys only.

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.

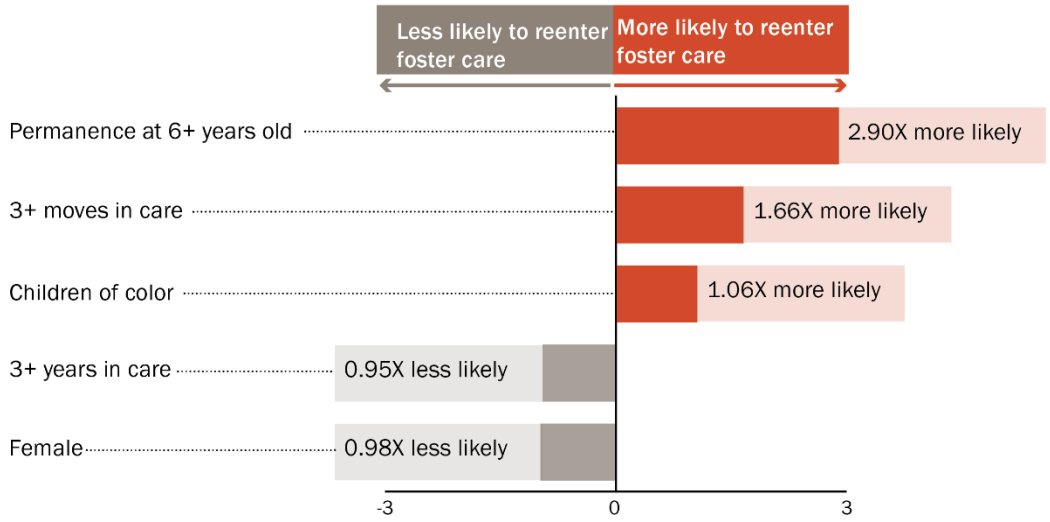
In sites that used BPI and caregiver commitment measures, families were compared across the continuum to see if there were differences in the families targeted for outreach. Specifically, it was hypothesized that families targeted for outreach at the Universal level would, on average, have low-risk scores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

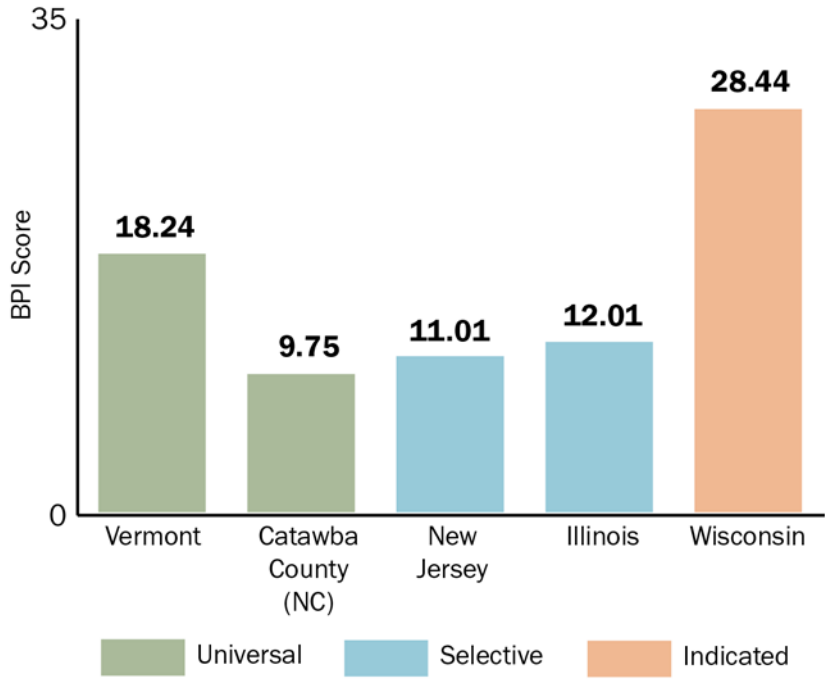



Figure 10.2 note: It should be noted that we expect to see higher levels of behavior problems in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are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

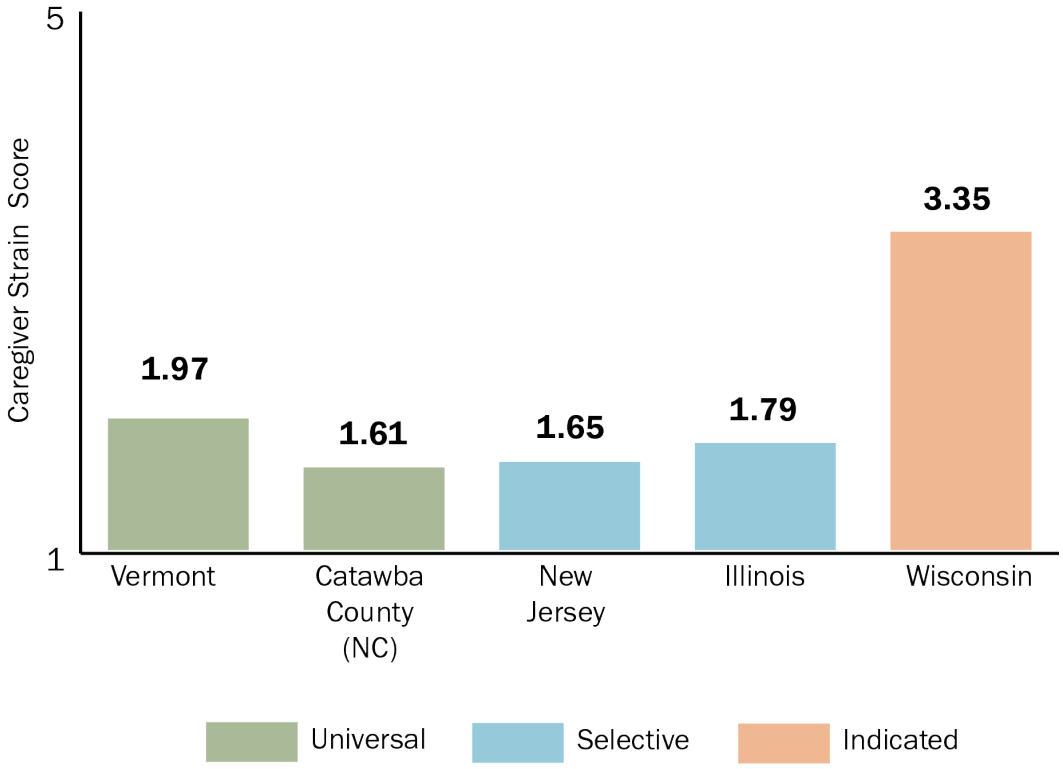



Figure 10.3 note: It should be noted that we expect to see higher levels of caregvier strain in the site that is serving families who reach out to request assistance (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin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

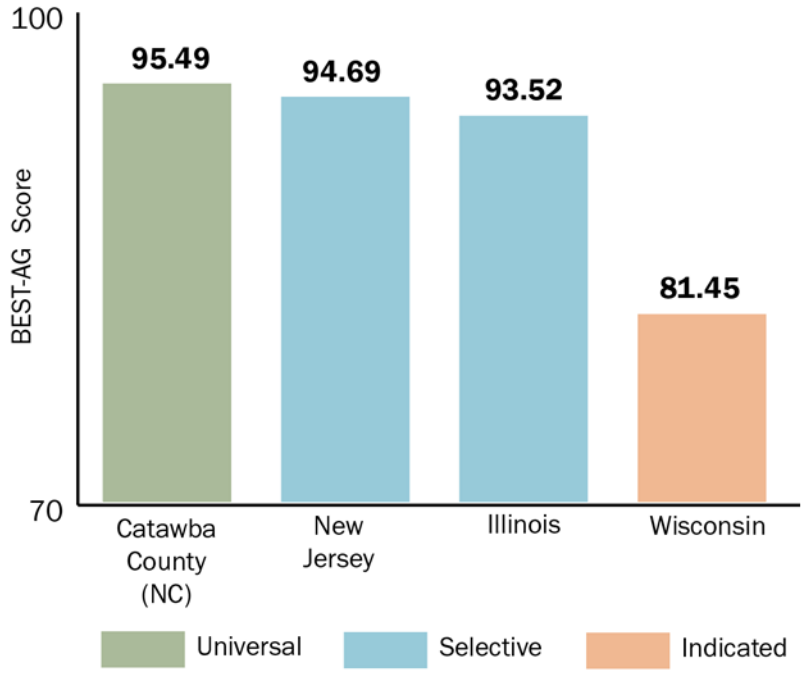


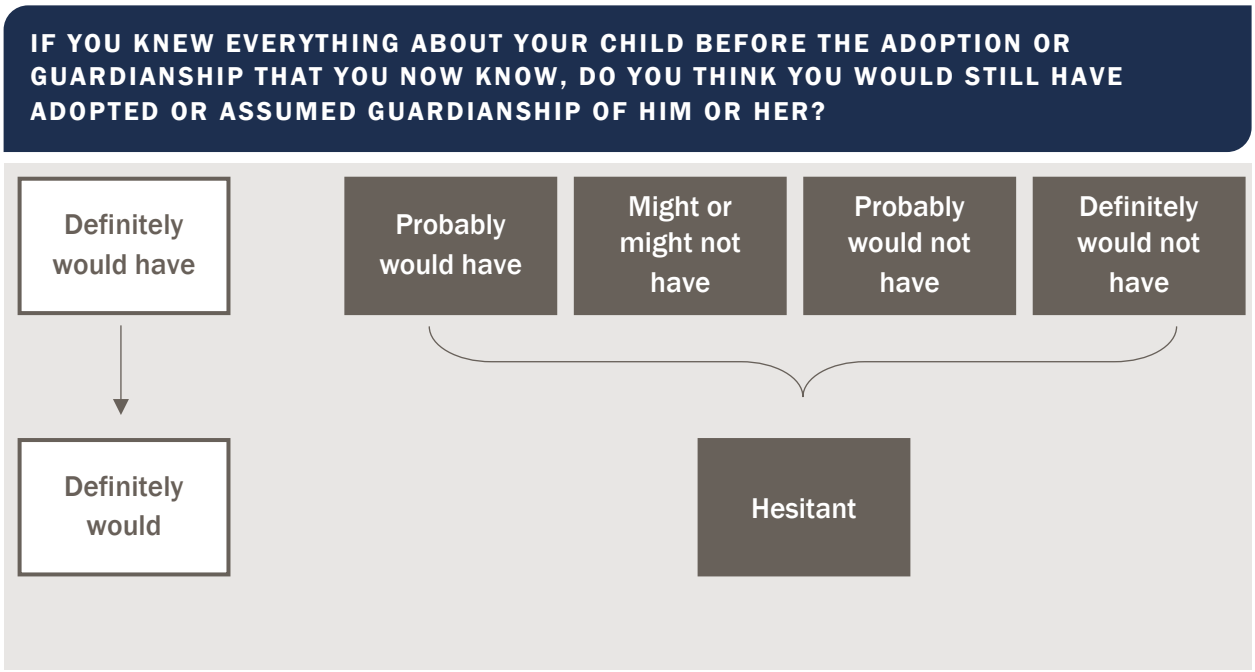

Figure 10.4 note: It should be noted that we expect to see lower levels of belonging and emotional security in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families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

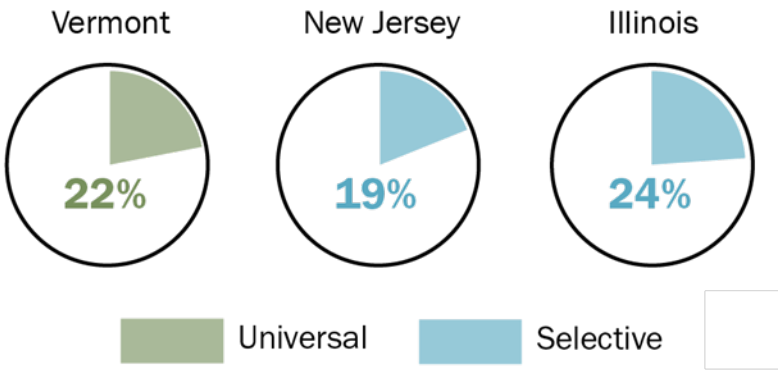
Keeping in mind the significant role caregiver commitment has played in understanding post permanency discontinuity and other challenges in prior studies (Liao & Testa, 2016; Testa et al., 2015; White et al., 2018), a series of commitment questions were asked of parents and guardians involved with this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

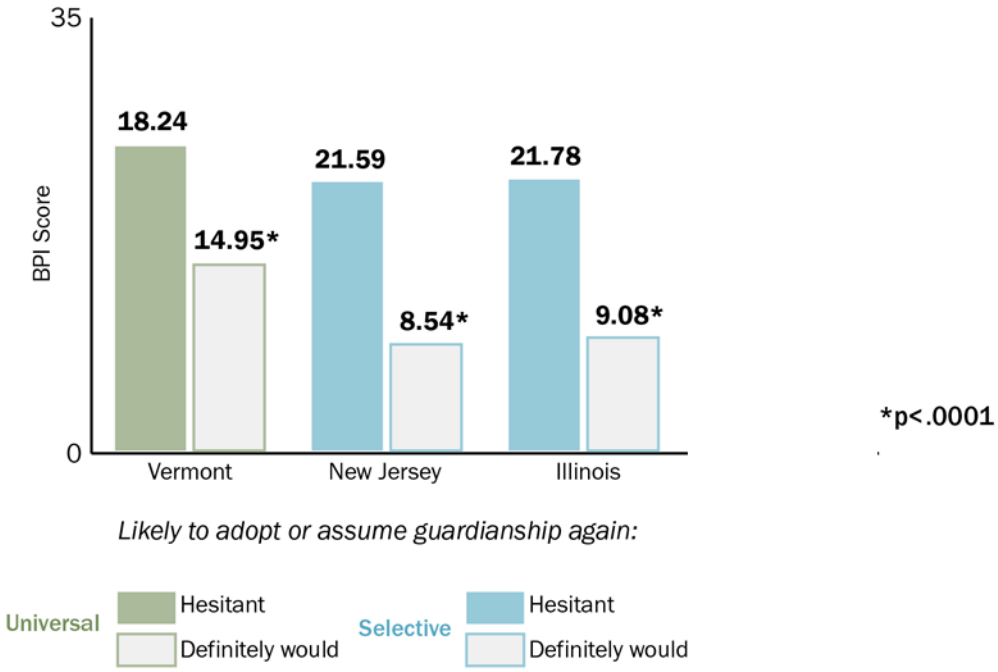
- Families who were hesitant to adopt or assume guardianship again.
- Families who expressed no hesitancy (definitely would adopt or assume guardianship again).

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.

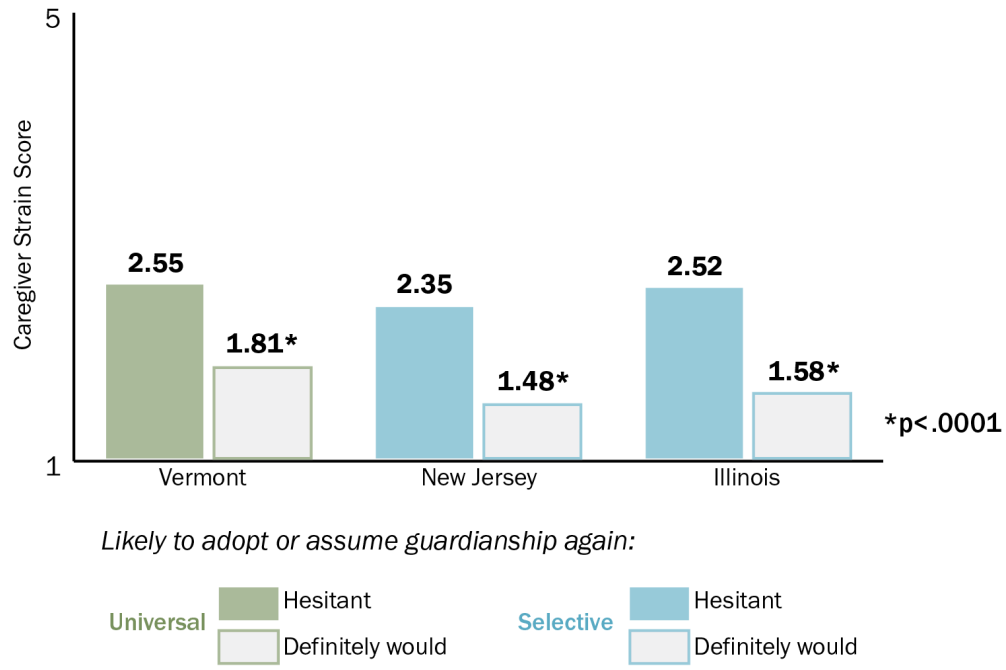
This analysis revealed some interesting trends that are examined along the continuum and across three key measures: The Behavioral Problem Index (BPI), Caregiver Strain (CS), and the Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG).

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.

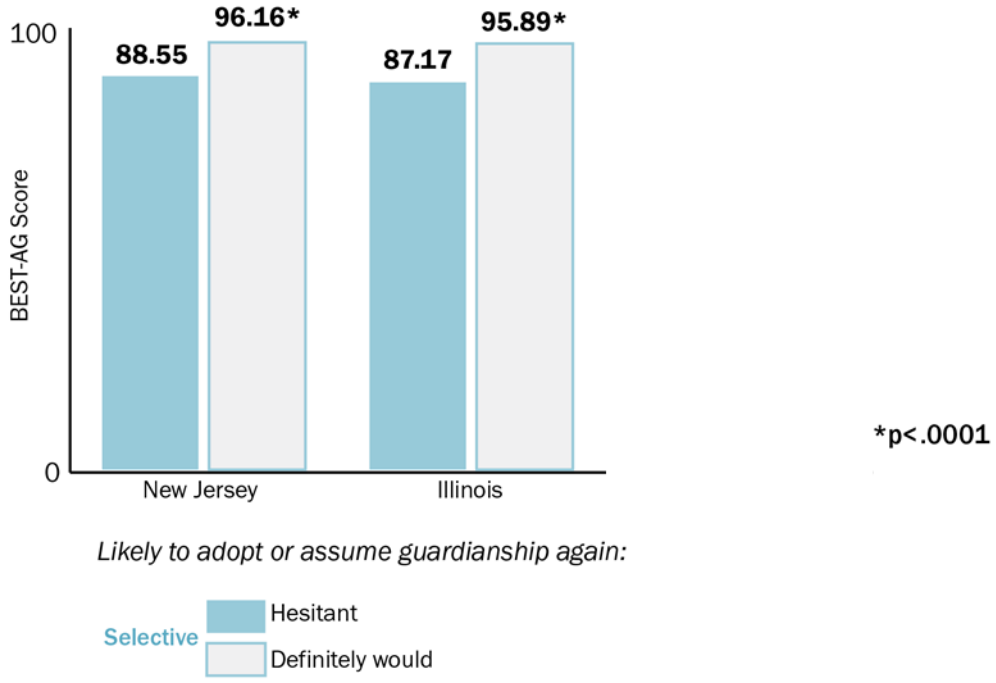
Figure 10.7. Caregiver Strain by Inclination to Adopt or Assume Guardianship Again




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.

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# Appendices

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

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

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

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

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

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

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

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

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

# Appendix B. Data Tables

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

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

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

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

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

Note: HR stands for Hazard Ratio.

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