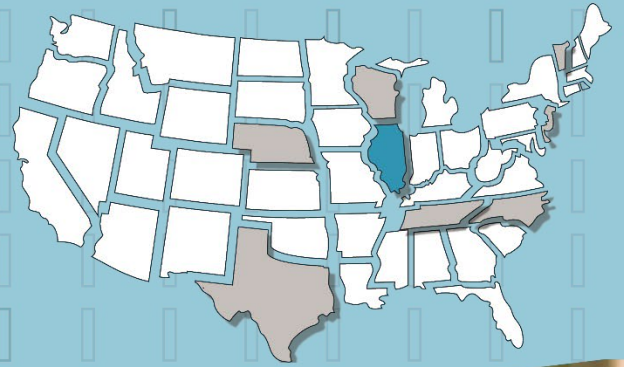


Evaluation Results from

Illinois

Final Evaluation Report



September 2019

QIC•AG

National Quality Improvement Center for
Adoption & Guardianship Support and Preservation

Chapter 6: Illinois

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 (Illinois is Chapter 6), 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 #90C01122. 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

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

We would like to acknowledge the staff at the Illinois Department of Children and Family Services, Illinois Adoption Advisory Council, Metropolitan Family Services, Baby Fold, Family Core, Catholic Charities, Jewish Child and Family Services, and Healthy Families Chicago. Our partnerships these groups, their team leaders and the Site Implementation Managers (SIMS) guided this work in addition to their other roles within the agencies they work. These partnerships made this project a success.

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

A special appreciation goes to Advanced Trauma Solutions, the purveyor of TARGET, who supported the site in adapting their model for this study.

Evaluation Results from Illinois

PROJECT PARTNERS

QIC-AG partnered with the **Illinois Department of Children and Family Services (DCFS)**, **Metropolitan Family Services** and **Baby Fold**.

CONTINUUM PHASE

Selective

INTERVENTION

Illinois DCFS implemented **Trauma Affect Regulation: Guide for Education and Therapy (TARGET)**. TARGET is a strengths-based, psycho-educational intervention for children affected by trauma or exposed to adverse childhood experiences that includes 7 essential core skills.

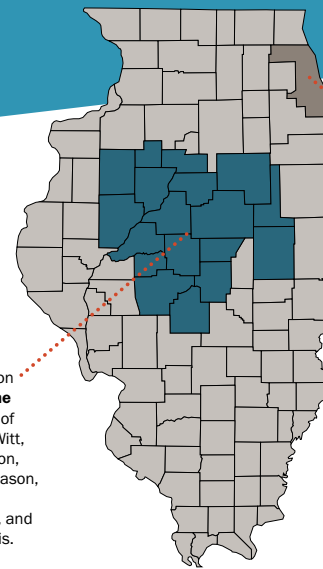
STUDY DESIGN

Experimental: **Cook County:** Random Assignment

Central Region: Random Consent Design

The target population was **children between the ages of 11 and 16 with a finalized adoption or guardianship**.

Comparison and intervention groups were identified in the **Central Region** composed of Champaign, Christian, De Witt, Ford, Fulton, Knox, Livingston, Logan, Macon, Marshall, Mason, McLean, Menard, Peoria, Sangamon, Stark, Tazewell, and Woodford Counties in Illinois.



Comparison and intervention groups were identified in **Cook County, IL**.

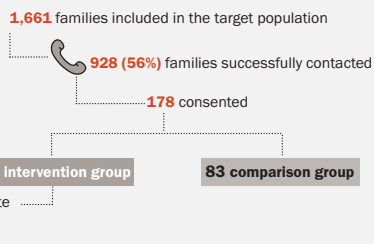
RESEARCH QUESTION

Will children between the ages of 11 and 16 in Cook County or in specific counties within the Central Region with a finalized adoption or guardianship, experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health if they are provided TARGET as compared to similar children who are provided services as usual?

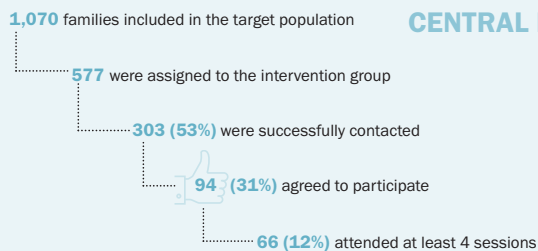
Findings

RECRUITMENT

COOK COUNTY



CENTRAL REGION



TO PARTICIPATE OR NOT?

Compared to caregivers who chose not to participate, caregivers who chose to participate were, on average:

- Less confident in meeting their child's needs
- Struggling more to effectively manage their child's behavior
- Less likely to report a warm relationship with their child
- Less likely to view the impact of adoption or guardianship on their family as positive

OUTCOMES

The study's short-term outcomes for Cook County and the Central Region were measured by examining differences between the TARGET participants and the comparison group on:



Child behavioral issues
School-based problematic behaviors
Caregiver commitment
Caregiver strain

There were no statistically significant intervention effects after six months; however, in both Cook County and Central Region, we did see fewer school-based problematic behaviors in children whose families received TARGET. It is important to keep in mind that TARGET families were experiencing significant needs at baseline that may require a longer observation period to detect change.

WHAT CAREGIVERS HAD TO SAY...

The majority of families reported positive adoption and guardianship experiences.



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

Families also provided suggestions for improvements:

"I feel that the social worker should call and check-up. I reached out for help and help was never given."



Promoting the wellbeing of families formed through adoption and guardianship may require an approach where a variety of services are offered that take into account developmental considerations, cultural issues, lifestyle choices, and work or other life stressors faced by adoptive and guardianship families.



The University of Texas at Austin

Texas Institute for Child & Family Wellbeing

Steve Hicks School of Social Work



JACK, JOSEPH AND MORTON MANDEL
SCHOOL OF APPLIED SOCIAL SCIENCES

CASE WESTERN RESERVE
UNIVERSITY

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

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



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Executive Summary

Overview

The Illinois Department of Children and Family Services (DCFS) support adoptive and guardianship families by providing services that promote child wellbeing, stable homes, and family permanence through adoption support and preservation programs. DCFS has a long history of conducting evidence-based research to ensure barriers to permanency are reduced for children in foster care. The Illinois site of the National Quality Improvement Center for Adoption and Guardianship Support (QIC-AG) selected Trauma Affect Regulation: Guide for Education and Therapy (TARGET) as the evaluable intervention in Illinois. The intervention was located in the **Replicate and Adapt** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. The study's Theory of Change postulated that offering timely services to adoptive parents and guardians at the earliest signs of difficulty would enable them to anticipate issues that may arise and therefore decrease post permanency discontinuity. TARGET was implemented at the Selective Interval of the QIC-AG Permanency Continuum.

Intervention

TARGET, a strength-based, psycho-educational intervention for children affected by trauma or exposed to adverse childhood experiences, includes 7 essential core skills called FREEDOM Steps:

1. **FOCUS**: Reducing anxiety and increasing mental alertness
2. **RECOGNIZE**. Helping individuals recognize stress triggers
3. **EMOTIONS**. Identify a primary emotion
4. **EVALUATE**. Evaluate a primary thought
5. **DEFINE**. Determine a primary goal
6. **OPTION**. Identify and focus on prior success
7. **MAKE A CONTRIBUTION**. Identify a way to make a difference in others' lives (Advanced Trauma Solutions; ATS)

Primary Research Question

The study's primary research question was:

Will children between the ages of 11 and 16 in Cook County or in specific counties within the Central Region with a finalized adoption or guardianship experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health for children and youth if they are provided TARGET as compared to similar children who are provided services as usual?

An experimental design was employed to test the effectiveness of TARGET with different randomization techniques employed in the two selected geographic regions (Cook County and Illinois' Central Region). In both areas of the state, random assignment was employed to ensure that the comparison and intervention groups were balanced and that each group had a representative mix of children.

The study's short-term outcomes for Cook County and the Central Region were:

- Reduced child behavioral issues
- Reduced school-based problematic behaviors
- Increased caregiver commitment
- Reduced caregiver strain

Key Findings and Discussion

In prior research, most families formed through adoption or guardianship report that they are doing well with the supports and services they are currently receiving and that they do not need additional services. In this study, we found that the majority (64% to 65%) of families who said they were not interested in participating in the study, largely reported that everything was fine and that they did not need services at this time. This study found that, in both Cook County and the Central Region, families who chose to participate in the intervention (TARGET participants) were families who were struggling more than families who did not participate in the intervention. Compared to non-participants, TARGET participants were, on average:

- Less likely to report a warm relationship with their child
- Less confident that they could meet the needs of their child
- More likely to struggle to effectively manage their child's behavior
- Less likely to report that the impact of their child's adoption or guardianship on the family has been positive

These questions were effective in identifying families who reported that they were experiencing difficulty in caring for their children. These questions might be good questions for future research to consider when attempting to identify families at an elevated risk for post permanency discontinuity.

Due to the different evaluation designs used in the two evaluation sites in Illinois (Cook County and specific counties within the Central Region), intervention-related results are presented for each evaluation site separately. In Cook County, 39 families received the intervention, and 32 (82%) returned the primary outcome survey. In the Central Region, 66 families received the intervention and 49 (64%) returned the outcome survey. In addition, primary outcome surveys were administered to families in the comparison group, (46 were received in Cook and 281 in Central).

Based on the analysis of these data, the study did not find a strong intervention effect. In other words, on the outcomes measured (e.g., child behavioral issues and wellbeing measures) families who received TARGET and reported outcome data ($n = 81$ total for both sites) did not fare better than families who received services-as-usual and reported outcome data ($n = 327$). While not statistically significant, in both Cook County and Central Region, fewer school-based problematic behaviors were reported for children in the intervention group compared to children in the

comparison group. However, the sample size was small, and the observation period rather limited (6 months).

It is important to keep in mind that pretest findings showed TARGET participants (who received a minimum of four sessions) were also experiencing more family difficulties prior to the study than those in the comparison group who did not participate in TARGET. To account for these differences, TARGET participants were matched to a subset of the comparison group who profiled more similarly to the families who received the intervention. However, this also did not yield an intervention effect. Thus, despite efforts to make TARGET participants and the comparison group as alike as possible, any comparisons between the groups after the intervention may be biased by these pre-existing differences and are a limitation to the study.

It is possible that no intervention effects were observed due to the limited observation window of about 6 months post intervention. Personal and interpersonal change is difficult and takes time, especially given the long history of trauma that many adoptive and guardianship youth have experienced due to maltreatment and previous placement moves (Jones & Schulte, 2019).

The target population in Illinois included a wide variety of families with a wide variety of experiences. This was illustrated by the diverse comments received from adoptive parents and guardians who responded to the surveys. For example, while some families said they were doing well, others were struggling and were reported to be in crisis by program staff. Over 200 caregivers wrote positive responses such as:

“Adoption is a gift. I would do it again in a heartbeat.”

“Adopting my child is the best thing I have ever done in my life.”

The word “love” or “loved” was mentioned 114 times in these comments. However, some families described their adoption or guardianship experiences in less than positive terms and had more mixed or negative feelings such as:

“We don’t recommend to anyone that they adopt from foster care. You never get help.”

“The kids are angry with us, the people that raise them, ‘cause they want their parents.”

In sum, families in the study reported needing additional or different services than what is currently available, and that the services need to be provided by someone who understands issues related to adoption and guardianship. Furthermore, project staff in one of the Illinois sites reported that many (over half) of the TARGET recipients became engaged in services-as-usual after receiving TARGET. This suggests that perhaps a single intervention is not what was needed for some adoptive and guardianship families. They may have needed a wider array, or a different array, of services. Perhaps, similar to other prevention efforts, preventing adoption and guardianship instability and promoting the wellbeing of families formed through adoption and guardianship may require an approach where a variety of services are offered that take into account the diversity of issues families face. These may include providing services that address significant mental health and medical health needs of adopted and guardian children and youth. Future projects should consider how to address the wide array of needs that families who have adopted or assumed guardianship are struggling with.

Cross-Site Summary

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

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

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

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

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

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

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



Chapter 1

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QIC-AG Overview

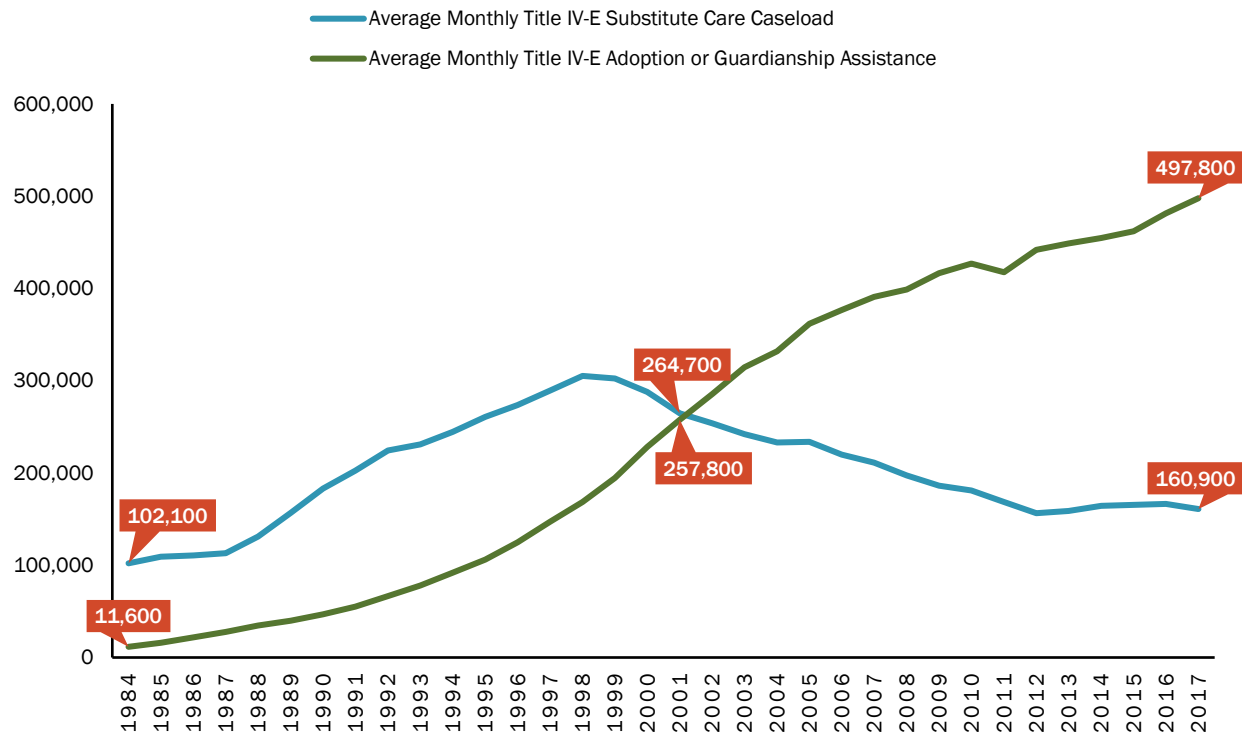
The Children's Bureau, Administration for Children and Families, and Department of Health and Human Service established the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG). In October 2014, the QIC-AG was awarded to Spaulding for Children in partnership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

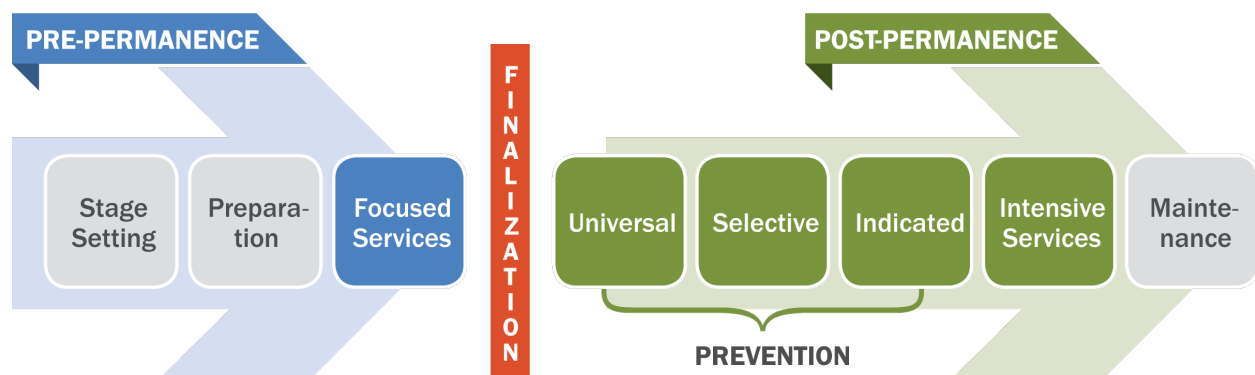
The challenges associated with providing a stable, long-term and permanent home are not consigned to adoptions and guardianships that occur through the child welfare system. Private domestic and intercountry adoptive families can also encounter post permanency disruptions and discontinuity. Children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

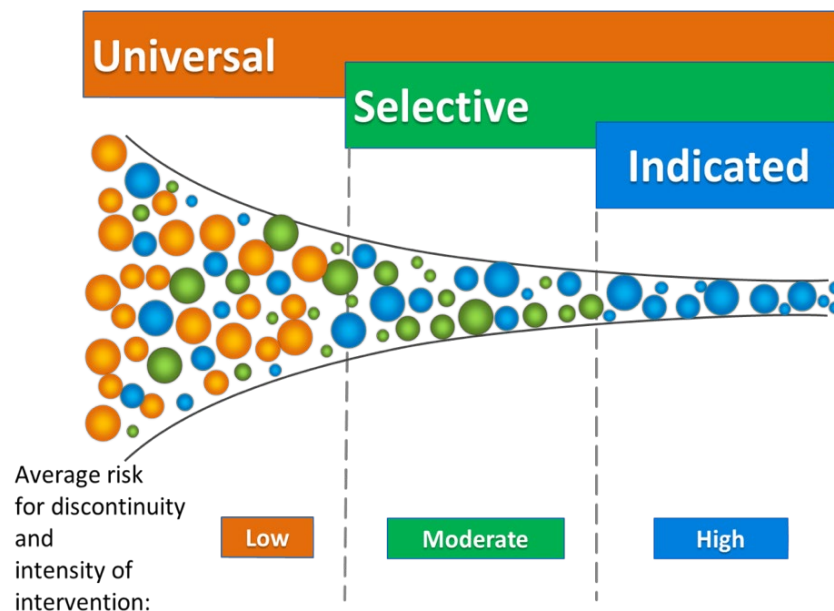
Focused Services

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.

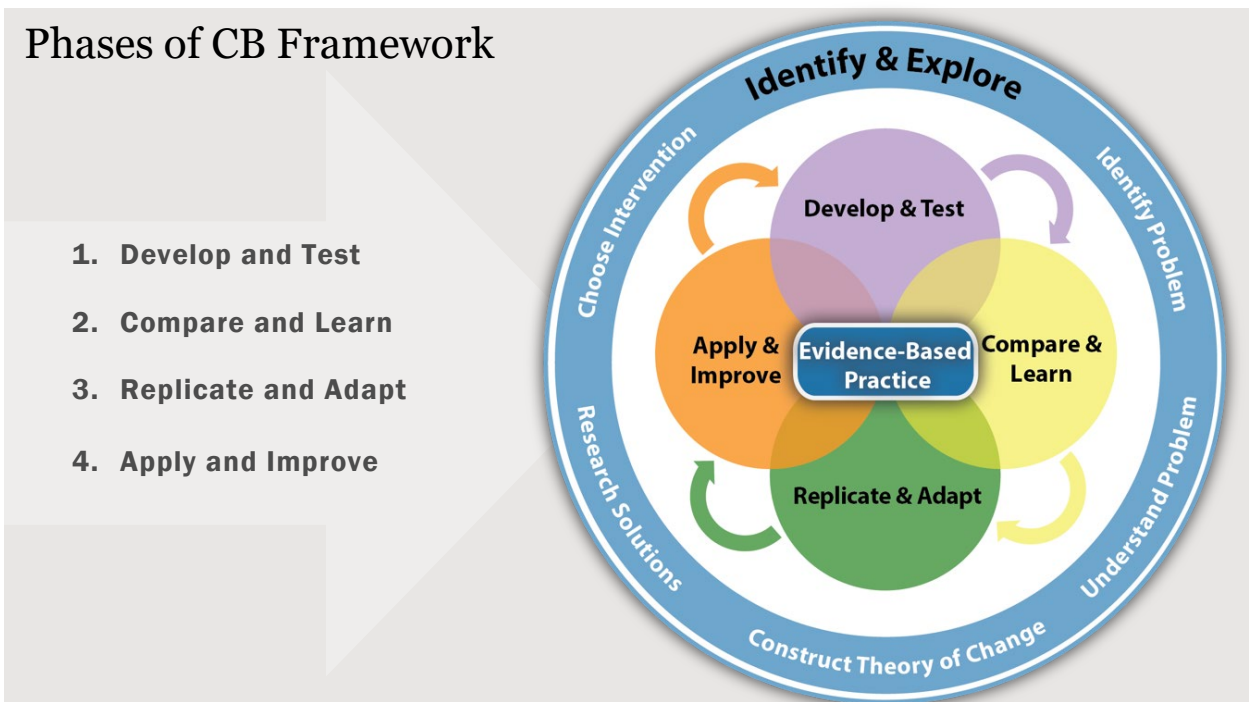
Guiding Frameworks

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

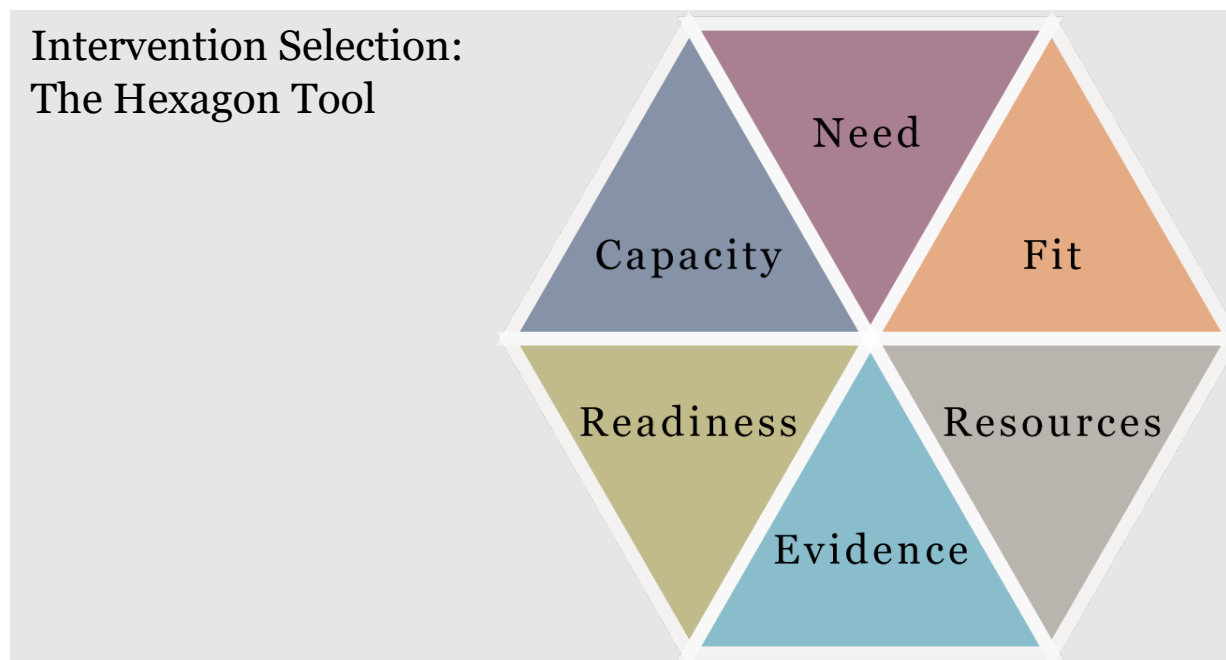


Table 1.1. Site, Target Population, Intervention and Study Design

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 6

ILLINOIS: TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY (TARGET)

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Site Background

The Illinois Department of Children and Family Services (DCFS) is a state-run child welfare organization that has supported adoptive and guardianship families to gain stability and prevent out of home placement through the Adoption Support and Preservation program since 1991. Services provided to families include comprehensive assessments, case management, crisis intervention, counseling, support groups, and limited cash assistance. These services are contracted through private agencies in each region of the state. The goal of the state's family preservation services is to promote child safety, development, wellbeing, prevent placement disruption and support family permanence (Illinois DCFS website, 2018).

DCFS's earlier efforts in supporting families of children who exited foster care did not ensure stable placements once adoptions were finalized (Smith, Howard, Garnier & Ryan, 2006). A study examining all children in Illinois who exited foster care through adoption or guardianship (N= 51,576) between 1998 and 2010 found that 13% (N= 6,781) of children experienced post permanency discontinuity (Rolock & White, 2016).

The Illinois National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG) project in Illinois selected a manualized intervention called Trauma Affect Regulation: Guide for Education and Therapy (TARGET) as their evaluable intervention. TARGET uses a strength-based, psycho-educational approach to education and therapy for youth who have been affected by trauma or exposed to adverse childhood experiences. The intervention has been shown to be effective with juveniles in detention facilities in improving their ability to self-regulate emotions and behaviors (Ford & Hawke, 2012). Also, the intervention has been shown to be effective with delinquent girls diagnosed with either full or partial posttraumatic stress disorder (Ford, Steinberg, Hawke, Levine & Zhang, 2012).

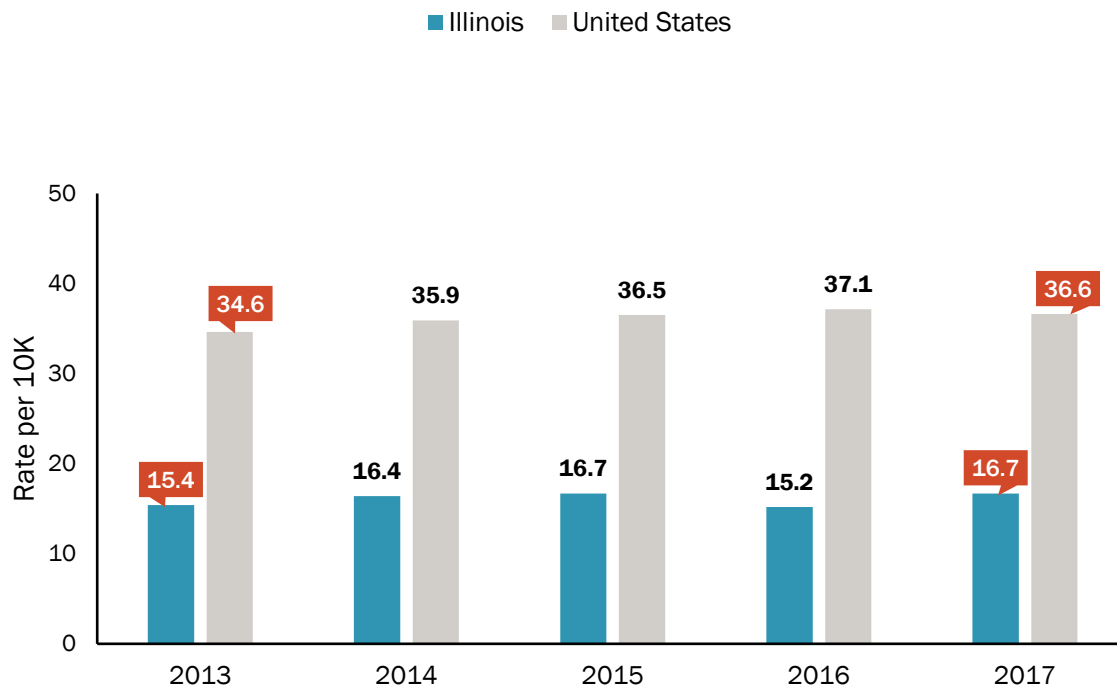
The Theory of Change in the Illinois QIC-AG project postulated that adoptive parents and guardians should be connected to supports and services to help them meet the emerging and future mental health, educational, and other needs of the children in their care. If parents and guardians are offered services at a time when a child's needs do not exceed the capacity of the adoptive parent or guardian, they will be better able to anticipate issues that may arise and have a basic understanding of available resources and services. If parents and guardians are connected to services and supports early, they will be more likely to use these services and supports at the earliest signs of difficulty. If adoptive parents and guardians have the capacity to meet the emerging needs of the children in their care, there will be a decrease in discontinuity including high-end placements and lockouts.

At the onset of the QIC-AG, Illinois was ending a federally-funded project (the Permanency Innovations Initiative [PII] project) that tested TARGET with a foster care population. Given that Illinois has recent experience with, and training on, TARGET, there was an economic advantage to using existing resources for the QIC-AG (TARGET-trained therapists and staff expertise on the intervention). Although the PII project in Illinois ended and the study's results were pending at the start of the QIC-AG project period, TARGET has been successfully implemented in various locations in the U.S., including Connecticut, Ohio, and Maine. Yet, TARGET had not been tested with adoptive and guardianship families.

National Data: Putting Illinois in Context

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

Figure 6.1. Illinois Foster Care Entry Per Capita Rate (2013-2017)

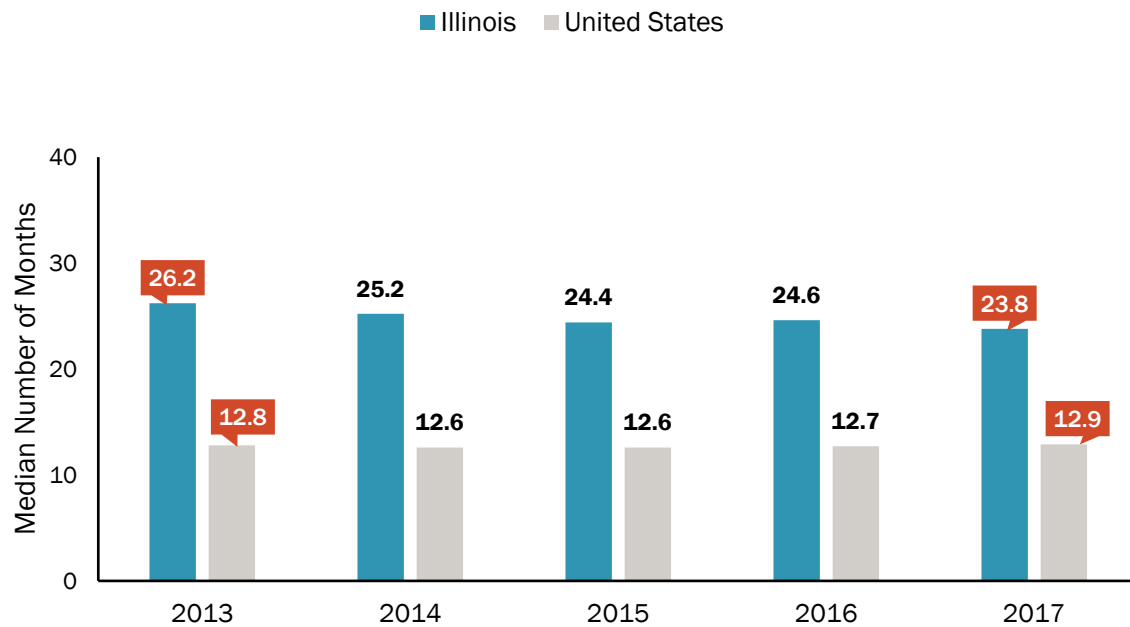


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, <https://cwoutcomes.acf.hhs.gov/cwodatasite/>

As displayed in Figure 6.1, between Fiscal Years 2013 and 2017, the rate¹ of children entering foster care in Illinois and the U.S. increased slightly. Between 2013 and 2017, the state's foster care entry rate decreased from 15.4 per 10K (4,648 children) to 16.7 per 10K (4,843 children). This per capita rate was lower than the per capita rates for the U.S. The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. In other words, fewer children, per capita, entered foster care in Illinois than in the U.S., but increases occurred over the past five years occurred at the state level and at the national level.

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

Figure 6.2. Illinois Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)

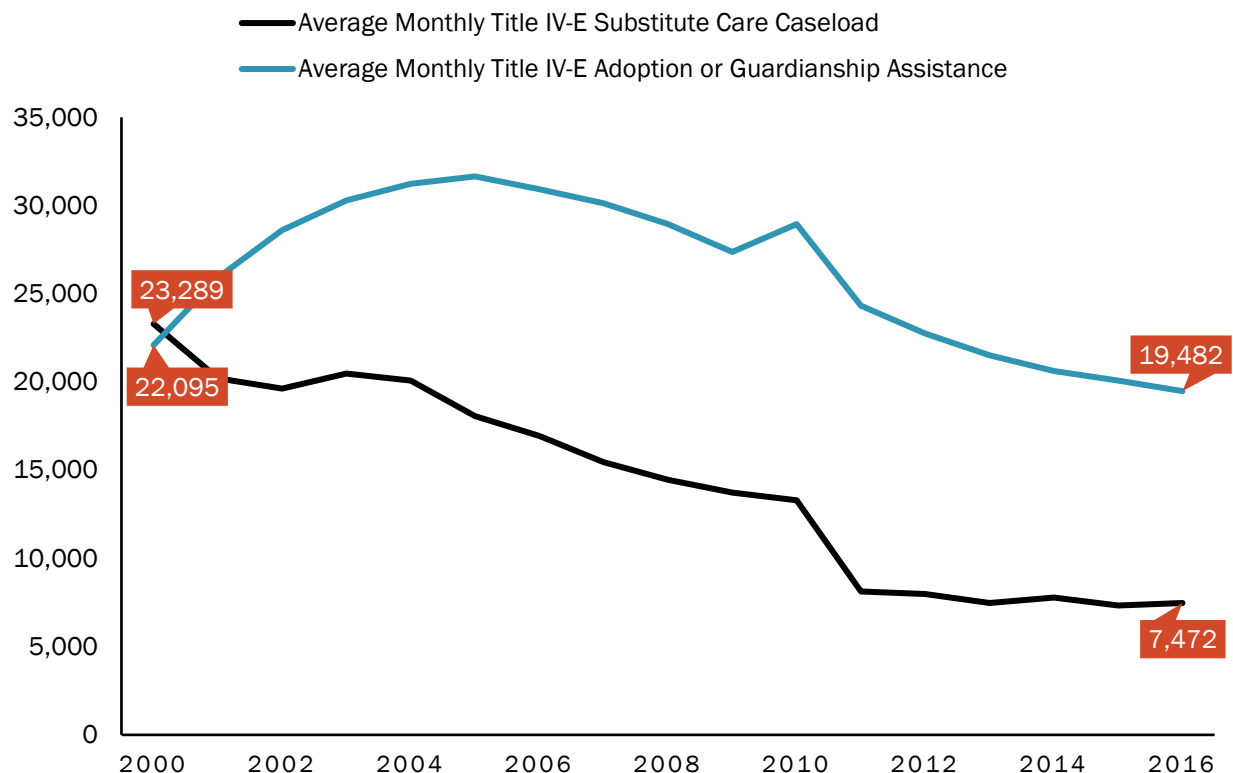


Data Source: United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Bureau, <https://cwoutcomes.acf.hhs.gov/cwodatasite/> Data current as of Oct. 2017.

Between 2013 and 2017, the median length of stay for children in foster care at the end of each year (shown in Figure 6.2) was relatively flat in Illinois and the U.S., but overall stays in care were markedly higher in the state. The length of stay in Illinois was 26.2 months in 2013 to 23.8 months in 2017, and in the U.S, it was 12.8 months in 2013 and 12.9 months in 2017.

Nationally, we have seen a shift in the number and proportion of children living in IV-E supported foster care and IV-E funded adoptive or guardianship homes. As shown in Figure 6.3, the number of children in Illinois in IV-E funded foster care and the number of children in IV-E funded adoptive and guardianship homes were approximately the same in 2000 (23,289 and 22,095 respectively), yet in 2016 these numbers have diverged. In 2016 there were 7,472 children in IV-E funded substitute care and 19,482 children in IV-E funded adoptive and guardianship homes.

Figure 6.3. Illinois Caseloads (2000 – 2016)



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

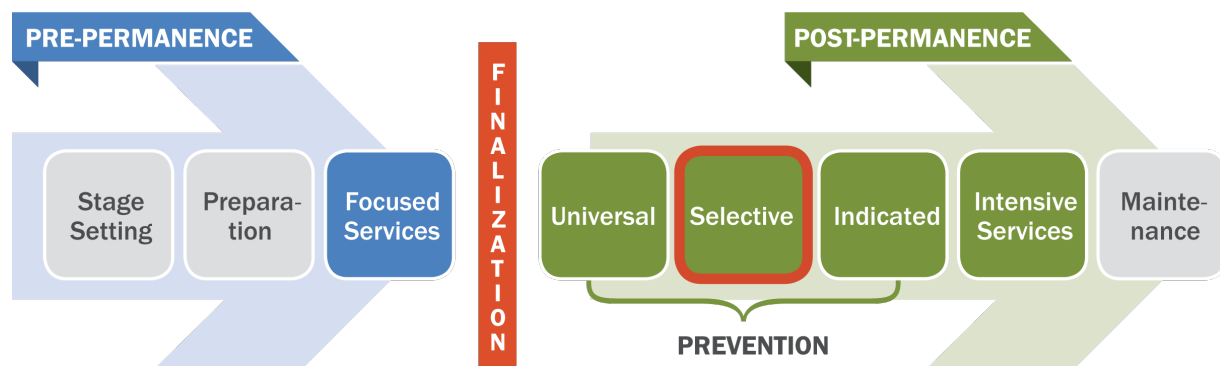
QIC-AG Permanency Continuum Interval

Illinois implemented a trauma-focused intervention in the **Selective Interval** of the QIC-AG Permanency Continuum Framework. In **selective** prevention efforts, services are offered to subgroups of individuals identified based on their membership in a group that has an elevated risk for a particular outcome (Offord, 2000; Springer and Phillips, 2006). Selective services are preventive and offered proactively, seeking to engage families before a specific need is indicated.

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

Previous research in Illinois and additional analysis conducted by the QIC-AG evaluation team found the risk for post permanency discontinuity for children in adoptive and guardianship homes was most likely to occur when children enter their teen years (i.e., average 13-years old), and that the risk of discontinuity increases as children age (Roelock, 2015; Roelock & White, 2016). Based on this research, the Illinois QIC-AG initiative focused on the child's current age as the primary risk factor in selecting families for the intervention.

Figure 6.4. Illinois QIC-AG Permanency Continuum





Primary Research Question

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

Will children between the ages of 11 and 16 in Cook County or in specific counties within the Central Region with a finalized adoption or guardianship (P), experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health (O) if they are provided TARGET (I) as compared to similar children who are provided services as usual (C)?

Each component of the PICO is described below.

Target Population

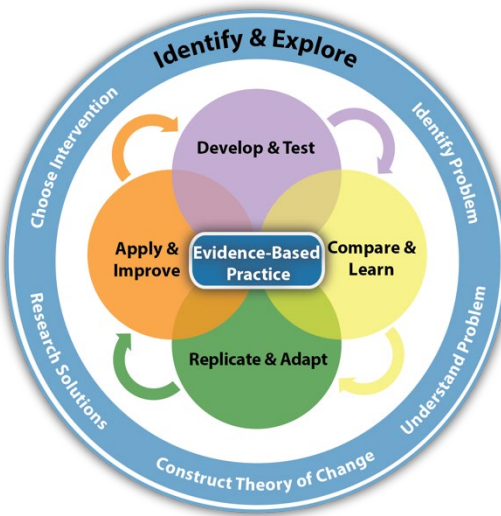
The Illinois QIC-AG prevention efforts focused on adopted youth who were currently in, or about to begin, their teenage years, a population of children who may be at risk for discontinuity. Analysis of the available administrative data from Illinois found that children who experienced post permanency discontinuity were, on average, 13 years old when they experienced discontinuity. Given the project's focus on prevention, it was decided that the target population would be children and youth between the ages of 11 and 16. TARGET was also offered to youth older than 10 years old who were adopted either internationally or domestically. The age for intercountry and private adoptions was based on the purveyor's recommendation for the applicable age range for the intervention.

Youth must have met the following criteria were to be offered TARGET. Parents or guardians were asked about these eligibility criteria:

- Currently residing in the home of their adoptive parent or guardian
- An IQ over 70
- The ability to learn new concepts and apply what he/she had learned to new situations
- The ability to understand cause and effect
- Could perform tasks or activities at the same level as his/her peers
- Could generally follow basic instruction
- Did not have developmental disabilities of sufficient severity to prevent comprehension of or participation in TARGET activities
- Did not currently use or misuse substances, or currently in treatment for these issues
- Had not made suicidal threats or plans within the last 24 hours

The initiative was implemented in Cook County, and in several counties within the Central Region including Champaign, Christian, DeWitt, Ford, Fulton, Knox, Livingston, Logan, Macon, Marshall, Mason, McLean, Menard, Peoria, Sangamon, Stark, Tazewell, and Woodford.

Intervention



Illinois, already implementing TARGET as part of their PII project, had buy-in from leadership at DCFS. DCFS had been training its workforce to understand the difficulties associated with traumatic events, recognize how the children and families they work with were impacted by trauma, and evaluate how trauma impacts the staff working with children and families. TARGET built upon these skills and the current knowledge in the field to enhance trauma-related services. The testing of TARGET with adoptive and guardianship families in Illinois fit into the **Replicate and Adapt** phase of the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. The goal of this phase is “widespread, consistent, and appropriate implementation of the adopted intervention with other populations and in other contexts that continue to achieve the desired outcomes” (Framework Workgroup, p. 4).

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY (TARGET)

TARGET is a strengths-based intervention that teaches participants about the impact of trauma on cognitive, emotional, behavioral, and relational processes. It is designed to address difficulties with emotional regulation and relational engagement that occur across a wide range of trauma-related and mental health issues. TARGET teaches a set of skills, called the Freedom Steps, to help participants learn new ways of understanding their stressors and regulating their reactions and responses to stressors. The goal in TARGET is to help people recognize their personal strengths, make good decisions and build healthy relationships.

TARGET is designed to benefit children and families by:

- Providing youth with a set of skills they can employ when a trigger that could cause emotional or behavioral issues is identified. As youth maintain control over their reactions, they will experience a reduction in emotional or behavioral issues, resulting in increased capacity to form and maintain healthy relationships.
- Assisting parents or guardians in addressing issues that children and youth may be struggling with, including struggles with alcohol or other substance abuse issues. Through participation in TARGET, they will also gain knowledge and be able to support their children as they develop their own set of emotional regulation skills through TARGET.
- Providing parents and guardians with training and support in the foundation and skills necessary to assist youth when a trigger occurs, working with the youth to employ the skills that will ultimately result in improved self-regulation for the youth.

TARGET focuses on providing a safe learning environment for the children and their adoptive families that is conducive to understanding the impact of stress and the skills that increase their personal control over feeling stressed. The program includes 12 sessions in a home environment where the child and their adoptive parents or guardians learn 7 essential core skills called the FREEDOM steps. Sessions can be repeated, so some participate in more than 12 sessions. The FREEDOM steps are:

- **FOCUS:** Reducing anxiety and increasing mental alertness
- **RECOGNIZE:** Helping individuals recognize stress triggers
- **EMOTIONS:** Identify a primary emotion
- **EVALUATE:** Evaluate a primary thought
- **DEFINE:** Determine a primary goal
- **OPTION:** Identify and focus on prior success
- **MAKE A CONTRIBUTION:** Identify a way to make a difference in others' lives (Advanced Trauma Solutions; ATS)

These steps were designed to help participants change their reactions, from stress reactions driven by hypervigilance to proactive emotional regulation.

A TARGET therapist trains adoptive parents or guardians to understand, support and reinforce the FREEDOM steps. The program also builds on and incorporates the child's strengths. A session typically lasts 50-90 minutes and one or two sessions per week were recommended.

Comparison

COOK

Project staff attempted to reach all families in the target population. Random assignment to the intervention (TARGET) or comparison group (services as usual) occurred after families agreed to participate in the research. Families assigned to the comparison group were eligible for services as usual.

CENTRAL

Families assigned to the comparison group were randomly assigned at the start of the study. These families did not receive outreach from the QIC-AG program and were eligible for services as usual.

Outcomes

The short-term and long-term outcomes for the Illinois QIC-AG project were the same for Cook County and Central Region.

Short-term outcomes included:

- Reduced child behavioral issues
- Reduced school-based problematic behaviors
- Increased caregiver commitment
- Reduced caregiver strain

Long term outcomes included:

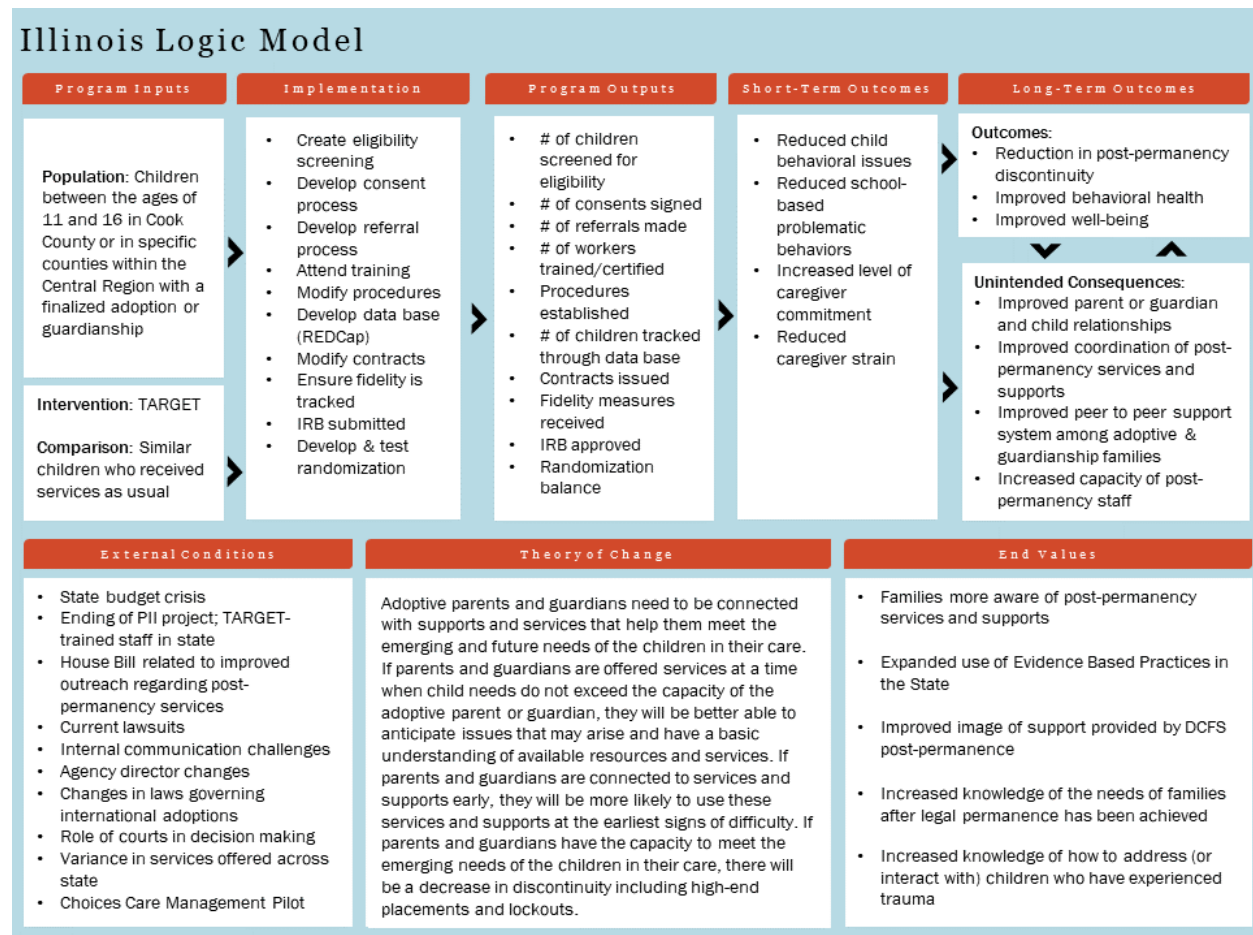
- Improved post permanency stability
- Improved child and family wellbeing
- Improved behavioral health for children and youth

Surveys were sent to families in the intervention and comparison groups to assess outcomes at the end of the project period.

Logic Model

The Logic Model (Figure 6.5) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and core developmentally informed interventions to the intended proximal and distal outcomes. The model identifies the core programs, services, activities, policies, and procedures that were studied as part of the process evaluation, as well as contextual variables that may affect their implementation.

Figure 6.5. Illinois Logic Model





Evaluation Design & Methods

The QIC-AG evaluation team was committed to using the most rigorous evaluation design possible in each of the eight QIC-AG sites. This meant that experimental designs were used whenever possible. In Illinois, this resulted in different randomization methods in the two Illinois sites: Cook County and Central Region. This decision to use different randomization approaches was based on prior research in Illinois where there was low uptake of the intervention, and the early experiences with the QIC-AG project. However, in the Central Region, there was a waiting list for families seeking post permanency services. The QIC-AG team was concerned that this waiting list could grow if families were being contacted proactively to engage in TARGET. Additional families seeking services from the existing Preservation programs in the Central Region could make it difficult for them to obtain services. These constraints were evaluated when selecting the evaluation design.

As a result, an experimental design was employed to test the effectiveness of TARGET, but different randomization techniques were applied in the two geographic regions (Cook County and Central Region). In both sites, random assignment was employed to ensure that the comparison and intervention groups were balanced and that each group had a “representative mix” of youth. Even though the causal effect of TARGET on any individual family cannot be known with certainty, with random assignment the average differences in outcomes between families assigned to the intervention or comparison group can be attributed to the effects of the intervention rather than to any preexisting differences at baseline (selection), changes that would have occurred in any event (maturation), happenings that unfold over time (history), or differences in how the measurements are made (instrumentation). However, for random assignment of participants in experiments to balance intervention and comparison groups, one assumption is that participants who are eligible for the intervention actually participate in the intervention, without differential participation as a result of other characteristics. In the Illinois QIC-AG site, this did not occur; not all families assigned to the intervention group received TARGET. Important caveats related to this issue are highlighted in the Findings section below.

The selection of participating children was determined using administrative data supplied to the QIC-AG by DCFS. Once eligibility was established, random assignment was used to assign children to intervention and comparison conditions.

CENTRAL REGION

In the Central Region, the evaluation team used a random consent design for assignment to the intervention or comparison group (Zelen, 1979, 1990). In this design, families were randomized into either the intervention or the comparison group by the evaluation team in advance of any outreach. Subsequently, only adoptive parents or guardians assigned to the intervention group received outreach.

This design builds on Zelen’s argument that because a client’s only legitimate expectation is to receive that best standard treatment, obtaining informed consent from clients who were randomized to receive services as usual, was not ethically necessary (Ellenberg, 1984) and is congruent with work done in other federal projects (e.g., Testa & White, 2014). Therefore, we asked for a waiver of consent to examine the administrative data for those assigned to the intervention but did not participate.

COOK COUNTY

In Cook County, a traditional random assignment protocol was used. Families were notified by mail about the study, and then an outreach worker followed up with a phone call. After describing the study the outreach worker asked families to consent to be part of the study. Once adoptive parents and guardians consented to participate in the study, the outreach worker used an online random assignment calculator to assign families to the intervention or comparison group, and families were informed of their assignment.

The evaluation design and protocol were reviewed by the Institutional Review Board (IRB) at the University of Wisconsin-Milwaukee (UWM), the University of Illinois at Chicago (UIC), and the IRB at the Illinois Department of Children and Family Services.

Procedures

USABILITY TESTING

During usability testing, the program outputs listed in the Logic Model were tracked. The program successfully completed all the output measures. In addition, several different approaches to outreach were examined (e.g., addressing envelopes by hand, changing the wording of the outreach letters) in an effort to increase the level of participation in the study. However, these changes did not result in an increased rate of participation.

In order for program staff to have contact with a regular and deliberate supply of families, the evaluation team randomly assigned participants to one of 19 cohorts. The first two cohorts were usability testing, and the remainder made up the formative evaluation sample.

RECRUITMENT: COOK COUNTY

The QIC-AG evaluation team was provided access to the DCFS administrative data. Using the administrative data, the Principal investigator (PI) of the study identified the target population. Eligibility was determined at the child level’s eligibility status, but outreach was conducted at the family level. In each family, one target child was selected, and adoptive parents or guardians were asked to respond to the surveys about that child.

An address-locating service (LexisNexis) was used to obtain current contact information for the parents or guardians. These data were shared with DCFS staff who printed and mailed letters to potential study participants.

The outreach procedures in Cook County involved mailing a letter from DCFS that alerted potential participants that they were selected to participate in a research study, and that someone would call them with additional information, or that they could call the outreach worker to find out more information. This mailing included a copy of the consent form.

Contact information was securely shared by the project PI with the project staff. Project staff contacted families approximately two weeks after the introductory letter was sent to ascertain their interest in the study.

Agency staff tracked program data into a REDCap database hosted at DCFS. REDCap is a secure web application for building and managing data. REDCap allowed multiple users to simultaneously enter data into the system.

RECRUITMENT: CENTRAL REGION

The QIC-AG evaluation team was provided access to the DCFS administrative data. Using the administrative data, the PI identified the target population. Eligibility was determined based on the child's eligibility status, but outreach was conducted at the family level. In each family, one target child was selected, and adoptive parents or guardians were asked to respond to the surveys about that child.

An address-locating service (LexisNexis) was used to obtain current contact information for the parents or guardians. These data were shared with DCFS staff who printed and mailed letters to potential study participants.

The outreach procedures in Central Region involved the mailing of a letter from DCFS that alerted adoptive families that they had been selected to participate in a research study, and that someone would call them with additional information, or that they could call the outreach worker to find out more information.

Contact information was securely shared by the project PI with the project staff. Project staff initiated attempts to contact families approximately two weeks after the introductory letter was sent.

Families assigned to the intervention group were screened in, and, if eligible, offered TARGET services. Project staff contacted the designated agency to inform them that they have been assigned a new family who has agreed to participate. Agency staff tracked program data into a REDCap database hosted at DCFS.

FIDELITY AND ADHERENCE

Adherence and exposure variables for both Cook and Central Region were measured in terms of the degree of practitioners' adherence (fidelity) to the best practice model of service delivery as intended by the developers and the numbers of children families reached.

Advanced Trauma Solutions (ATS; the TARGET purveyor) has trained Fidelity Monitors who reviewed videos of therapists as they conducted TARGET sessions. Videos were uploaded by the therapists into a secure web-based system. ATS Fidelity Monitors reviewed a random sample of videos and reviewed and rated sessions for model fidelity.

OUTCOMES

The primary evaluation in Cook County and Central Region was the comparison between the intervention and comparison groups. The QIC-AG contracted with an outside firm, The Survey Research Lab (SRL) at the University of Illinois at Chicago (UIC) to administer one-page questionnaires and primary outcome surveys to families in both the intervention and comparison groups. All surveys were administered to an adoptive parent or guardian.

- A one-page questionnaire was sent prior to outreach by the program staff. The purpose of the questionnaire was to gather preliminary information about all families. The SRL protocol for survey administration included a \$5 non-contingent incentive attached to the request to participate. The questionnaire informed respondents that they should expect a follow-up survey in approximately 6 months and asked the respondent to contact SRL if they moved before receipt of the main survey. These questionnaires began with Cohort 6 and continued through Cohort 19. Cohorts prior to 6 received the primary outcome survey only. This questionnaire asked questions related to the caregivers' views of their relationship with their child, a child who they had assumed guardianship of, or who they adopted.
- The primary outcome survey was administered to all families assigned to both the intervention and comparison groups, in both Cook and Central, for all 19 cohorts. The purpose of the survey was to gather information related to the outcomes. The SRL protocol for survey administration included a \$5 non-contingent incentive attached to the request to participate and a \$20 incentive for survey completion.

In addition, administrative data, provided by DCFS to the evaluation team, was used to track post permanency discontinuity and to examine foster care experiences of the target population prior to adoption or guardianship.

Measures

OUTCOME EVALUATION MEASURES

The specific outcomes measures used in the Illinois evaluation are described below. The selection of measures for this study were based on findings from extant research. In surveys from Illinois with adoptive parents and guardians, a series of questions were asked that, in later analysis, were predictive of post permanency stability (Testa, Snyder, Wu, Roelock, & Liao, 2015). Specifically, the study found that children and youth with behavioral problems were more likely to experience post permanency instability, which was not surprising. What was surprising was that once caregiver thoughts about ending the relationship were added to the statistical models, children with behavioral problems were no more likely to experience instability than children with no behavioral problems. In other words, thoughts about ending the relationship mediated, or explained away, the effect of child behavioral problems on the risks of post permanency instability, meaning that caregiver thoughts about ending the relationship likely provide a more immediate and reliable signal of post permanency discontinuity than child behavior problems alone (Testa, et al., 2015). The selection of measures used in the QIC-AG study (Illinois Post Permanency Commitment Items, BEST-AG, and BPI) were selected to build upon findings from prior post permanency research. Outcomes for the QIC-AG evaluation in Illinois were measured through the following scales or items.

Illinois Post Permanency Commitment Items

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

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

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

Behavior Problem Index (BPI)

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

Education Outcomes

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

Caregiver Strain Questionnaire – FC/AG22

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

Missing Data

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



Findings

Sample Frame and Participant Profile

Tables 6.1 and 6.2 depict characteristics for the samples in Cook County and Central Region, respectively. The descriptive statistics in the table provide a profile of the families involved with the QIC-AG in both IL sites. In addition, bivariate statistical tests for variables help examine if characteristics differed between intervention and comparison groups. If characteristics were different, this would indicate that perhaps the random assignment procedures did not balance intervention and comparison groups on pre intervention characteristics. However, it is important to note that even with random assignment, it is possible that groups may differ on a few variables on bivariate statistical tests, simply due to chance.

The descriptive results for Cook County in Table 6.1 show that the majority of youth (86%) spent two or more years in foster care, with an average time in foster care for all youth in the sampling frame of over 3 years. Only 9% of the youth overall in Cook County had three or more moves in foster care. Most youth were Black/African-American (84% of the sampling frame), and the average age at permanency was close to 4 years old. Bivariate tests showed no statistically significant differences between intervention and comparison groups on the descriptive characteristics, which provides support that randomization was successful in balancing the characteristics between groups on these observed characteristics. Public Adoptive or Guardianship Families

Table 6.1. Cook County: Characteristics of Public Adoptive and Guardianships Families

ILLINOIS: COOK	SAMPLE FRAME (N = 1,661)	ASSIGNED TO INTERVENTION GROUP (N = 95)	ASSIGNED TO COMPARISON GROUP (N = 83)	BIVARIATE COMPARISON		
	%	%	%	χ^2	df	p
3+ MOVES IN FOSTER CARE	9%	7%	13%	1.69	1	0.194
CHILD RACE OR ETHNICITY				5.01	3	0.171
WHITE	8%	9%	12%			
BLACK	84%	82%	87%			
OTHER RACE	1%	1%	0%			
HISPANIC	7%	7%	1%			
CHILD IS FEMALE	50%	49%	45%	0.43	1	0.514
AGE AT PERMANENCE				4.96	4	0.291
0-2 YEARS OLD	33%	33%	28%			
3-5 YEARS OLD	48%	45%	55%			
6-8 YEARS OLD	14%	17%	11%			
9-11 YEARS OLD	4%	3%	6%			
12-14 YEARS OLD	1%	2%	0%			
15+ YEARS OLD	0%	0%	0%			
	M (SD)	M (SD)	M (SD)	t	df	p
CHILD AGE AT PERMANENCE	3.82 (2.39)	3.93 (2.39)	3.90 (2.17)	-0.07	176	0.947
MEAN TIME (IN YEARS) IN FOSTER CARE	3.28 (1.88)	3.41 (1.79)	3.36 (1.74)	-0.19	176	0.853

For the Central Region, the results in Table 6.2 show a similar length of time in foster care as the youth in Cook County, with 82% of youth spending two or more years in foster care and an average length of time in foster care of slightly over 3 years. However, in contrast to Cook County, a majority youth in the Central Region were White (53%) and a smaller proportion of youth were Black/African-American (42%, or close to half of the proportion in Cook County). The average age of permanence for youth in the Central Region was about 5 years old. All bivariate tests except one were not statistically significant, providing support that randomization in Central Region was largely successful in balancing groups on these observed pre intervention descriptive characteristics. However, results did show some slight differences in child age between intervention and comparison groups.

Table 6.2. Central Region: Characteristics of Public Adoptive and Guardianships Families

ILLINOIS: CENTRAL	SAMPLE FRAME (N = 1,070)	ASSIGNED TO INTERVENTION GROUP (N = 557)	ASSIGNED TO COMPARISON GROUP (N = 513)	BIVARIATE COMPARISON		
	%	%	%	χ^2	df	p
3+ MOVES IN FOSTER CARE	14%	14%	14%	0.03	1	0.865
CHILD RACE OR ETHNICITY				6.12	3	0.410
WHITE	53%	52%	54%			
BLACK	42%	42%	42%			
OTHER RACE	2%	2%	2%			
HISPANIC	3%	3%	2%			
CHILD IS FEMALE	49%	50%	48%	0.40	1	0.526
AGE AT PERMANENCE				22.40	5	0.000
0-2 YEARS OLD	26%	28%	23%			
3-5 YEARS OLD	37%	38%	36%			
6-8 YEARS OLD	20%	15%	25%			
9-11 YEARS OLD	13%	13%	12%			
12-14 YEARS OLD	4%	5%	4%			
15+ YEARS OLD	0%	1%	0%			
	M (SD)	M (SD)	M (SD)	t	df	p
CHILD AGE AT PERMANENCE	5.04 (3.23)	4.95 (3.39)	5.13 (3.04)	0.88	1068	0.380
MEAN TIME (IN YEARS) IN FOSTER CARE	3.03 (1.87)	3.03 (1.99)	3.03 (1.73)	-.014	1068	0.989

PRIVATE DOMESTIC AND INTERCOUNTRY ADOPTIVE FAMILIES

In Cook County, 17 Private and Intercountry adoptive families expressed interest in TARGET, and 14 attended at least 4 sessions, demographic characteristics of these 14 children are listed below (see Table 6.3). In the Central Region, 21 Private and Intercountry adoptive families expressed interest in TARGET, of those 21 families, 18 attended at least 4 sessions, demographic characteristics of these 18 children are listed below.

Note: The primary outcome surveys sent to public adoptive and guardianship families were not administered to private or intercountry adoptive families. Hence, the information we have for these participants is limited in this report. Please refer to a report by the University of Nebraska, Lincoln, for additional information on private and intercountry adoptive families.

Table 6.3. Characteristics of Private and Intercountry Adoptive Families

CHARACTERISTIC	COOK (N=14)	CENTRAL (N=18)
BOYS+	7	13
GIRLS+	6	5
MEAN AGE AT ADOPTION+	0.7 years old (SD=2.20)	3.9 years old (SD=4.12)
MEAN AGE AT INTERVENTION	12.3 years old (SD=2.02)	12.6 years old (SD=1.92)
DOMESTIC ADOPTION	5	9
INTERCOUNTRY ADOPTION	9	9

Notes:

+ In Cook we have missing information for one child's gender and one child's date of adoption.

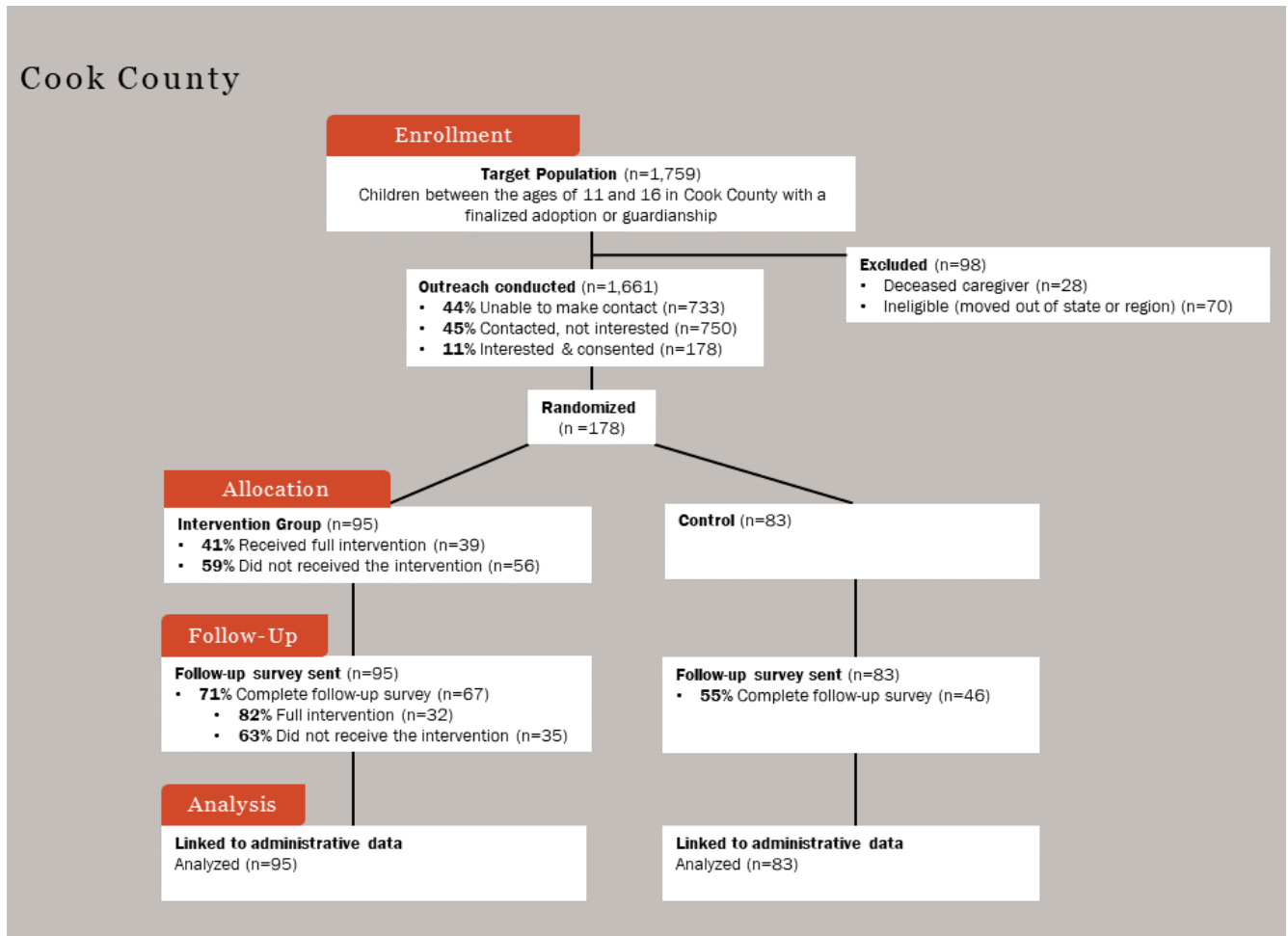
Consort Diagram

The Consort Diagram (Figure 6.6) depicts the randomization procedure and response to outreach for the intervention and surveys. This is different than the uptake chart on subsequent pages (Figures 6.8 and 6.9). The consort diagram reports the number of research subjects with data. The uptake charts report on how many subjects were recruited and participated. In Cook County, 1,661 children were eligible for the intervention. Staff successfully reached 56% of families, and 178 agreed and consented to randomization. Of those families, 95 were randomly assigned to the intervention group and 83 to the comparison group.

Depicted on the left side of Figure 6.6 is the intervention group's response to outreach efforts (i.e. Allocation) and their response to survey procedures (i.e. Follow-up). For example, of those that were allocated to the intervention group, 41% (n=39) received the full intervention and 59% (n=56) agreed to participate in the study but did not follow-through with the intervention. Further, of those in the intervention group, 71% (n=67) completed the follow-up survey and 82% (n=32) of those that participated in the full intervention completed the follow-up survey. We were successfully able to link all 95 of those in the intervention sample to administrative data using their encrypted ID codes.

Depicted on the right side of Figure 6.6 in the comparison group (n=83). The comparison group did not receive any further contact directly after allocation to the group, so no additional information is provided at Allocation. The comparison group did receive a survey around six months after being allocated to the comparison group and 55% (n=46) of them completed the survey. Additionally, all 83 of those in the comparison group were able to be linked to administrative data using their encrypted ID codes.

Figure 6.6. Cook County: Consort Diagram

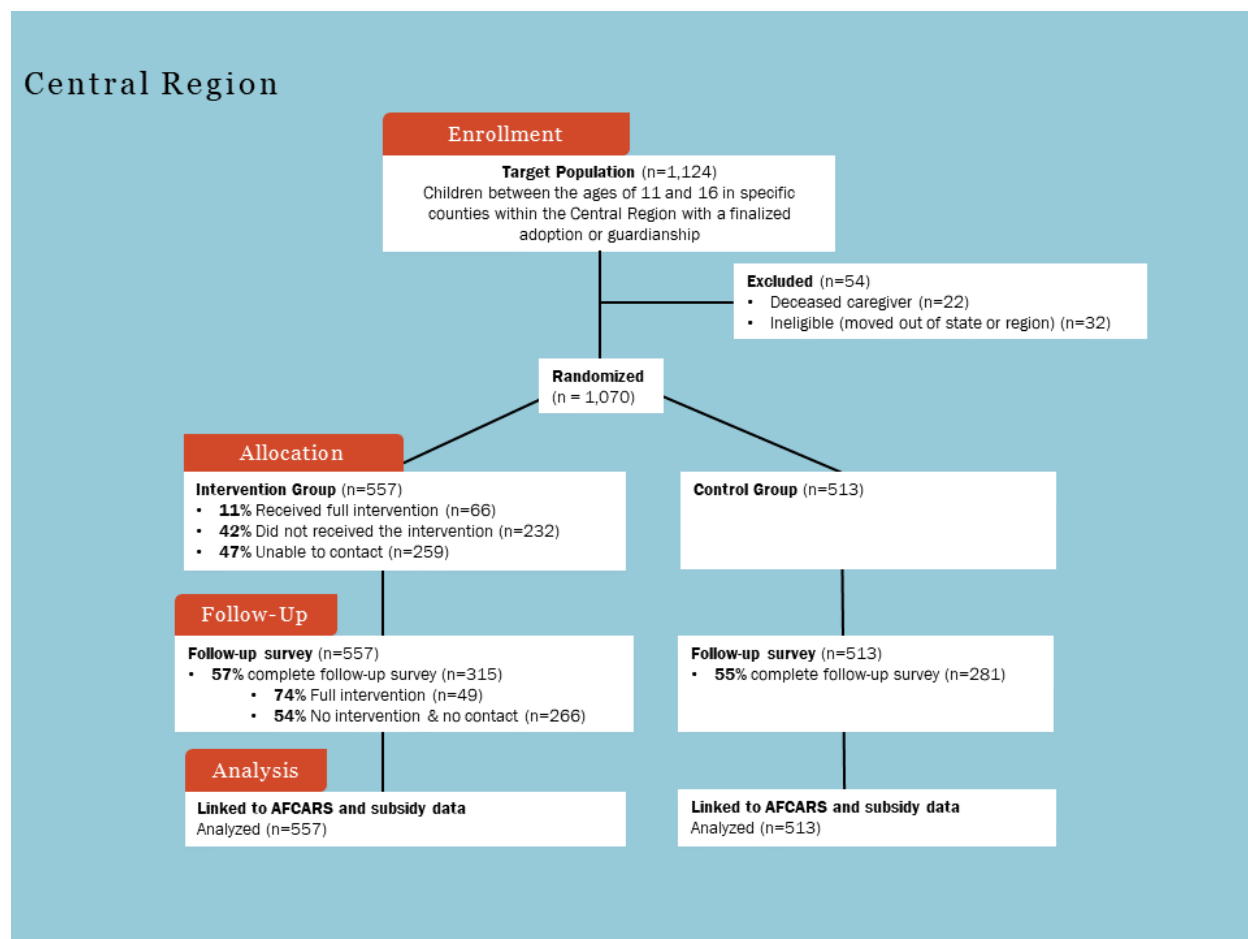


The Consort Diagram for Central Region (Figure 6.7) depicts the randomization procedure and response to outreach for the intervention and surveys. In the Central Region, of the 1,070 families eligible for the intervention, 557 (52%) were assigned to the intervention and 513 (48%) to the comparison group.

Depicted on the left side of Figure 6.7 is the intervention group's response to outreach efforts (i.e. Allocation) and their response to survey procedures (i.e. Follow-up). For example, of those that were allocated to the intervention group, 11% (n=66) received the full intervention, 42% (n=232) were contacted but did not participate in the intervention and 47% (n=259) were not successfully contacted. Further, of those in the intervention group, 57% (n=315) completed the follow-up survey and 74% (n=49) of those that participated in the full intervention completed the follow-up survey. We were successfully able to link all 557 of those in the intervention sample to administrative data using their encrypted ID codes.

Depicted on the right side of Figure 6.7 in the comparison group (n=513). The comparison group did not receive outreach directly after allocation to the group, so no additional information is provided at Allocation. The comparison group did receive a survey around six months after being allocated to the comparison group and 55% (n=281) of them completed the survey. Additionally, all 513 of those in the comparison group were able to be linked to administrative data using their encrypted ID codes.

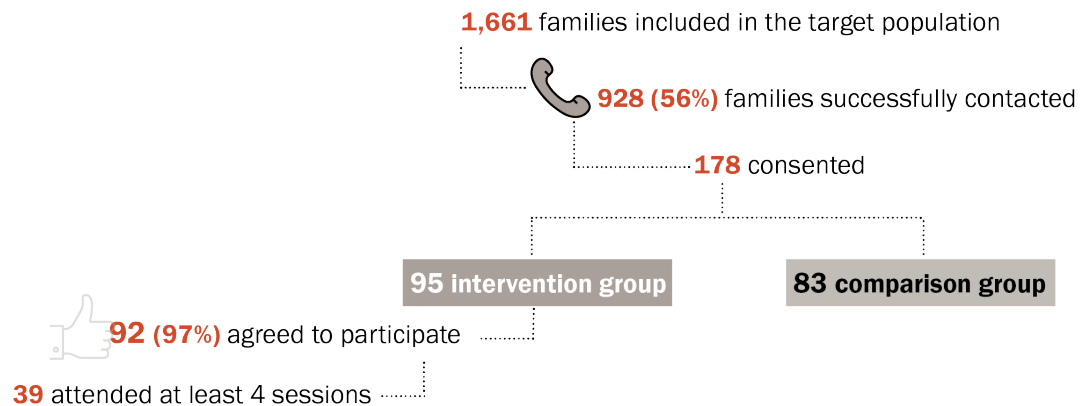
Figure 6.7. Central Region: Consort Diagram



RESPONSE TO INTERVENTION RECRUITMENT: COOK COUNTY

Figures 6.8 and 6.9 provide a more nuanced depiction of the results of outreach to the intervention group than the Consort figure. In Cook County, letters were sent to 1,661 families, and staff subsequently called families to assess their interest in the program. Among these families, 928 families chose to speak with the workers, and 178 families consented to participate. Among the 178 families, 95 families were randomized to the intervention group, and 83 families were randomized to comparison group. Finally, 92 families in the intervention group agreed to participate in TARGET program, yet many of the families who agreed to participate did not end up participating. Ultimately, 39 families attended at least 4 sessions, the minimum number of sessions, according to the purveyor, needed to observe an intervention effect. Of the 39 families who attended at least 4 sessions, 31 (79%) completed all TARGET sessions (“graduated” from the program).

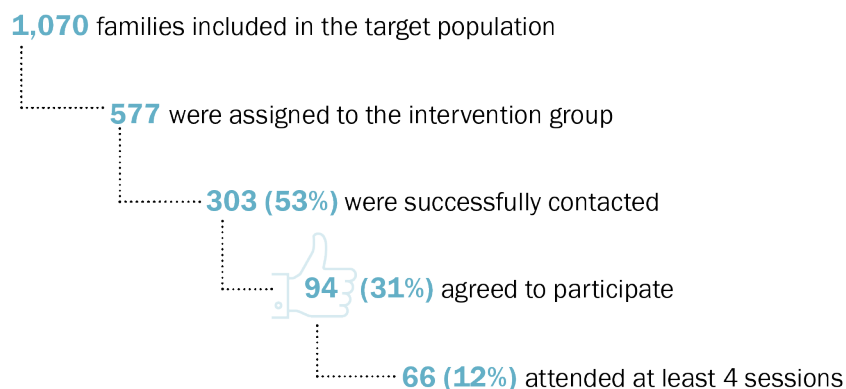
Figure 6.8. Cook County: Uptake



RESPONSE TO INTERVENTION RECRUITMENT: CENTRAL REGION

For Central Region, the target population was 1,070 families, who were randomized to comparison or intervention group. Letter were sent to the 557 families randomly assigned to the intervention program. 303 of those families chose to speak with the workers, and 94 families consented to participate. Among the 94 families, 66 families have attended at least 4 sessions, the minimum number of sessions, according to the purveyor, needed to observe an intervention effect. Of the 66 families who attended at least 4 sessions, 64 (97%) completed all TARGET sessions (“graduated” from the program).

Figure 6.9. Central Region: Uptake



In both of the Illinois sites, a variety of outreach methods were used to make contact with families. For example, at the suggestion of the stakeholders in Illinois, project staff attempted to address envelopes with different colored ink, the outreach letters were redesigned several times, and additional follow-up calls to families who initially said they wanted to participate but later declined were attempted. However, these additional efforts did not yield additional uptake.

SAMPLE CHARACTERISTICS

This section examines whether there were differences between families assigned to the comparison and intervention groups, and between TARGET participants and families who opted not to participate in the intervention. Demographics and key characteristics of families assigned to the intervention or comparison groups in both Illinois sites found that the two groups were largely similar, suggesting randomization was successful in creating balanced groups at assignment on observed characteristics. However, the analysis below goes one step further by asking if there were differences between families who actually participated in TARGET and families who did not participate in TARGET, even though they were assigned to receive the intervention.

COOK COUNTY

Differences were found between families who said that they were interested, and consented to randomization, and families who were not randomized. Of the 113 families who agreed to being randomized in cohorts 6 – 19 (cohorts prior to 6 did not receive the one-pager), 102 (90%) returned the one-page questionnaires; of the 1,345 families who were not randomized, 813 (60%) returned one-pagers. The results found statistically significant differences on all the questions asked (see Table 6.10 in the Appendix). In sum, this analysis found that families who agreed to participate in the study (those who agreed to randomization) were not doing as well as families who did not participate (they did not speak to the outreach worker or they actively declined participation).

On average, families who opted into randomization:

- **Were less:**
 - likely to report a warm relationship with their child
 - confident that they could meet the needs of their child
 - likely to report that the impact of their child's adoption or guardianship on the family has been positive
 - inclined to consider adopting or entering into guardianship again
- **More frequently:**
 - struggled to effectively manage their child's behavior
 - experienced stress as a parent
 - struggled to appropriately respond to their child
 - thought of ending the adoption or guardianship

In other words, those who said that they were interested in participating in the study (agreed to be randomized) were not doing as well as those who did not participate. This means that this evaluation of TARGET involved a higher risk group of adoptive and guardianship families than average. These families likely had significant needs that may require a longer observation period than was available with this study to observe change.

What do families say about why they do not want to participate? Of the 647 families in Cook County who spoke to a worker, declined services, and provided a reason for not wanting to participate, the following reasons were reported:

- **65% (420)** reported that everything is fine and that they don't need services at this time
- **13% (83)** reported that their needs were being met elsewhere
- **9% (59)** reported that they were not interested
- **13% (85)** reported other reasons, primarily ineligible (e.g., parents divorced, not living at home; moving out of state)

Differences between families assigned to the intervention and comparison groups. Of the 38 families assigned to the intervention group in cohorts 6 - 19, 37 (97%) returned the questionnaires; of the 75 assigned to the comparison group, 65 (87%) returned questionnaires.

Responses to these questions were examined to understand if, at baseline there were statistically significant differences between children assigned to the intervention group and those assigned to the comparison group. There were no statistically significant differences between these two groups, on any of the questions, suggesting that randomization was successful in creating intervention and comparison groups that were balanced on these characteristics at baseline (see Table 6.11 in the Appendix).

CENTRAL REGION

Differences between families assigned to the intervention and comparison groups. Of the 424 families assigned to the intervention group in cohorts 6 - 19 (cohorts prior to 6 did not receive the one-pager), 249 (59%) returned the one-page questionnaire; of the 385 assigned to the comparison group, 213 (55%) returned questionnaires. There were no statistically significant differences between these two groups, on any of the questions, suggesting that randomization was successful in creating intervention and comparison groups that were balanced on these observed characteristics (see Table 6.12 in the Appendix).

Differences between TARGET participants and families assigned to the comparison group. Given the relatively low rate of participation among the intervention group, additional tests were run. The next test examines differences between the comparison group and families who participated in the intervention. These results found statistically significant differences between these two groups (see Table 6.13 in the Appendix). On average, compared to the comparison group, families who opted to receive the TARGET intervention reported that they were:

- Less likely to have a warm relationship with their child
- More likely to struggle to effectively manage their child's behavior
- Less confident that they could meet the needs of their child
- Less likely to report that the impact of the child on their family has been positive

These results suggest that, compared to the comparison group, TARGET participants were families who were struggling to provide adequate care for their child. As noted above, when families who are assigned to receive an intervention in an experimental study do not participate in the intervention, a comparison that examines the TARGET participants to the entire comparison group, may not be an apples-to-apples comparison. In other words, for this study, the comparison group was made up of all types of families – those who were not interested in services, and those who, if offered services, would have been interested in receiving services. But TARGET participants were higher-risk families interested in services. Therefore, to provide an alternative assessment of the effectiveness of TARGET, the goal is to compare TARGET participants with a sample of families who have a profile similar to them, and who may have similar concerns about their relationship with their child as those who were offered TARGET and agreed to participate.

Differences within the intervention group. The next test was to examine the intervention group as a whole and see if there were differences between those who were offered the service and opted to participate, and those who were assigned to the intervention group, were sent the materials about participation, but did not participate. Results found statistically significant differences between those who participated and those in the intervention group who did not participate (see Table 6.14 in the Appendix). On average, compared to non-participants within the intervention group, **TARGET participants** reported that they were:

- Less likely to have a warm relationship with their child
- Less confident that they could meet the needs of their child
- Less likely to report that the impact of the child on their family has been positive

In other words, those who participated in the intervention appear to be those who were struggling the most.

What do families say about why they do not want to participate? During the outreach process, staff working with the project in Illinois were able to make contact with about half of the adoptive and guardianship families they reached out to. Of the 135 families in the Central Region who spoke to a worker, declined services, and provided a reason for not wanting to participate, the following reasons were reported:

- **64% (87)** reported that everything was fine and that they did not need services at that time
- **5% (7)** reported that their needs were being met elsewhere
- **30% (41)** reported other reasons (e.g., not living in Illinois; too busy)

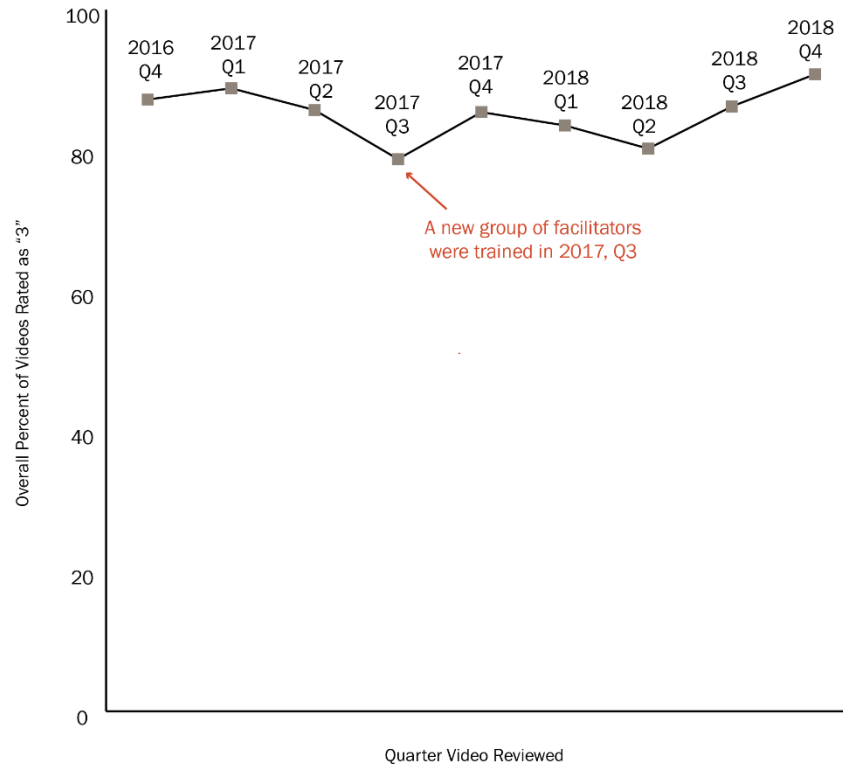
Process Evaluation

A process evaluation “determines whether program activities have been implemented as intended and resulted in certain output” (Centers for Disease Control and Prevention, 2015). The process evaluation tested whether the early phases of the initiative were associated with the expected program outputs of the intervention.

Fidelity and Adherence

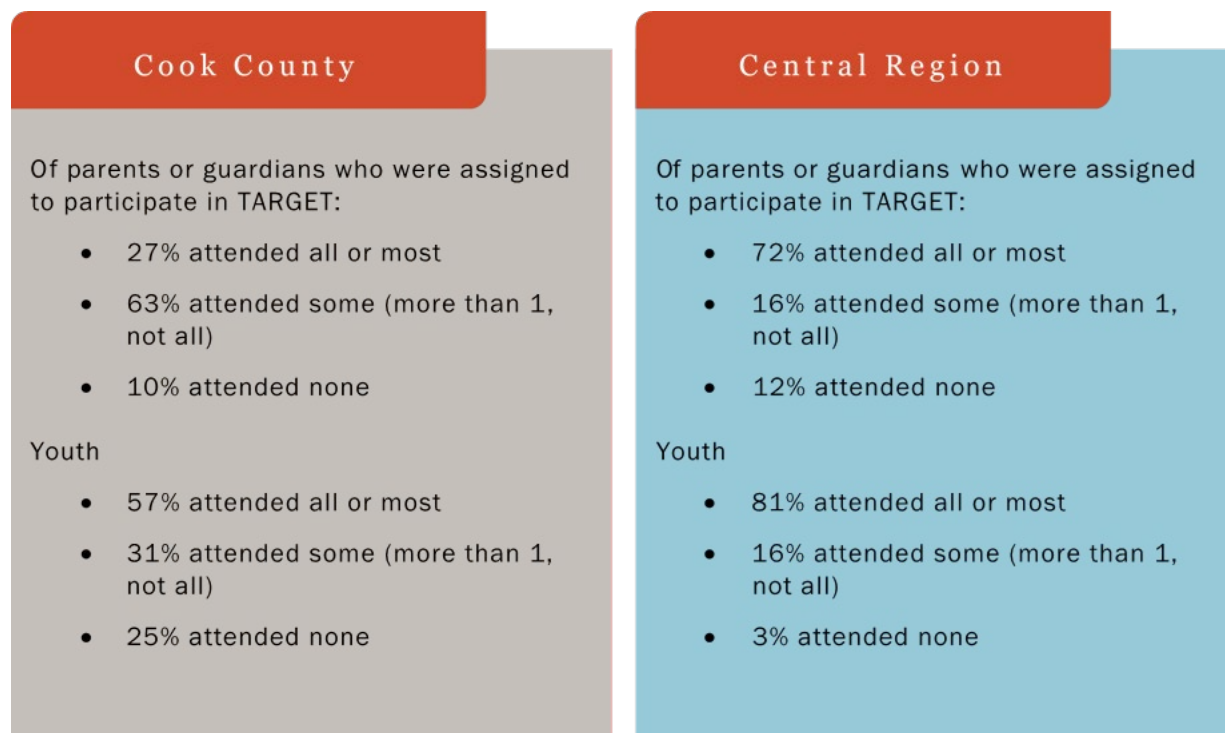
Results of the reviewed taped sessions are summarized in the graph below. ATS provided information on the “percent of items rated 3,” where “3” represents TARGET facilitators who met TARGET manual/guidelines for structure and content of the reviewed session. The graph below represents the average number of videos per quarter where the overall percent for structure and content of items were rated as “3.”

Figure 6.10. Illinois: Average Number of Videos Rated as Proficient



In general, the graph shows that a large proportion of the facilitators' videos that the purveyor reviewed met the TARGET manual/guidelines (over 80% in all but one quarter). A dip in the percentage is observed in 2017Q3, and this corresponded with an influx of newly trained facilitators.

Who participated in TARGET sessions? TARGET is designed for family participation – youth and parental or guardian participation is encouraged.



Families who participated in TARGET were asked to complete satisfaction surveys, and generally reported feeling positive about their experiences with TARGET. This was true for both the youth and their parents or guardians. Examples of their responses to what they would change about the program are reported below.

From the youth who participated:

“They have done a great job explaining and going through the steps and do a great job discussing what was discussed at the last session as a reminder.”

“Once done with all lessons it would be a great last session to role play/go through the FREEDOM chart with examples to help solidify the lessons.”

“I enjoyed the games and think it would be nice to have more times to play games.”

From the adoptive parents or guardians who participated:

“TARGET is a great program that gives families more tools to work with to help save the family from dividing.”

“Love how the program was brought to us. The convenience for us was huge.”

“Might be worth noting to families that not all children will respond to TARGET. Once I changed my expectations it was easier.”

In 2017 and 2018, 48 adoptive parents or guardians and 71 youth completed satisfaction surveys. These results are summarized for both sites in Tables 6.9 and 6.10. Families were asked to complete satisfaction surveys at the mid-point (after 4 sessions) and at the end (after 10 sessions). The last response for each family was used. Multiple respondents per family were gathered, one parent or guardian response and one youth response per family were included in this summary.

Parents or guardians were asked to rate questions on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) with 4 of the questions listed in Table 6.4. Reaching almost the maximum rating of 5, parents or guardians reported they clearly understood how stress affected the alarm system in their child's brain ($M = 4.74$). They also reported feeling very skilled in using the Freedom Skills to handle their own and their child's stress and using the SOS skills to help their child focus in stressful situations.

Table 6.4. Parent or Guardian Satisfaction Survey

PARENTS AND GUARDIANS	N	M	SD	MIN	MAX
UNDERSTAND HOW STRESS AFFECTS THE ALARM SYSTEM IN MY CHILD'S BRAIN.	47	4.74	0.49	3	5
USE THE FREEDOM SKILLS TO HELP MY CHILD MANAGE STRESS REACTIONS.	47	4.45	0.80	2	5
USE THE SOS SKILLS TO HELP MY CHILD FOCUS IN STRESSFUL SITUATIONS.	47	4.57	0.65	2	5
USE THE FREEDOM SKILLS TO HANDLE STRESS EFFECTIVELY IN MY LIFE.	48	4.58	0.77	2	5

Youth who participated in TARGET were asked to rate questions on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) with 5 of the questions listed in Table 6.5. Similar to their parents or guardians, every question youth rated was at least a 4.5 or higher. The young people reported they understood how stress affected their brain's alarm system ($M = 4.59$). They also reported feeling skilled in using the SOS skills in helping them focus during stressful situation ($M = 4.49$).

Table 6.5. Youth Satisfaction Survey

YOUTH	N	M	SD	MIN	MAX
UNDERSTAND HOW STRESS AFFECTS THE BRAIN'S ALARM SYSTEM?	71	4.59	0.75	1	5
USE THE FREEDOM SKILLS TO MANAGE STRESS REACTIONS?	69	4.32	0.81	1	5
USE THE SOS SKILLS TO HELP YOU FOCUS IN STRESSFUL SITUATIONS?	71	4.49	0.83	1	5
USE THE STRESS AND CONTROL SCALES TO DO A SELF CHECK?	68	4.43	0.87	1	5
HANDLE STRESSFUL SITUATIONS SUCCESSFULLY?	69	4.30	0.90	2	5

Outcome Evaluation

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

- Reduced child behavioral issues. This was measured through the Behavioral Problem Index (BPI).
- Increased caregiver commitment. This was measured through the Belonging and Emotional Security Tool for Adoptive Parents and Guardians (BEST-AG).
- Reduced caregiver strain. This was measured through the Caregiver Strain (CS).
- Reduced school-based problematic behaviors. This was measured through a series of questions related to school outcomes.

The primary outcome survey was administered to all families assigned to both the intervention and comparison groups in both Cook County and the Central Region. The purpose of this survey was to gather data related to the project outcomes. In addition to completing the surveys, parents and guardians contacted the evaluation team to request services (these requests were referred to the agency staff). They also contacted the evaluation team to let us know that they appreciated the outreach. An example of this can be seen in what one adoptive parent said:

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

COOK COUNTY

The randomization method used in Cook resulted in two groups of families whose results were compared to see if there was a difference between TARGET participants and similar children in the comparison group (families who received services as usual). The two groups were:

- **Treatment (TARGET) participants:** Families were successfully contacted by the outreach worker and randomized into the intervention group. Families received at least 4 sessions of TARGET. Four sessions are the minimum dosage, according to the purveyor, needed to observe an intervention effect.
- **Comparison group:** Families were successfully contacted by the outreach worker and randomized into the services-as-usual group.

The response rates associated with these two groups can be found in Table 6.6. The comparison group in Cook are only families who were successfully contacted and agreed to participate in the intervention, a much smaller comparison group than in Central Region (see Table 6.7).

Cook County Terminology

INTERVENTION GROUP: The families assigned to the intervention group. In Cook County, families were randomly assigned to the intervention group while on the phone with the outreach worker.

TARGET PARTICIPANTS (ALSO CALLED TREATMENT PARTICIPANTS): Families who participated in the intervention, and received at least 4 TARGET sessions.

COMPARISON GROUP: Families assigned to the comparison (or control) group. In Cook, random assignment into the comparison group occurred while the family was on the phone with the outreach worker. These families were eligible to receive services as usual.

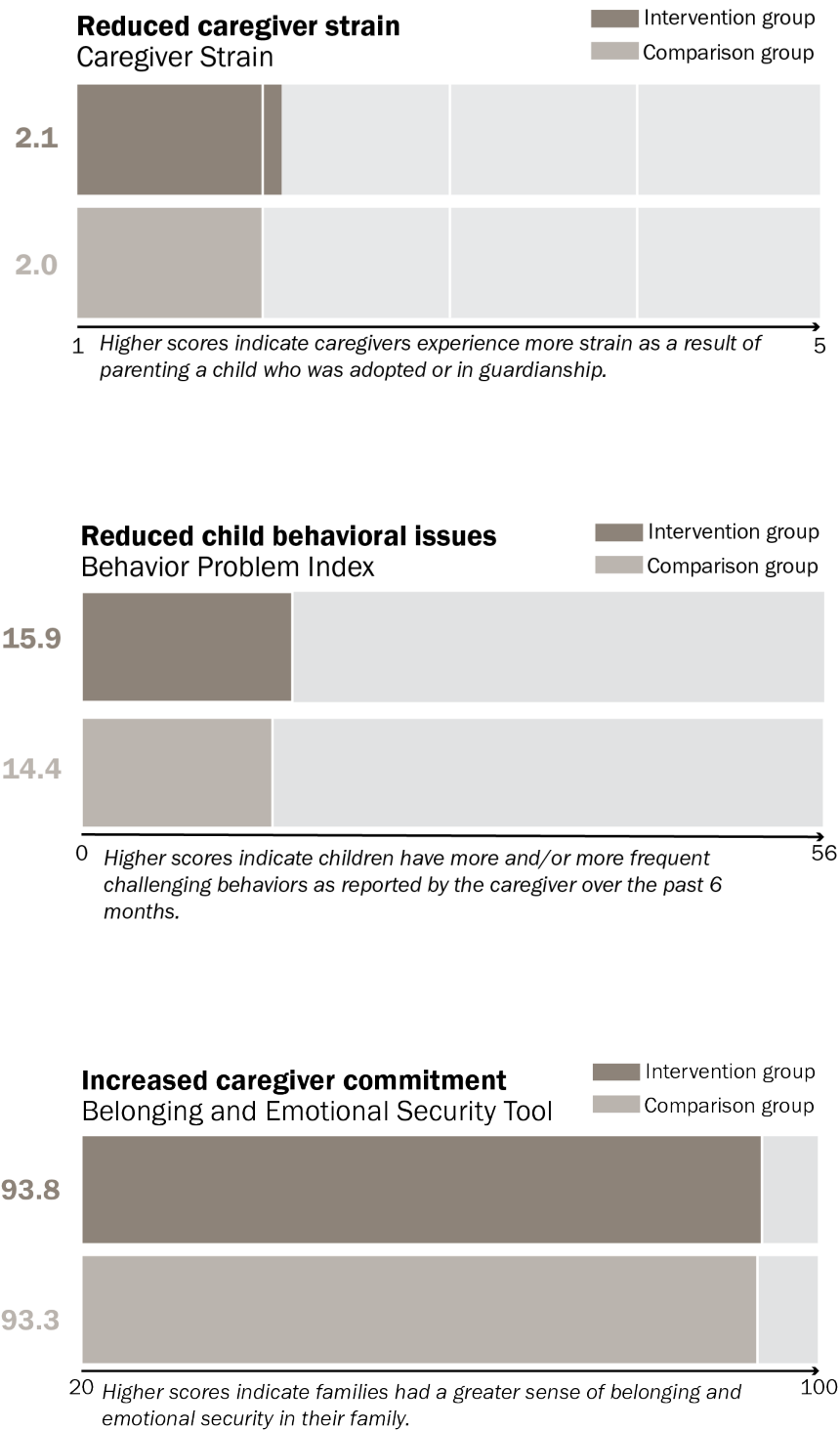
Table 6.6. Cook County: Primary Outcome Survey Response Rate

COOK COUNTY	SURVEYS SENT (N)	RESPONDED (N)	RESPONSE RATE
TARGET PARTICIPANTS	39	32	82%
COMPARISON GROUP	83	46	55%

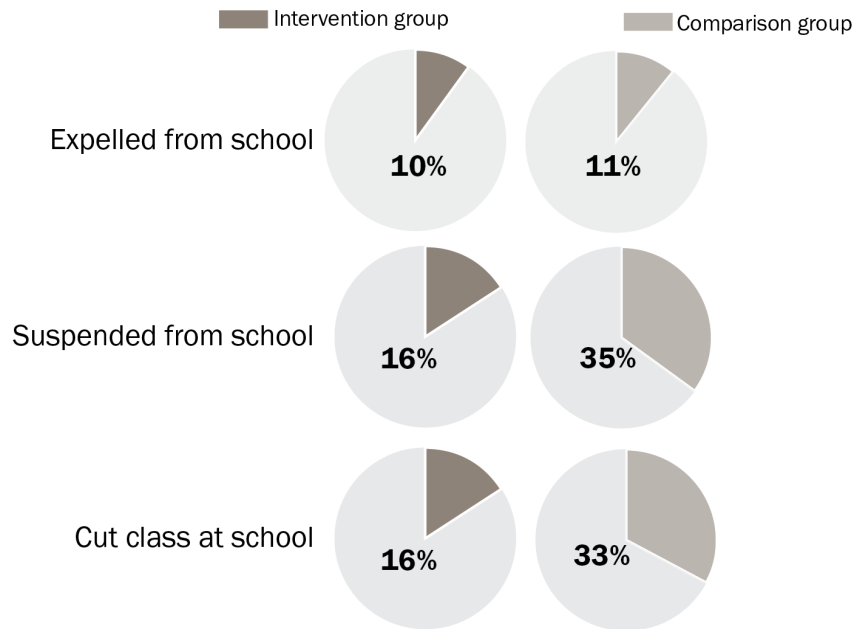
As previously noted, simple randomization was used in Cook County. Randomization resulted in statistically equivalent groups at baseline when comparing intervention and comparison groups on observed baseline descriptive characteristics. The analysis of short-term outcomes found very little difference between the intervention and comparison groups. Primary outcomes are summarized below, and in Figure 6.11. Results are duplicated in the Appendix, Table 6.15, where all subscales are included.

- **Behavioral Problem Index (BPI).** There was no statistically significant difference in the mean BPI scores between the treatment and comparison group (M= 15.92 and 14.44 respectively).
- **Caregiver Strain (CS).** On Caregiver Strain, there were no statistically significant differences between the treatment and comparison group (M= 2.07 and 1.99 respectively).
- **Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG).** There were no statistically significant differences in the mean BEST-AG scores between the treatment and comparison group (M=93.84 in the treatment and 93.26 in the comparison group).
- **School-based behaviors.** There were no statistically significant differences between the treatment and comparison groups. Results did show that the percentage of TARGET participants who cut classes at school or who experienced suspension from school was smaller than the percentage in the comparison group who experienced those school outcomes, a result that was trending towards statistical significance (for suspension from school, $p = .072$). However, caution should be used in interpreting these results given the small number of intervention participants.

Figure 6.11. Cook County Outcomes



Reduction in school-based problematic behaviors



CENTRAL REGION

The randomization method used in Central also resulted in two groups of study families whose results were compared to see if there was a difference between TARGET participants and similar children in families who received services as usual. The two groups were:

- **TARGET (treatment) participants:** Families were randomly assigned to the intervention group and received at least 4 sessions of TARGET. Four sessions is the minimum dosage, according to the purveyor, needed to observe an intervention effect.
- **Comparison Group:** Families were NOT contacted by the program. They were randomly assigned to the comparison group and could receive services-as-usual if they wanted services.

Central Region Terminology

INTERVENTION GROUP: The families assigned to the intervention group. In the Central Region, families were assigned at the start of the project. Outreach occurred with all families assigned to the intervention group in the Central Region.

TARGET PARTICIPANTS (ALSO CALLED TREATMENT PARTICIPANTS): Families who participated in the intervention, and received at least 4 TARGET sessions.

COMPARISON GROUP: Families assigned to the comparison (or control) group. In the Central Region, random assignment into the comparison group occurred prior to the start of the project. Outreach workers did not contact families assigned to the comparison group. These families were eligible to receive services as usual.

MATCHED COMPARISON GROUP: Statistically significant differences were observed when comparing TARGET participants to the comparison group on baseline measures of caregiver commitment (i.e., caregiver relationship and commitment variables assessed at pretest). Thus, propensity score analysis was conducted using matched groups, to provide a less biased comparison of outcomes. This group is referred to as a matched comparison group. Although differences are still possible between groups using propensity score matching, particularly on unobserved characteristics, it provides an alternative way to examine intervention effects, with some control for potential participation biases after randomization.

The response rates associated with these two groups is found in Table 6.7. Because the comparison group was not contacted in advance of the survey, the number of participants in this group is much larger than the comparison group in Cook County.

Table 6.7. Central Region: Primary Outcome Survey Response Rate

CENTRAL REGION	SURVEYS SENT (N)	RESPONDED (N)	RESPONSE RATE
COMPARISON GROUP	513	281	55%
TARGET PARTICIPANTS	66	49	74%

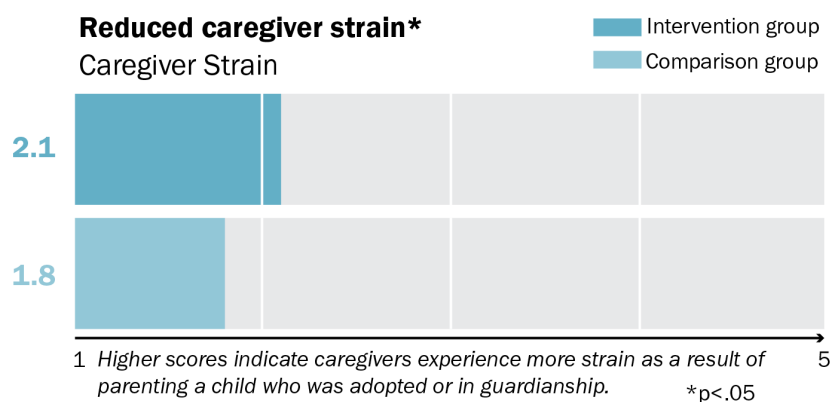
As noted above, the randomized consent design was used in the Central Region. Randomization resulted in statistically equivalent groups when comparing characteristics of the intervention and comparison groups overall. However, TARGET participants were statistically different from the comparison group. Therefore, the results of the experimental design compared: 1) the TARGET participants with the overall comparison group and 2) the TARGET participants with a matched sample from the comparison group.

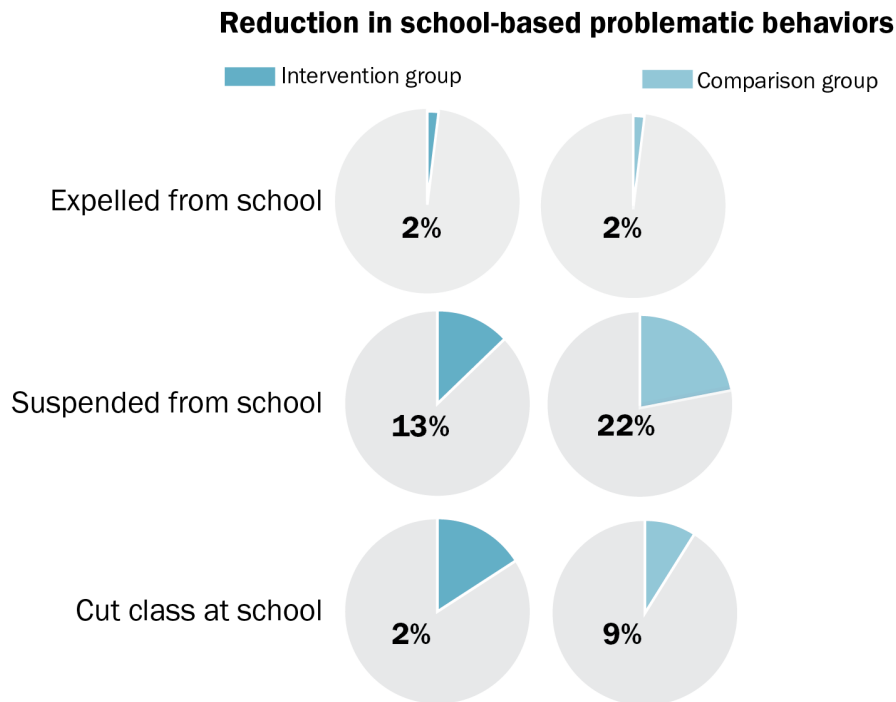
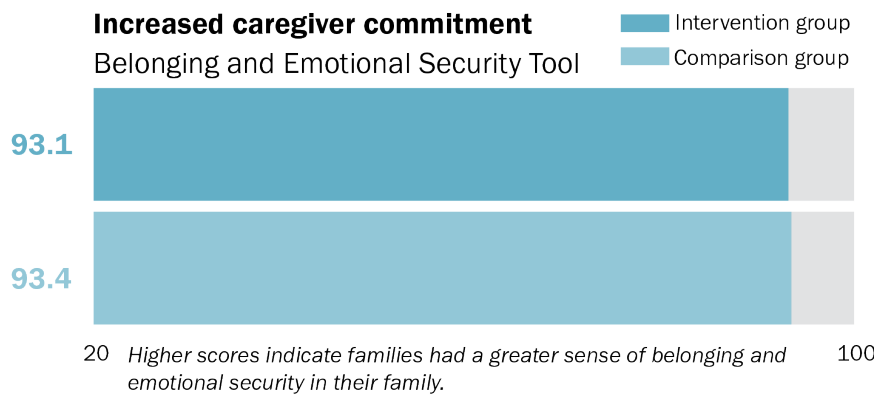
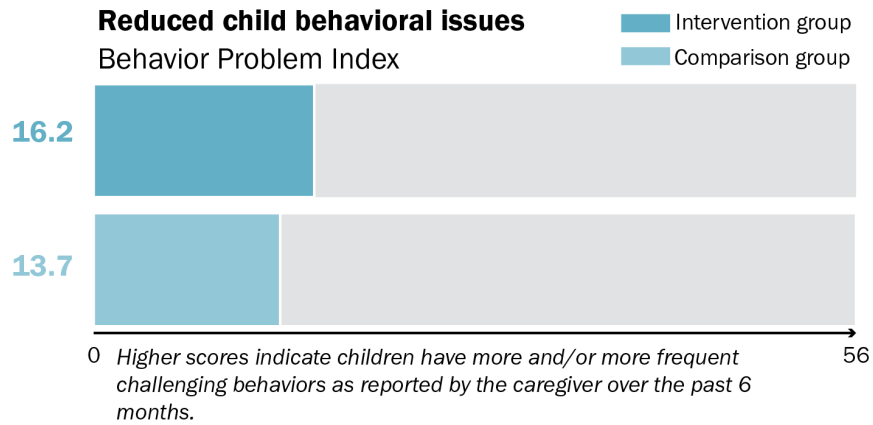
(1) TARGET participants compared with the entire comparison group

The analysis of short-term outcomes found little differences between the intervention and comparison groups on a few key measures. Primary outcomes are summarized below (Figure 6.12), and are duplicated in the Appendix, Table 6.16, where all subscales are included:

- **Behavioral Problem Index (BPI).** There was no statistically significant difference in the overall mean BPI scores between the treatment and comparison group (M= 16.22 and 13.74 respectively). However, higher levels of internalizing behavioral problems among the intervention group were observed relative to the comparison group (M=5.33 [SD=3.67] vs M=4.08 [SD=3.96], $p=0.043$ respectively).
- **Caregiver Strain (CS).** Results found statistically significant differences in the Caregiver Strain measure, (M= 2.07 and 1.80 respectively). In other words, caregivers in the comparison group fared better on this measure than caregivers in the intervention group.
- **Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG).** There were no statistically significant differences in the mean BEST-AG scores between the treatment and comparison group (M=93.06 in the treatment and 93.43 in the comparison group).
- **School-based behaviors.** There were no statistically significant differences between the treatment and comparison groups. However, similar to the results for Cook County summarized above, a smaller percentage of TARGET participants were suspended from school, and a smaller percentage cut classes, relative to the comparison group. However, this difference was not statistically significant, and caution should be used in interpreting these results given the small number of intervention participants.

Figure 6.12. Central Region Outcomes





It is important to note again that for both Cook County and the Central Region, TARGET participants were substantively different on baseline measures of caregiver commitment than families in the overall comparison group. These baseline differences between groups may explain the lack of statistically significant differences between groups. To help address this issue, the second comparison, presented next, attempted to control for differences in baseline measures of caregiver commitment between intervention and comparison groups.

(2) TARGET participants with a matched comparison group

A sensitivity analysis using propensity scores to match groups was conducted, to provide a somewhat less biased comparison of outcomes between intervention participants and a matched comparison group. Specifically, the evaluation team:

1. Matched a group of children from the intervention group ($n = 41$) to a group of children in the comparison group ($n = 41$), based on the values of four caregiver commitment variables measured at pretest: the extent to which caregivers struggled to manage their children's behavior, the level of warmth in the child-caregiver relationship, the amount of confidence caregivers had to meet children's needs, and the extent to which children had a positive impact on families. After matching, intervention participants and the matched comparison group were statistically similar on the four pretest caregiver commitment variables.
2. The outcome variables were compared at posttest for the two matched groups.²
3. Bivariate *t*-tests were run to examine whether ATEs were statistically significant for each outcome.

Findings showed no statistically significant differences between matched intervention and comparison groups, and therefore provided no evidence of an intervention effect for any of the primary outcomes (see Table 6.17 in the Appendix). Specifically, after matching between the treatment and comparison groups on the following measures, no statistically significant differences were observed in any of these measures:

- Behavioral Problem Index (BPI)
- Caregiver Strain (CS)
- Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG)
- School-based behaviors

Limitations

As with any research study, there were several limitations for the QIC-AG evaluation in Illinois. First, Illinois has provided proactive, family support services (e.g., crisis counseling) to adoptive and guardianship families since at least the early 1990's (Smith, Howard, & Monroe, 1991), and was one of the first states in the U.S. to provide subsidized guardianship as a permanency option to caregivers (Testa & White, 2014). Thus, the post permanency experiences of families in Illinois may not be representative of other states in the U.S.

² The Average Treatment Effect (ATE) was estimated for each outcome (average score [Comparison Group] – average score [Treatment Group]).

Another limitation for this study was that only a small proportion of the eligible population in both sites participated in the research, and a significant proportion of those who agreed to participate in TARGET did not actually receive the full intervention. For example, in Cook County, 41% (39) of the 95 families who were randomized to the intervention group participated in the intervention (at least the minimum required four sessions of TARGET). Participation was higher in the Central Region, perhaps due to the use of the random consent design (Zelen, 1979, 1990), which may be useful for increasing participant enrollment in child welfare studies (Testa & White, 2014). In Central Region, 70% (66) of those caregivers who agreed to participate in the intervention attended at least four sessions of TARGET. These findings show the limitations and potential biases of sophisticated, randomized evaluation designs in child welfare research. Specifically, external validity may be compromised when only a small proportion of the eligible population agrees to participate in the study, and internal validity may also be compromised when those who agree to participate do not actually complete the required, full intervention (or the full “dose”) at significant rates, a problem analogous to attrition in medical intervention studies. This problem with internal validity limits what is supposed to be a key advantage of random assignment to intervention groups: making groups comparable on baseline characteristics. But as noted above, it is unclear from the results whether non-participation in TARGET among those who were eligible led to biases in the outcome results, and future studies that examine TARGET with adoptive or guardianship families should specifically examine this potential issue.

Related to low intervention uptake, a final limitation of this study was that a small number of families had outcome data available for analyses (105 families in both sites combined). This meant diminished power to detect statistically significant differences between intervention and comparison groups. This limitation of small sample size, combined with a fairly small observation window to observe changes among the intervention group from enrollment until outcome data collection (i.e., about 6 months), made detecting any changes due to the intervention very challenging. Thus, future studies should increase sample sizes and observe families for longer periods of time to examine if TARGET has an impact on longer-term wellbeing or placement instability outcomes. However, the current study should be helpful for future research, to provide information about what proportion of families are likely to engage, the types of families who are likely to engage with TARGET and a better understanding of how families who have adopted or assumed guardianship are faring. As previously stated, the upside to the low uptake rates is that the majority of families reported not needing services at this time. This should help alleviate fears in jurisdictions that are considering offering post permanency services and supports, that they should not expect a large proportion of families to express a need for additional services.

Thoughts from Adoptive Parents and Guardians

At the end of the primary outcome survey sent to all adoptive parents and guardians, we asked respondents, *“Is there anything else about your experience of adoption or assuming guardianship of your child that you would like to share?”* Their responses reflect a wide variety of experiences within the narrow target population that we defined. Over 500 families (40% of respondents) provided us with their thoughts on their experiences. For those interested in helping families formed through adoption or guardianship, the direct responses from parents and guardians may assist in thinking through what is needed. Regarding the experience of being an adoptive parent or guardian:

The word “love” or “loved” is mentioned 114 times. There were 204 adoptive parents or guardians that commented on their positive experience with their adoptive or guardian child, and 20 commented about negative experience with their adoptive or guardian child. Here are several quotes from adoptive parents or guardians involved in this study:

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

"Just that I've adopted a wonderful son who and will always be a very big part of our family, and I don't use the word adopted; he is my son, period."

"My adoption experience has been positive. I think adoption can be more positive depending on the age of a child and the amount of information known about the child prior to finalization of the adoption."

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

"My adoption worker really worked hard to prepare for all possible needs when writing our subsidy. My daughter is a beautiful 17-year-old. We love her very much. Having raised 9 other children (3 adopted/6 bio), we thought we knew what to expect but this generation is more challenging!"

"We don't recommend to anyone that they adopt from foster care."

"We also adopted his bio sister who can now not live here because she is too dangerous."

Regarding things that have worked, or not, and thoughts on what could be improved, 98 adoptive parents and guardians commented about what has not worked, 15 commented on what has worked, examples include:

"It's been hard. I still have a 24-year old I adopted she don't want to work. I had a 22-year old that still feels like I owe her something, always begging, has a baby of her own... it does not stop."

"I have another adopted son. He [has] on-going emotional challenges. I was forced to do a lock-out on him after he was hospitalized multiple times. This was the only way to get him properly diagnosed and medicated."

"When children are in DCFS and get an IEP, DCFS should offer more help to these children. Schools do not want to support children that are through DCFS. Ever since my daughter has been in school I had to fight for services."

"The agency needs to be more willing to help a struggling family. My son has drug problems and needed to be in a drug residential treatment center for help with his drug problem before something happens that can damage for the rest of his life."

"I had a great adoption worker and attorney, therefore making it a smooth process."

"More guidance or support...She's 15 and wants to know her family history, especially on dad's side, never knew him."

"My adoption worker really worked hard to prepare for all possible needs when writing our subsidy."

"I feel that the social worker should call and check-up. I reached out for help and help was never given."



Cost Evaluation

The Illinois QIC-AG project implemented and tested the effectiveness of TARGET, an intervention that teaches youth and parents about trauma and skills to manage trauma responses. The project served 105 families formed by adoption and guardianship, across the two Illinois sites.

Cost Evaluation Approach

The cost-effectiveness research (CER) analysis provides information for policymakers and administrators to help maximize desired outcomes based on the associated cost of achieving them (Meunnig, 2002). CER analysis was applied to the outcomes identified by Illinois.

Assumptions, Conditions, and Constraints

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

ASSUMPTIONS

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

We also assume multiple positive outcomes are likely impacted by the QIC-AG site programs. For TARGET, the desired impact of the programs is to improve behavioral health and wellbeing. However, other positive outcomes may not necessarily be captured within the intervention. A final assumption is that the resource allocation captured in costs paid to sites is accurate. It is likely that staff time may be over or under-budgeted depending on the time constraints. For example, at the beginning of an intervention, more staff effort may be needed, but as a program continues, staff effort may be less intense because of the familiarity with the intervention.

CONSTRAINTS

Constraints are factors that have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For Illinois, constraints may include the availability and costs associated with the intervention purveyor, the availability of TARGET-trained facilitators in the locations where interested families reside. A constraint might also be agency staff turn-over, and state employees (internal to DCFS) who serve as champions for the project and oversee its implementation, and state budgetary concerns.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. For Illinois, conditions include the state's prior familiarity with implementing the intervention, the availability of TARGET-trained facilitators who were trained by prior to the start of this project. The ready availability of an on-line database at DCFS that can be easily modifiable for use on this project. Prior experience with rigorous research designs within the state.

Cost Estimation

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

KEY POINTS IN COST ESTIMATION

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

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. Prior to implementation, Illinois's intervention site, The Department of Children and Family Services, had substantial infrastructure as a state agency. Infrastructure costs specific to these non-profits were not estimated for this cost evaluation. The sites also received substantial technical support from consultants and evaluators during implementation. Although the consultation was crucial to moving sites into implementation, the costs associated with the consultation will only be noted in the conclusion as additional costs for future programs to consider. Evaluation costs are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates.

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

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

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

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

COST ESTIMATION STEPS

The steps involved in the cost estimation of this analysis are described below. All QIC-AG sites used a standardized budget form and cost reimbursement form. Costs for Illinois were taken from monthly budget forms and summarized into Table 6.8.

Table 6.8. Costs for Illinois

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL COSTS				
SITE IMPLEMENTATION MGR- SALARY	\$24,460	\$66,237	\$62,910	\$153,608
SITE IMPLEMENTATION MGR- FRINGE	\$369	\$4,953		\$5,321
NON-PERSONNEL DIRECT COSTS				
CONTRACTED SERVICES: ATS	\$1,742	\$65,056	\$56,051	\$122,848
CONTRACTED SERVICES: FAMILYCORE		\$24,755	\$6,252	\$31,007
CONTRACTED SERVICES: LEXISNEXIS		\$2,758	\$4,624	\$7,382
CONTRACTED SERVICES: NORTHWESTERN	\$3,697	\$17,955	\$3,135	\$24,787
CONTRACTED SERVICES: THE BABY FOLD	\$51,051	\$160,278	\$153,712	\$365,042
CONTRACTED SERVICES: THE CRADLE		\$1,146	\$2,343	\$3,489
CONTRACTED SERVICES: HEALTHY FAMILIES CHICAGO		\$10,858		\$10,858
CONTRACTED SERVICES: METROPOLITAN FAMILY SERVICES		\$22,962		\$22,962
CONTRACTED SERVICES: VIDEO SERVICES		\$2,500		\$2,500
CONTRACTED SERVICES: COMMUNICATION	\$7,034	\$20,354		\$27,389
GIFT CARD INCENTIVES		\$4,290	\$487	\$4,777
POSTAGE		\$2,372	\$747	\$3,119
PROGRAM SUPPLIES	\$947	\$3,588	\$4,615	\$9,151
TELEPHONE	\$371			\$371
INDIRECT COSTS				
DISSEMINATION COSTS			\$41	\$41
IT SUPPORT		\$473	\$4,463	\$4,935
OTHER: ASAP TRAINING		\$4,784		\$4,784
OTHER: TARGET TRAINING		\$185	\$1,819	\$2,004
TRAVEL		\$838	\$3,464	\$4,302
TOTAL	\$89,671	\$416,341	\$304,664	\$810,676

*FY2019 ended 3/31/19

**FY2017 began 3/1/17

Collect Data on Resource Costs

In order to collect accurate information, monthly expense forms were used to track actual costs. All QIC-AG sites developed an annual budget. The actual costs billed to QIC-AG were provided to the evaluation team via monthly expense reports. These expense reports contained a year-to-date summary of expenses. Expenses for each fiscal year were then compiled into Table 6.8.

Collect Data on Resource Allocation

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

Estimation of Direct Costs

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

Personnel

Personnel costs totaled \$163,890 for staff time allocated to the project during the implementation phase. Personnel costs only included the salary of the SIM.

Fringe

Overall fringe for all employees totaled \$5,321. Fringe was calculated based on state guidelines.

Contractual Expenses

Illinois contracted for services from ten entities.

- *Advanced Trauma Solutions (ATS)*. Advanced Trauma Solutions, Inc. (ATS) is the purveyor of TARGET. Costs are for consultations, fidelity and adherence reviews.
- *Northwestern*. Northwestern University provided training to facilitators in TARGET.
- *Baby Fold*. Baby Fold is a private agency in the Central Region of Illinois. Outreach workers and TARGET facilitators were employed by this agency and paid for by the program.
- *The Cradle*. The Cradle is a private adoption agency. Staff were paid to recruit private and intercountry adoptive families to participate in TARGET.
- *LexisNexis*. LexisNexis was used as a look-up agency, where the evaluation team would submit family contact information, and LexisNexis would return the most current contact information.
- *Family Core*. Family Core is a private agency in the Central Region of Illinois. Outreach workers and TARGET facilitators were employed by this agency and paid for by the program.
- *Healthy Families Chicago*. Healthy Families Chicago is a private non-profit agency that provided two facilitators the TARGET facilitators.

- *Communication Services.* A member of the Illinois Department of Children and Family Services, Department of Communications was hired to contribute Capacity Building activities.
- *Metropolitan Family Services.* Metropolitan Family Services is a private agency in the Chicago area. Additional part-time outreach coordinators were employed by this agency to assist with outreach in the Cook region.
- *Video Services.* A videographer who was employed by Spaulding for capacity building activities.
- *Adoption Support and Preservation Program.* ASAP are programs that are provided by private agencies throughout the state. These programs provide post adoption and guardianship children and families with a wide range of clinical, case management, advocacy, respite, and other support services. They are funded through the Illinois Department of Children and Family Services.

Gift Cards

Gift cards were provided to participants for completing surveys. A total of \$4,776 was spent on gift cards. To incentivize participation, \$25 gift cards were provided to each family at mid-point and at the conclusion.

Materials and Supplies

Over the implementation period, \$8,054 was spent on program supplies that were specific to the operation of the intervention.

Travel

Over implementation and installation, \$4,302 was paid for travel.

Facilities/Office Space

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

Other Direct Charges

Other direct charges include all non-personnel direct costs that do not fit into the categories listed above such as postage (\$3,118), and phones (\$371).

Estimation of Indirect Costs

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

IT Support

IT support includes all expenses related to IT including computers, contract with a person for IT work, database design, and software. Computer and IT network charges include \$6,000 and an additional \$4,935 for IT support.

Other

In addition, \$41 was spent on dissemination costs; \$4,784 for ASAP training; and \$2,004 was spent on TARGET training.

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

Summary of Costs

Total implementation costs for Illinois were \$810,676.

Cost Calculations

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

COST PER PARTICIPANT

Based on the total costs of \$810,676 and 105 participants, the cost per participant for this intervention was \$7,721.

COST-EFFECTIVENESS ESTIMATION

Because there were no statistically significant findings, a cost-effectiveness ratio was not calculated.

Sensitivity Analysis

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

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

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

1. The salary and fringe for the Site Implementation Manager were removed. At this site, the Site Implementation Manager was not needed to implement the actual intervention. This position served as a liaison with external entities and managed internal processes. The implementation can be managed by TARGET facilitators.
2. Gift cards were removed from the cost calculation. Gift cards were provided to thank people for their time in completing evaluation materials.
3. Program supplies not related to Family Group Decision Making materials were excluded.
4. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings.
5. Fees related to postage, phone, IT support and dissemination costs were removed.
6. The amount of payment to The Baby Fold was reduced in 2019 because roughly \$9,000 of funds were used for non-intervention related capacity building.
7. In year five, the amount paid to Northwestern was reduced because it was related to capacity building.
8. The amount paid to Communications Specialist was removed because that related to capacity building.
9. The amount paid to the videographer was removed because it was related to capacity building.
10. LexisNexis costs were removed. These costs were to assist in locating families to advertise the intervention. Other agencies would likely provide these services to their own clients.
11. Other direct charges were also excluded. These expenses were not necessary for the implementation of the intervention.
12. Indirect charges were also excluded. Indirect costs will vary extensively by different agencies. In some cases, agencies may have no additional indirect costs.

Based on these exclusions, Table 6.9 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was \$574,423 which amounted to \$5,471 per participant.

Table 6.9. Sensitivity Analysis: Adjusted Costs for Illinois

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
NON-PERSONNEL DIRECT COSTS				
CONTRACTED SERVICES: ATS	\$1,742	\$65,056	\$56,051	\$122,848
CONTRACTED SERVICES: FAMILYCORE		\$24,755	\$6,252	\$31,007
CONTRACTED SERVICES: NORTHWESTERN	\$3,697	\$17,955	\$3,135	\$24,787
CONTRACTED SERVICES: THE BABY FOLD	\$51,051	\$160,278	\$153,712	\$365,042
CONTRACTED SERVICES: THE CRADLE		\$1,146	\$2,343	\$3,489
CONTRACTED SERVICES: HEALTHY FAMILIES CHICAGO		\$10,858		\$10,858
CONTRACTED SERVICES: METROPOLITAN FAMILY SERVICES		\$22,962		\$22,962
INDIRECT COSTS				
OTHER: ASAP TRAINING		\$4,784		\$4,784
OTHER: TARGET TRAINING		\$185	\$1,819	\$2,004
TOTAL	\$43,132	\$307,978	\$223,313	\$574,423

*FY2019 ended 3/31/19

**FY2017 began 3/1/17

Cost Evaluation Summary

Based on the total costs of \$810,676 and 105 participants, the cost per participant for this intervention was \$7,721. However, the sensitivity analysis demonstrated that many costs could be reduced if the intervention were replicated. Thus, a more realistic cost of the project was \$574,423, which results in \$5,471 per participant.



Discussion

The QIC-AG project in Illinois tested TARGET, a strengths-based, psycho-educational intervention for children affected by trauma or exposed to adverse childhood experiences. This study extended previous research on TARGET to test the effectiveness of families formed through adoption and guardianship in two areas of Illinois: Cook County and the Central Region. Due to the different evaluation designs used in the two evaluation sites in Illinois (Cook County and specific counties within the Central Region), intervention-related results are presented for each evaluation site separately.

In Cook County, 39 families received the intervention, and 32 (82%) returned the primary outcome survey. In the Central Region, 66 families received the intervention and 49 (64%) returned the outcome survey. In addition, primary outcome surveys were administered to families in the comparison group, (46 were returned in Cook and 281 in Central). Based on the analysis of these data, the study did not find a strong intervention effect. In other words, on the outcomes measured (e.g., child behavioral issues and wellbeing measures) TARGET participants did not fare better than families who received services-as-usual. While not statistically significant, in both Cook County and Central Region, fewer school-based problematic behaviors were reported for children in the intervention group compared to children in the comparison group. However, the sample size was small, and the observation period rather limited (6 months).

It is possible that no intervention effects were observed in this study due to the limited observation window. Personal and interpersonal change is difficult and takes time, especially given the long history of trauma that many adoptive and guardianship youth have experienced due to maltreatment and previous placement moves (Jones & Schulte, 2019). The observation window in this study was only about 6 months post intervention. Thus, perhaps with additional time, and more families enrolled, different results regarding the TARGET intervention may have emerged.

One of the challenges of conducting prevention outreach is that it is difficult to know when an event has been prevented, such as post adoption and guardianship instability, since the goal is for the event to not occur. In prior research, and in this study, most families formed through adoption or guardianship report that they are doing well, with the supports and services they are currently receiving, and that they do not need additional services. As the project was unfolding, and the relatively low uptake rate was observed, one question that was asked was, are we reaching the right families? This study found that, in both Cook County and Central Region, families who chose to participate in the intervention were families who were struggling more. Specifically:

In Cook County families who said, ‘yes’ when the outreach worker asked them if they wanted to participate in the research study (agreed to be randomized into either the comparison or intervention group) were, on average:

- Less likely to report a warm relationship with their child
- Less confident that they could meet the needs of their child
- Less likely to report that the impact of their child’s adoption or guardianship on the family has been positive
- Less inclined to consider adopting or entering into guardianship again

They were also:

- More likely to struggle to effectively manage their child's behavior
- More likely to experience stress as a parent
- More likely to struggle to appropriately respond to their child
- More likely to think of ending the adoption or guardianship

For families in Cook County who said they were not interested in participating in the study, the majority (65%) reported that everything was fine and that they did not need services at that time.

In the Central Region, a similar pattern emerged in terms of the profile of families who selected into the intervention. On average, compared to the comparison group, TARGET participants reported that they were:

- Less likely to have a warm relationship with their child
- More likely to struggle to effectively manage their child's behavior
- Less confident that they could meet the needs of their child
- Less likely to report that the impact of their child's adoption or guardianship on the family has been positive

Similar to Cook County, 64% of families in the Central Region who spoke to a worker & declined services reported that everything was fine and that they did not need services at that time.

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

Consistent with previous studies on the experiences of adoptive and guardianship families, this study provides evidence that the majority of families are adjusting well (White, Rolock, Testa, Ringeisen, Childs, Johnson, & Diamant-Wilson, 2018). To enhance preventative services for adoptive and guardianship families, the field may want to identify families most at risk for instability. For example, researchers could examine rates of service utilization (e.g., mental health counseling or respite) or indicators of poor school adjustment (e.g., low grades, frequent referrals to in-school suspension) to indicate those families who most need services and supports, or responses to key questions that might suggest familial struggles (e.g., the caregiver-child relationship questions asked in this study).

The target population, families with children or youth with similar experiences and ages, was heterogeneous. There is a wide variety of families, with a wide variety of needs. Some of these families are struggling – the project has heard stories of families in crisis – and some seem to be doing well. In the primary outcome survey, parents and guardians were asked to share their experiences of adoption or guardianship. Their responses reflect this wide variety of experiences within the narrow target population that the project defined. Over 500 families (40% of respondents) provided reflections. Notably, the word “love” or “loved” is mentioned 114 times in their responses. Many reported positive responses (204 commented about their positive experience with their adoptive or guardian child):

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

"Just that I've adopted a wonderful son who and will always be a very big part of our family and I don't use the word adopted... he is my son period."

"My adoption experience has been positive. I think adoption can be more positive depending on the age of a child and the amount of information known about the child prior to finalization of the adoption."

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

"My adoption worker really worked hard to prepare for all possible needs when writing our subsidy. My daughter is a beautiful 17-year-old. We love her very much. Having raised 9 other children (3 adopted/6 bio) we thought we knew what to expect but this generation is more challenging!"

Some families (20) reported a negative experience with their adoptive or guardian child (e.g., "We don't recommend to anyone that they adopt from foster care," "The kids are angry with us, the people that raise them, 'cause they want their parents.>"). Some provided specific examples of what has not worked, for example:

"Finding psychiatric care for her was difficult."

"He has a lot of issues we were not told about prior to adoption."

"Our foster care agency was horrible."

Families also provided suggestions for what could be improved:

"When children are in DCFS and get an IEP. DCFS should offer more help for these children. Schools do not want to support children that are through DCFS. Ever since my daughter has been in school I had to fight for services."

"My child receives bimonthly therapy and medications to address mental health. I think this is something the needs more awareness."

"The agency needs to be more willing to help a struggling family. My son has drug problems and needed to be in a drug residential treatment center for help with his drug problem before something happens that can damage for the rest of his life."

"Need more resources to find locations for a neuropsychological evaluation. Somewhere that will take her insurance or have grants of funding to cover the cost of testing. We need more answers about her neurological development or lack thereof."

"More guidance or support...She's 15 and wants to know her family history especially on dad's side, never knew him."

"I feel that the social worker should call and check-up. I reached out for help and help was never given."

The majority of families reported positive adoption and guardianship experiences. Yet families also report ongoing issues, including service gaps, child emotional and behavioral difficulties, and limited agency support. In addition, project staff in one of the Illinois sites reported that many (over half) of the TARGET recipients became engaged in services-as-usual after receiving TARGET. This suggests that perhaps a single intervention is not what was needed for some of these families. Similar to other prevention efforts, preventing post permanency discontinuity and promoting the wellbeing of families formed through adoption and guardianship may require an approach that takes into account the diversity of issues families face. There are developmental considerations, cultural issues, lifestyle choices, and work or other life stressors that may need to be considered in future prevention work intended to better understand and support the needs of adoptive and guardianship families.



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Appendix

Table 6.10. Cook County: Baseline Differences Between Families Randomized into the Intervention and Families Not Randomized

COOK COUNTY: BASELINE DIFFERENCES BETWEEN FAMILIES RANDOMIZED INTO THE INTERVENTION AND FAMILIES WHO WERE NOT RANDOMIZED									
	RANDOMIZED			NOT RANDOMIZED			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	t	df	p
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	102	4.10	1.06	811	4.38	0.86	3.03	911	0.003
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	102	2.99	1.42	803	2.40	1.39	-4.00	903	<0.001
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	102	3.36	1.26	803	2.66	1.36	-4.94	903	<0.001
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	99	2.81	1.45	783	2.36	1.51	-2.82	880	0.005
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	101	3.97	0.92	813	4.23	0.87	2.82	912	0.005
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	101	1.52	0.87	812	1.34	0.78	-2.26	911	0.024
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	101	6.04	1.65	808	6.40	1.20	2.73	907	0.007
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	102	4.23	1.15	808	4.58	0.92	3.55	908	<0.001

Table 6.11. Cook County: Baseline Differences Between Families Randomized into the Comparison Group and TARGET Participants

COOK: BASELINE DIFFERENCES BETWEEN COMPARISON GROUP AND TARGET PARTICIPANTS									
	COMPARISON GROUP			TARGET PARTICIPANTS			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	t	df	p
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	65	4.03	1.15	37	4.22	0.89	0.85	100	0.397
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	65	2.86	1.47	37	3.22	1.32	1.22	100	0.226
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	65	3.32	1.34	37	3.43	1.12	0.42	100	0.675
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	63	2.76	1.48	36	2.89	1.43	0.42	97	0.678
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	64	3.94	0.99	37	4.03	0.80	0.47	99	0.640
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	64	1.56	0.96	37	1.46	0.69	-0.57	99	0.568
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	64	5.98	1.74	37	6.14	1.51	0.44	99	0.661
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	65	4.34	1.09	37	4.03	1.24	-1.32	100	0.190

Table 6.12. Central Region: Baseline Differences Between Families Assigned to the Comparison and Intervention Groups

CENTRAL: BASELINE DIFFERENCES BETWEEN COMPARISON AND INTERVENTION GROUP									
	COMPARISON GROUP			ALL INTERVENTION GROUP			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	t	df	p
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	212	4.18	0.93	247	4.15	0.98	0.33	457	0.742
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	211	2.46	1.25	244	2.61	1.33	-1.20	453	0.231
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	210	3.15	1.33	246	3.17	1.26	-0.22	454	0.823
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	211	2.36	1.33	246	2.47	1.44	-0.89	455	0.374
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	210	4.24	0.89	248	4.16	1.02	0.90	456	0.370
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	213	1.29	0.78	249	1.31	0.78	-0.19	460	0.846
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	212	6.15	1.58	247	6.02	1.68	0.85	457	0.396
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	213	4.60	0.94	249	4.55	0.85	0.50	460	0.614

Table 6.13. Central Region: Baseline Differences Between Families Randomized into the Comparison Group and TARGET Participants

CENTRAL: BASELINE DIFFERENCES BETWEEN FULL C AND PARTICIPANTS									
	COMPARISON			TARGET PARTICIPANTS			BASELINE DIFFERENCES		
	N	M	SD	N	M	SD	t	df	p
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	212	4.18	0.93	42	3.81	1.06	2.30	252	0.022
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	211	2.46	1.25	41	2.98	1.33	-2.36	250	0.019
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	210	3.15	1.33	42	3.45	1.27	-1.36	250	0.174
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	211	2.36	1.33	42	2.67	1.44	-1.37	251	0.173
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	210	4.24	0.89	42	3.88	1.09	2.28	250	0.023
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	213	1.29	0.78	42	1.45	0.97	-1.18	253	0.240
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	212	6.15	1.58	42	5.36	1.95	2.84	252	0.005
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	213	4.60	0.94	42	4.62	0.85	-0.15	253	0.884

Table 6.14. Central Region: Baseline Comparisons Within the Intervention Group

CENTRAL: WITHIN INTERVENTION GROUP (NON-PARTICIPANTS VS FULL PARTICIPANTS)									
	NON-PARTICIPANTS			TARGET PARTICIPANTS			BASELINE DIFFERENCES WITHIN INTERVENTION		
	N	M	SD	N	M	SD	t	df	p
DESCRIBE THEIR RELATIONSHIP WITH THEIR CHILD	205	4.22	0.95	42	3.81	1.06	2.5	245	0.013
STRUGGLED TO EFFECTIVELY MANAGE THEIR CHILD'S BEHAVIOR IN THE LAST 30 DAYS	203	2.54	1.32	41	2.98	1.33	-1.93	242	0.055
EXPERIENCED STRESS AS A PARENT IN THE LAST 30 DAYS	204	3.12	1.25	42	3.45	1.27	-1.57	244	0.117
STRUGGLED TO APPROPRIATELY RESPOND TO THEIR CHILD IN THE LAST 30 DAYS	204	2.43	1.44	42	2.67	1.44	-0.96	244	0.336
HOW CONFIDENT THAT THEY CAN MEET THE CHILD'S NEEDS?	206	4.21	0.99	42	3.88	1.09	1.95	246	0.053
HOW OFTEN THINK OF ENDING THE ADOPTION OR GUARDIANSHIP?	207	1.28	0.74	42	1.45	0.97	-1.33	247	0.183
IMPACT OF THEIR CHILD'S ADOPTION OR GUARDIANSHIP ON THEIR FAMILY?	205	6.15	1.60	42	5.36	1.95	2.82	245	0.005
IF THEY KNEW EVERYTHING ABOUT THEIR CHILD BEFORE THE ADOPTION OR GUARDIANSHIP THAT THEY NOW KNOW, WOULD THEY HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF HIM/HER?	207	4.54	0.85	42	4.62	0.85	-0.54	247	0.589

Table 6.15. Cook County Outcomes

COOK COUNTY		INTERVENTION PARTICIPANTS						COMPARISON GROUP							
MEASURE		N	M	SD	MIN	MAX		N	M	SD	MIN	MAX	t	df	p
BEHAVIORAL ISSUES															
BEHAVIORAL PROBLEM INDEX		32	15.92	12.31	0	43		42	14.44	11.89	0	43	0.89	106	0.375
BPI - EXTERNALIZING		32	11.11	8.62	0	30		42	10.69	8.57	0	32	0.74	106	0.463
BPI - INTERNALIZING		32	5.44	5.11	0	17		42	4.44	4.50	0	16	0.98	106	0.331
CAREGIVER STRAIN															
CAREGIVER STRAIN (CS)		32	2.07	0.77	1	4		46	1.99	0.86	1	5	0.53	108	0.599
CS - OBJECTIVE STRAIN		32	1.90	0.96	1	4		46	1.68	0.90	1	4	1.3	108	0.195
CS - SUBJECTIVE STRAIN		32	2.21	0.73	1	4		46	2.25	0.92	1	5	-0.27	108	0.791
CAREGIVER COMMITMENT															
BEST-AG		32	93.84	5.09	81	100		46	93.26	6.87	74	100	-0.5	111	0.617
BEST-AG EMOTIONAL SECURITY		32	59.56	4.13	49	65		46	59.74	4.74	47	65	-0.72	111	0.476
BEST-AG CLAIMING		32	34.28	1.51	28	35		46	33.52	2.62	23	35	0.01	111	0.993
MEASURE		N	%					N	%				χ2	df	p
SCHOOL-RELATED OUTCOMES															
HAVE CUT CLASSES AT SCHOOL		5	16%					15	33%				2.56	1	0.110
HAVE BEEN SUSPENDED FROM SCHOOL		5	16%					16	35%				3.25	1	0.072
HAVE BEEN EXPELLED FROM SCHOOL		3	10%					5	11%				0.50	1	0.479

Table 6.16. Central Region Outcomes

CENTRAL REGION		INTERVENTION PARTICIPANTS					COMPARISON GROUP							
MEASURE		N	M	SD	MIN	MAX	N	M	SD	MIN	MAX	t	df	p
BEHAVIORAL ISSUES														
BEHAVIORAL PROBLEM INDEX		48	16.22	11.04	0	42	276	13.74	11.97	0	50	1.34	322	0.180
BPI - EXTERNALIZING		48	11.71	8.27	0	34	276	10.29	8.92	0	38	1.03	322	0.305
BPI - INTERNALIZING		48	5.33	3.67	0	15	276	4.08	3.96	0	19	2.04	322	0.043
CAREGIVER STRAIN														
CAREGIVER STRAIN (CS)		47	2.07	0.75	1	4	272	1.80	0.79	1	5	2.14	317	0.033
CS - OBJECTIVE STRAIN		47	1.86	0.80	1	4	272	1.61	0.84	1	5	1.9	317	0.059
CS - SUBJECTIVE STRAIN		47	2.24	0.80	1	4	272	1.97	0.81	1	5	2.17	317	0.030
CAREGIVER COMMITMENT														
BEST-AG		48	93.06	7.64	58	100	278	93.43	9.48	27	100	-0.26	324	0.797
BEST-AG EMOTIONAL SECURITY		48	59.23	6.11	33	65	278	59.87	6.65	16	65	-0.63	324	0.532
BEST-AG CLAIMING		48	33.83	2.02	25	35	278	33.56	3.22	11	35	0.57	324	0.572
MEASURE		N	%				N	%				χ2	df	p
SCHOOL-RELATED OUTCOMES														
HAVE CUT CLASSES AT SCHOOL		1	2%				25	9%				2.73	1	0.099
HAVE BEEN SUSPENDED FROM SCHOOL		6	13%				61	22%				2.25	1	0.133
HAVE BEEN EXPELLED FROM SCHOOL		1	2%				6	2%				0.00	1	0.960

The results of propensity score matching, shown in Table 6.17, indicated no statistically significant Average Treatment Effects (ATE). The ATE's were estimated as mean differences between intervention and comparison groups for each outcome. Intervention and comparison groups were matched using four caregiver commitment and relationship questions measured at pretest³. The initial matched data set contained 82 matched cases (41 intervention and 41 comparison), but only 62 of these cases (32 intervention and 30 comparison) were available for the analyses due to some cases missing data on the outcomes.

Table 6.17. Central Region: Comparison of Outcomes for TARGET Participants and Comparison Groups: Average Treatment Effect

CENTRAL REGION: COMPARISON OF OUTCOMES FOR TARGET PARTICIPANTS AND COMPARISON GROUPS A:					
OUTCOMES	AVERAGE TREATMENT EFFECT (ATE) B			t	p
	ATE	95% CI			
BEHAVIORAL PROBLEM INDEX (BPI)	-3.48	-8.88	1.92	-1.29	0.202
BPI - INTERNALIZING	-1.21	-3.04	0.61	-1.33	0.189
BPI - EXTERNALIZING	-2.39	-6.41	1.63	-1.19	0.240
BEST-AG	0.80	-4.05	5.65	0.33	0.743
BEST-AG CLAIMING	0.28	-1.04	1.59	0.42	0.676
BEST-AG EMOTIONAL SECURITY	0.52	-3.17	4.22	0.28	0.778
CAREGIVER STRAIN (CS)	-0.21	-0.61	0.18	-1.10	0.276
CS - SUBJECTIVE STRAIN	-0.21	-0.65	0.23	-0.96	0.340
CS - OBJECTIVE STRAIN	-0.22	-0.62	0.17	-1.12	0.268

Notes:

^a Nearest neighbor within-caliper matching, with the logit used as the propensity score, and caliper = .25 * standard deviation

^b ATE = Mean (Comparison Group) – Mean (Intervention Group)

³ The four questions used for matching were: (1) Which phrase best describes your relationship with your child? [Responses on a 5-point scale from 'not at all warm' to 'extremely warm'], (2) How often have you or your significant other struggled to effectively manage your child's behavior in the last 30 days? [Responses on a 5-point scale from 'never' to 'every day'], (3) How confident are you that you can meet your child's needs? [Responses on a 5-point scale from 'not at all confident' to 'extremely confident'], and (4) Overall, how would you rate the impact of your child's adoption or guardianship on your family? [responses on a 7-point scale from 'extremely' negative to 'extremely positive']

Chapter 10

CROSS-SITE EVALUATION

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Overview

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

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

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

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

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



Cross-Site Results

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

Engagement with Adoptive and Guardianship Families

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

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

SERVICE ENGAGEMENT FOR SELECTIVE PREVENTION SITES

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

- In the Central Region of Illinois, of the 557 families assigned to the intervention group, staff were able to successfully make contact with 53% of families, and ultimately 12% of those families targeted for outreach participated in the intervention.
- In New Jersey, of the 769 families assigned to the intervention group, staff were able to successfully make contact with 57% of families, and ultimately 12% of those families targeted for outreach participated in the intervention.

CENTRAL REGION, IL



NEW JERSEY



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

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

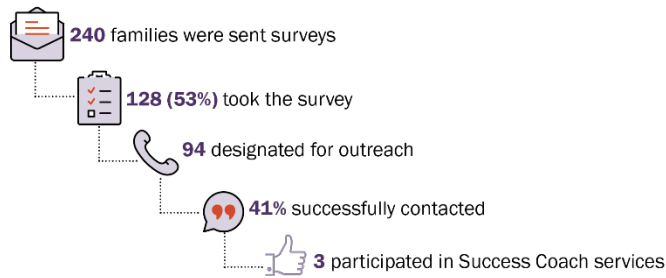
- Less confident that they could meet the needs of their child
- More likely to struggle to effectively manage their child’s behavior
- More likely to struggle to appropriately respond to their child

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

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

SERVICE ENGAGEMENT FOR INDICATED PREVENTION SITES

CATAWBA COUNTY (NC)



In Catawba County, the working hypothesis was that there were families in need of post adoption services who either did not know about the services or were unable to access the services. During the project period, 240 families in Catawba County were sent surveys. Of those 240 families, 53% (128) completed and returned surveys. Of the 128 families who returned surveys, 94 were designated for outreach. Of the 94 families designated for outreach, 41% (39) parents

were subsequently successfully contacted by Catawba County staff to assess their interest in Success Coach services. A total of 3 families signed service agreements and participated in Success Coach services. Families who were contacted through outreach but declined services largely reported they did not need extra support.

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

Survey Response Rates

Surveys were sent to families in Vermont, Catawba County (NC), Illinois and New Jersey¹. In Vermont, the survey could be completed electronically or by pen and paper. In all the other sites, the surveys were pen and paper only. In Catawba, Illinois, and New Jersey a pre-paid cash incentive was also included. A variety of methods were used to encourage participants to return the surveys: sites sent emails, made phone calls, and followed up with non-responders in a series of assertive outreach efforts. The sites also engaged a look-up service to acquire the most recent contact information for families. Surveys were sent to adoptive parents and guardians who were asked to respond to the survey focusing on one target child per family. Surveys assessed caregiver’s experiences related to adoption or guardianship (for example, respondents completed standardized measures, such as the Caregiver Strain scale, the Behavior Problem Index, and questions related to caregiver commitment, familial relationships, and service needs and use).

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

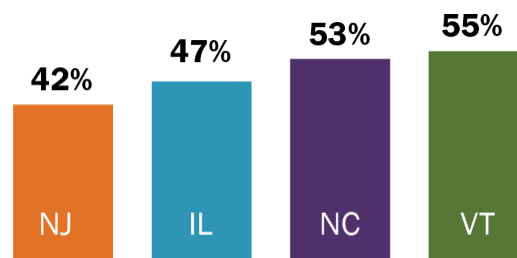
¹ The survey responses from Illinois and New Jersey discussed in this section are from the primary outcome surveys only.

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

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

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

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



Overall Response Rates

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

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

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

SERVICE ENGAGEMENT SUMMARY

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

Service Needs and Use

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

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

SURVEYS IN VERMONT AND CATAWBA COUNTY (NC)

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

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

Table 10.2. Vermont Service Use in Past 6 Months

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

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

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

SUMMARY OF SERVICE NEEDS FROM WISCONSIN, ILLINOIS AND NEW JERSEY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SERVICE NEEDS AND USE SUMMARY

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

Outcomes

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

- In Vermont, the project was able to provide a robust assessment of the needs, characteristics, and strengths of families formed through adoption and guardianship. The Vermont site developed an understanding of families who are struggling and those who seem to be doing well. Caregivers who would definitely adopt or assume guardianship of their child again had higher levels of resilience, open communication, perseverance in times of crisis, and more positive parent-child interaction compared to caregivers who indicated they were uncertain or definitely would not adopt or assume guardianship again. The “definitely adopt or assume guardianship again” group had less strain attributed to parenting their child and more confidence in knowing how to meet their child’s needs. Additionally, they felt more prepared at the time of their child’s finalization and used fewer services in the past six months than those who expressed hesitancy to adopt or assume guardianship again.
- In Illinois, intervention participants were struggling more than families who did not participate in the intervention. Yet, this study did not find that TARGET participants fared better than children in the comparison group on the outcomes measured (e.g., child behavioral issues and wellbeing measures). It is possible that no intervention effects were observed due to the limited observation window of about 6 months post intervention. With additional time, perhaps differences between the intervention participants and families assigned to the comparison group will emerge. It is also possible that families in Illinois needed something different than TARGET. Additional research is needed to develop next steps in Illinois.
- In New Jersey, no statistically significant differences were found between the TINT intervention participants and the overall comparison group and between the TINT participants and a sample of the matched comparison group on the key measures of child and family wellbeing. However, promising trends suggest that with additional time, statistically significant differences may emerge. Specifically, caregivers who participated in the intervention tended to feel better able to manage their child’s behavior, which is a key factor related to post permanency stability and family wellbeing. An extended observation period in New Jersey would enhance our understanding of these issues.
- In Wisconsin, parents and guardians reported that service providers often did not listen to them or believe how bad it could be at home. Results indicated that families felt supported when the AGES workers made home visits, listened to families’ concerns, and provided support and advocacy with other service providers or systems. The AGES workers were

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

- In Catawba County (NC), families who needed post adoption services and supports were largely already engaged in services through the existing outreach methods and service delivery systems. Few additional families requested Success Coach services as a result of Reach for Success. However, through the outreach survey sent to adoptive families, a profile of family characteristics, services sought and received, and responses to key measures related to post adoption stability provided valuable information to the child welfare agency to design future post adoption and guardianship interventions and supports.
- In Tennessee, compared to neuro-typical children their age, children and youth who participated in the intervention saw an increase, over baseline, of their functioning on key domains measured through the NMT Metrics. Importantly, a decrease in BPI scores from pretest to posttest, stronger for the intervention group compared to the comparison group, was observed. Trends found in this study are promising, but more research using a larger sample and a longer observation window is needed. Post adoption services should be designed to help children and families cope with prior experiences of trauma and placement instability.

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

Limitations

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

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



Examining Post Permanency Discontinuity

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

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

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

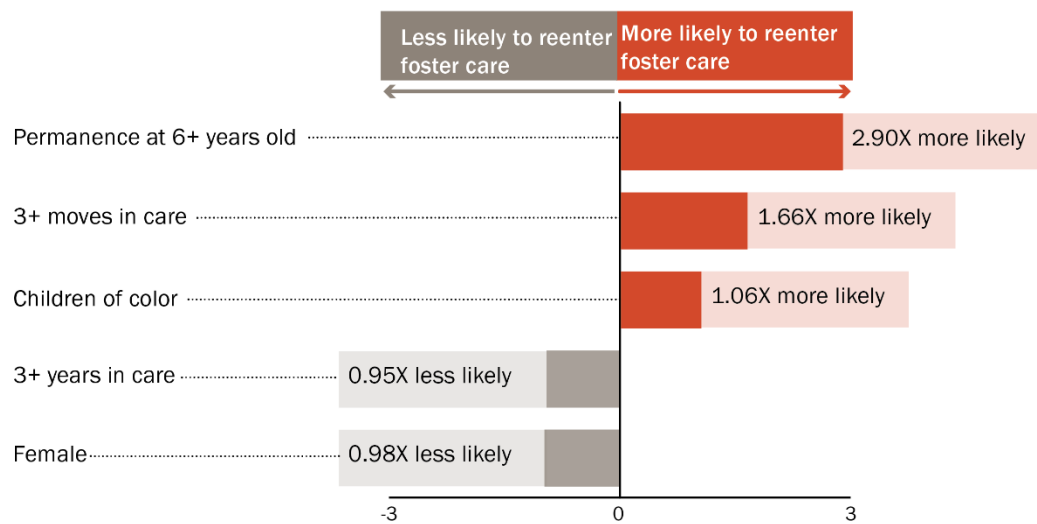
In sites that used BPI and caregiver commitment measures, families were compared across the continuum to see if there were differences in the families targeted for outreach. Specifically, it was hypothesized that families targeted for outreach at the Universal level would, on average, have low-risk scores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

Post Permanency Discontinuity

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

- Children aged six or older at the time of finalization were 2.9 times more likely to reenter foster care compared to children whose adoption or guardianship was finalized prior to the age of six.
- Children who had three or more moves in foster care were 66% more likely to reenter foster care, compared to children who had less than three moves while in foster care.
- Children of color (compared to White children) were 6% more likely to reenter foster care.

Figure 10.1. Characteristics of Children Most Likely to Reenter Foster Care after Adoption or Guardianship



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

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

Analysis Along the Prevention Continuum

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

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

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

- For this section of the report, Vermont and Catawba County (NC) are classified as Universal outreach. Although the Catawba intervention (Reach for Success) was an Indicated intervention, the initial survey sent to all adoptive families in the county who had not been previously engaged in post adoption services was a Universal outreach effort. This section grouped Vermont and Catawba results to examine Universal outreach data.
- For the analysis of data from Illinois and New Jersey, intervention participants were removed because we did not want to confound these findings with the effect of the intervention. In other words, for this section we are analyzing the characteristics of families identified in the Selective interval, not describing the impact of the intervention.
- In Wisconsin data were collected at **intake**, prior to participation in the intervention. This baseline data was used to understand the profile of families who indicate that they may be having some difficulty, and to compare their outcomes to families who responded to surveys in the other sites.
- The number of respondents varied by site. There is greater confidence in the results of sites where there are more respondents. In particular, caution should be exercised in the interpretation of the Wisconsin findings, given the lower number of respondents and the wide variety of types of adoptions or guardianships served in that site (please see the Wisconsin report for additional information).
- Not all sites collected the same information; therefore, some sites will not be represented in the graphs showing site-specific results.

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

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

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

Behavioral Problem Index (BPI)

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

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

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

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

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

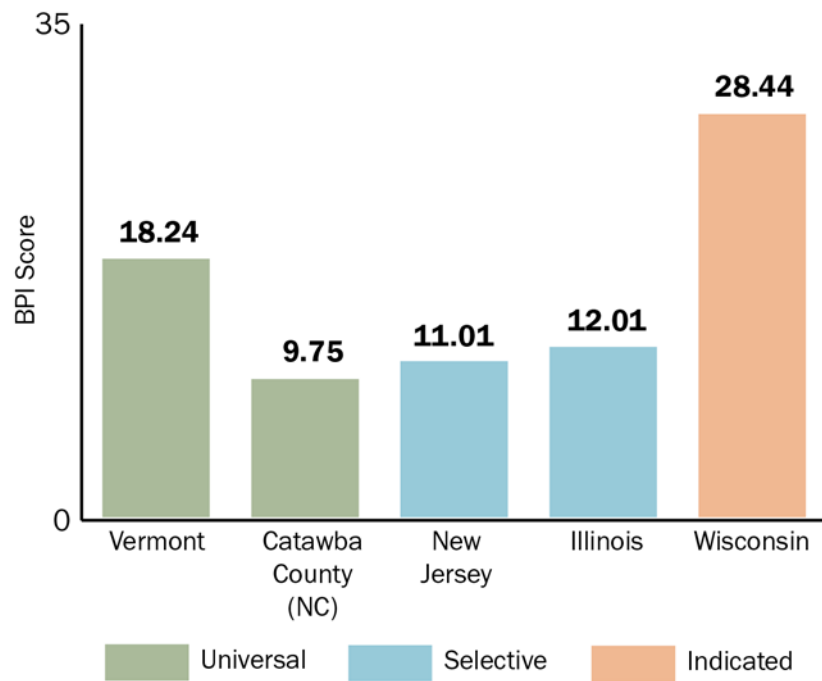


Figure 10.2 note: It should be noted that we expect to see higher levels of behavior problems in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are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

Caregiver Strain

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

Figure 10.3. Mean Caregiver Strain Scores by Site

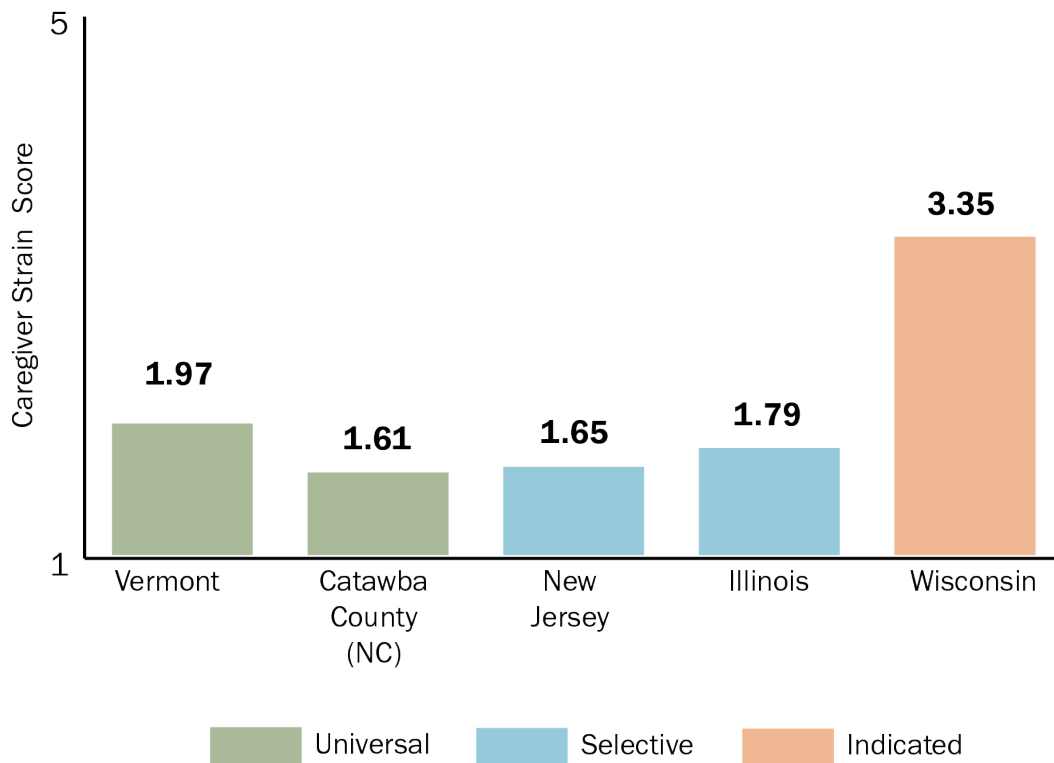


Figure 10.3 note: It should be noted that we expect to see higher levels of caregiver strain in the site that is serving families who reach out to request assistance (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin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

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

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

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

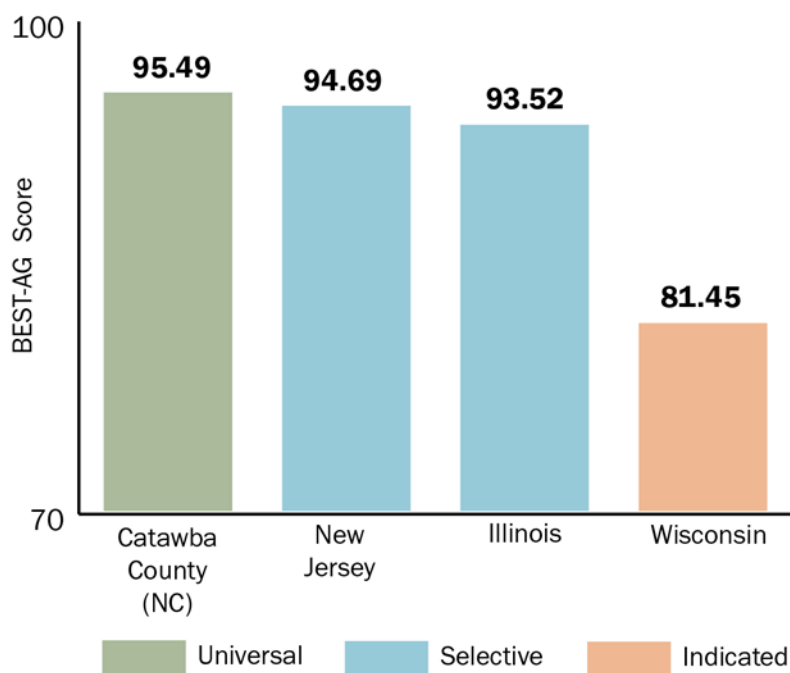


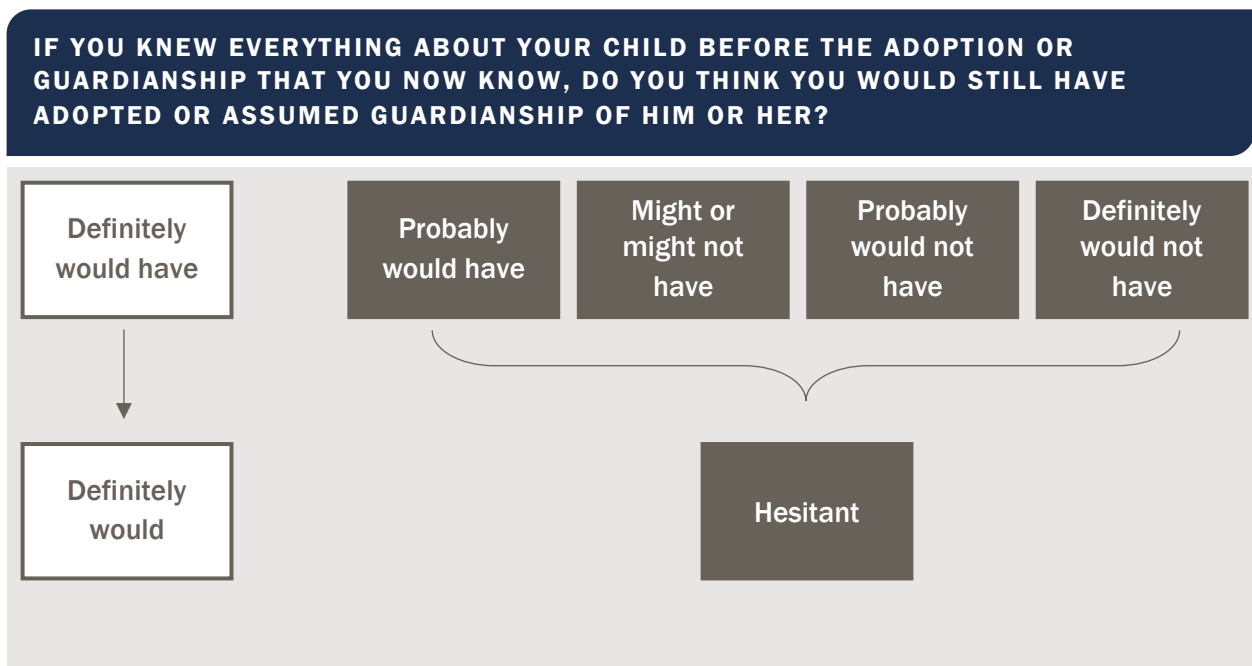
Figure 10.4 note: It should be noted that we expect to see lower levels of belonging and emotional security in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families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

Impact of Caregiver Commitment on Key Measures

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

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

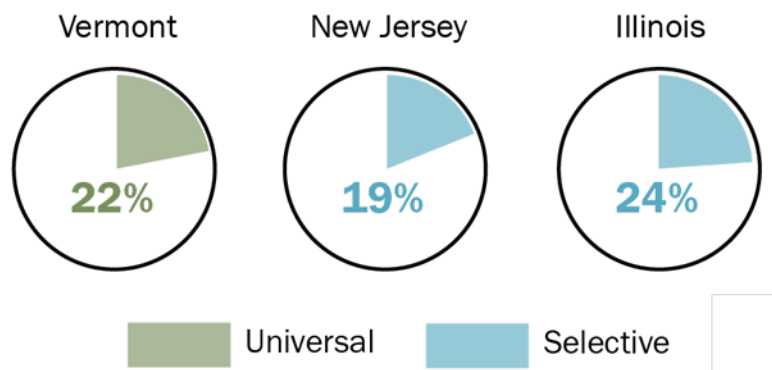
Keeping in mind the significant role caregiver commitment has played in understanding post permanency discontinuity and other challenges in prior studies (Liao & Testa, 2016; Testa et al., 2015; White et al., 2018), a series of commitment questions were asked of parents and guardians involved with this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



Results (depicted in Figure 10.5), show that between 19% and 24% of respondents from the prevention-related sites (Vermont, New Jersey and Illinois) expressed some level of hesitancy to adopt or assume guardianship again³:

- In Vermont, where outreach was Universal, 22% of families expressed hesitancy to adopt or assume guardianship again.
- In New Jersey, 19% of families expressed hesitancy to adopt or assume guardianship again.
- In Illinois, 24% of families expressed hesitancy to adopt or assume guardianship again.

Figure 10.5. Percent of Caregivers who Expressed Hesitancy to Adopt or Assume Guardianship Again



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

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

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

GUIDE TO FIGURES 10.6 – 10.8

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

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

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

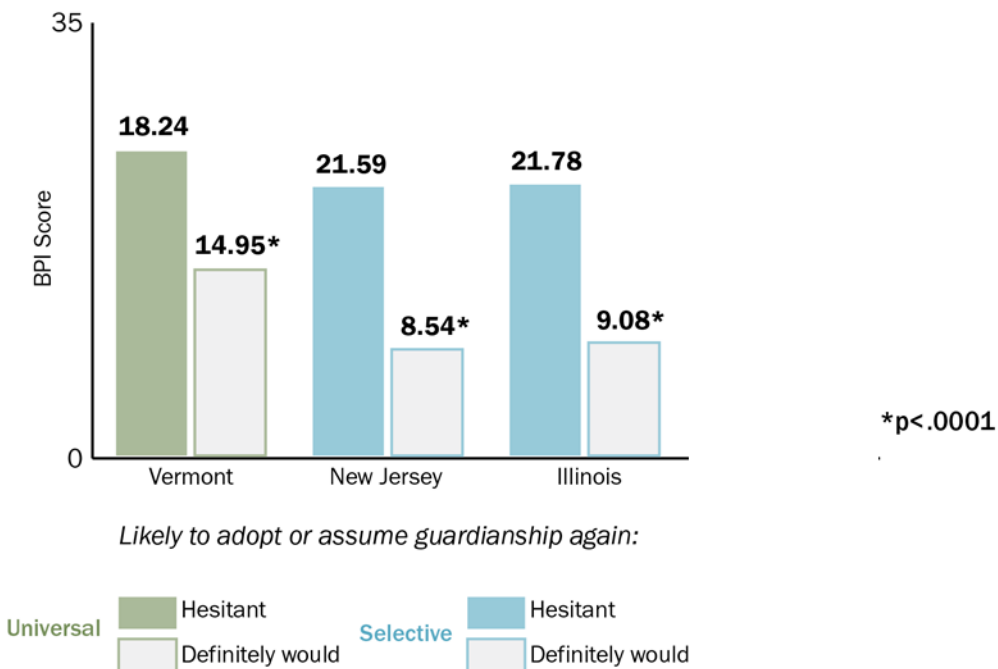
2. In Figure 10.6, the bars and the numbers above the bars are the mean BPI scores for each group.

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

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

BEHAVIORAL PROBLEM INDEX (BPI)

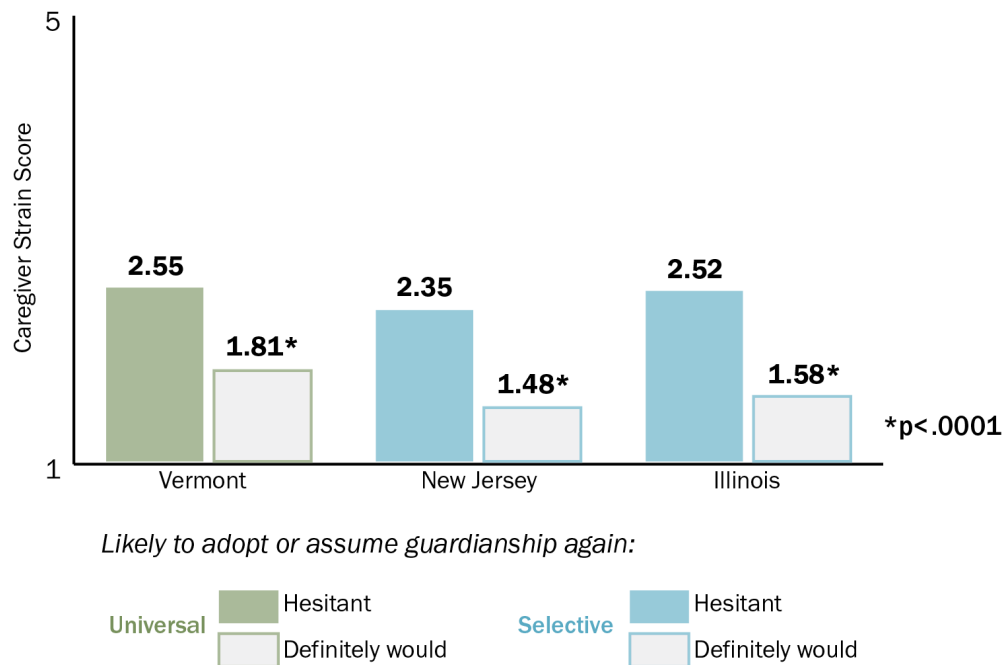
Figure 10.6. Behavior Problem Index (BPI) by Inclination to Adopt or Assume Guardianship Again



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

CAREGIVER STRAIN

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

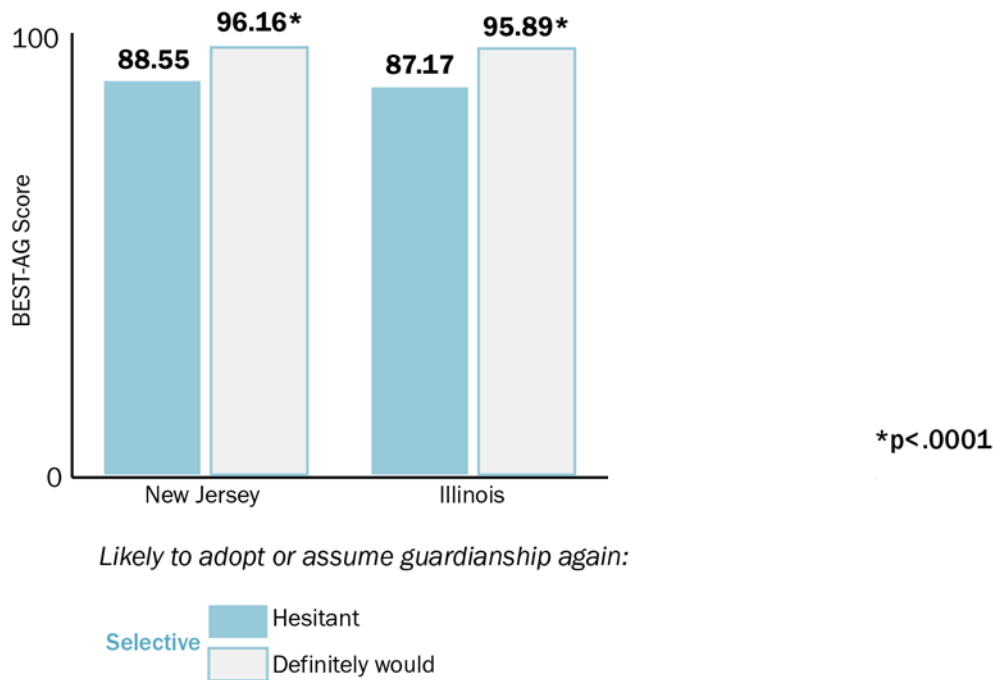


The Caregiver Strain Questionnaire-Adoption/Guardianship (CGSQ-AG) used in this project is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger, & Brickman, 1997), a measure to assesses the extent to which caregivers experience additional demands, responsibilities, and difficulties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

BELONGING AND EMOTIONAL SECURITY TOOL (BEST-AG)

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



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

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

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

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



Discussion

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

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

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

SERVICE UPTAKE DID NOT OVERWHELM POST PERMANENCY SERVICE PROVIDERS

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

ONGOING SERVICE NEEDS

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

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

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

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

In sum, some suggestions moving forward:

- Maintain connections with families after adoption and guardianship. Connections to services, supports, and resources should begin prior to adoption or guardianship finalization and continue to be maintained after finalization.
- Reduce barriers to post adoption service use and empower families to seek services and supports. This process may be made easier by maintaining connections through universal outreach, which includes providing information about availability and eligibility for services after adoption or guardianship finalization so that families know how and where to access supports and services.
- Offer support through periodic, targeted outreach to families who exhibit characteristics that suggest they may be at an increased risk for post permanency discontinuity. This could be, for instance, annual check-ins with families to see how they are doing.
- Encourage child welfare jurisdictions to develop systems to track and update families' addresses and contact information so that families receive the information that agencies send.
- Increase the availability of service providers experienced in working with families formed through adoption or guardianship, particularly for child and family mental health support.

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

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

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

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

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

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

IDENTIFYING FAMILIES AT RISK FOR POST PERMANENCY DISCONTINUITY

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

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

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

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

MULTI-PRONG APPROACH TO OFFERING SUPPORT AND SERVICES

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

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

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

ADOPTIVE PARENTS AND GUARDIANS REPORT ON THEIR POST PERMANENCY EXPERIENCES

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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Appendices

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

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

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

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

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

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

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

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

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

Appendix B. Data Tables

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

WOULD YOU ADOPT OR ASSUME GUARDIANSHIP OF YOUR CHILD AGAIN?			
VERMONT	HESITANT	DEFINITELY WOULD	% HESITANT
PARTICIPANTS	176	618	22%
	MEAN	MEAN	<i>p</i>
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	<i>p</i>
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	<i>p</i>
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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