# Chapter 8: Catawba County, NC

## 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 (Catawba County is Chapter 8), and a cross-site evaluation (Chapter 10). The chapter numbers reflect the chapters designated in the full report.

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# Acknowledgements

.

# Catawba County, NC

## PROJECT PARTNERS

QIC-AG partnered with **Catawba County Social Services.**

## CONTINUUM PHASE

**Indicated**

## INTERVENTION

**Reach for Success** is a proactive outreach program which aims to increase post-adoption engagement with Success Coach Services, which are designed to improve wellbeing and prevent adopted youth from re-experiencing foster care. The intervention was comprised of a survey to assess risk, followed by proactive outreach to families.

## STUDY DESIGN

**Experimental**
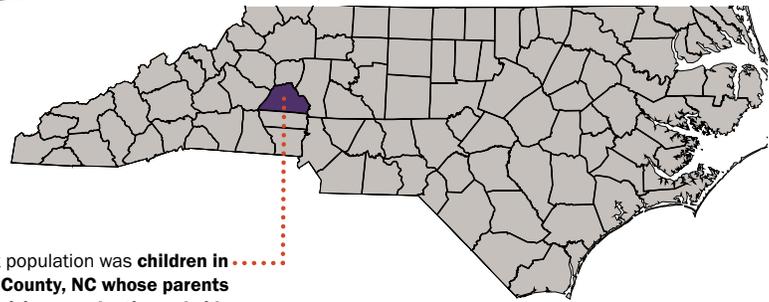
The target population was **children in Catawba County, NC whose parents were receiving an adoption subsidy** and were subsequently identified for outreach.

## RESEARCH QUESTION

Will the target population who receive Reach for Success experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health as compared to children who do not receive the additional Reach for Success outreach?

# Findings

## DEMOGRAPHICS

### Snapshot of Survey Respondents' Target Child:

**75%** white

**58%** female

**69%** parents were married

Average age at permanence:
**6.18 years old**

Average time in foster care:
**1.97 years**

## OUTREACH

**240** families were sent surveys

**128** took the survey

**94** designated for outreach

**37** high score  **57** low score

**39** successfully contacted

**3** participated in Success Coach services

**2** high score

**1** low score

Score groups are based on survey responses about service needs and parental assessments of their child's behavioral issues. The survey results supported the classification of families into high and low-score groups with high-score families having higher scores on the Behavioral Problem Index (BPI), and could be a useful way to identify families in need.

## 128 FAMILIES RESPONDED

## OVERALL, FAMILIES ARE THRIVING!

✓ **94%** of caregivers said they never thought about ending adoption or guardianship

✓ **71%** said that adoption/guardianship had an extremely positive impact on their family

✓ **35%** identified services their family needed (mental health, specialized medical or dental care, educational supports, and child developmental services)
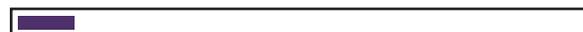
✓ only **10%** reported youth experienced negative school and legal outcomes.

## RECOMMENDATION

A small, but significant proportion of families reported unmet needs. Perhaps with additional time, families may contact the Success Coach program for services. CCSS should continue to track families over the next few years to see if families identified for additional outreach end up requesting services. In addition, it may be beneficial if CCSS would follow up with families 1-2 years after finalization to determine if they have any unmet needs and introduce them to services.

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**CASE WESTERN RESERVE UNIVERSITY**

**Children's Bureau**

# Executive Summary

## Overview

North Carolina is a county-administered, state-supervised child welfare system. The North Carolina Department of Health and Human Services (NCDHHS) encourages counties across the state to identify emerging best practices that strengthen families and stabilize placements in child welfare. In that spirit, the Catawba County Social Services (CCSS), in partnership with The Duke Endowment, established the Child Wellbeing Project. The Child Wellbeing Project originally created an intervention, the Success Coach program, to support post reunification stability in reunified families. However, Success Coach services were later expanded to address the needs of families who had adopted children through the foster care system. Specifically, Success Coach services were designed to address concerns that current services to families who had adopted children through the foster care system might not be sufficient to prevent youth from reentering state care (Wilson, Brandes, Ball, & Malm, 2012).

In 2010, Success Coach services were made available to all families in Catawba County formed through adoption. Success Coach Services included mentors, or Success Coaches, who engaged with families and provided in-depth assessments; case management; skill-building training; service coordination; advocacy; educational support; and referrals to other support services including mental health services.

Despite the initial promising results of Success Coach services in Catawba County, staff reported that by the time many families called to request services, the families were already in crisis. The CCSS staff felt they were missing the opportunity to proactively serve and intervene early with adoptive families who were either unaware of the support services available or reluctant to initiate contact with CCSS. Their idea was that if services were offered to families through direct, proactive outreach, then these previously unidentified families would receive the services that they needed. Given the need to reach out to families in a different manner, the National Quality Improvement Center for Adoption and Guardianship Support (QIC-AG) in conjunction with CCSS embarked upon a process for developing an outreach program, named *Reach for Success*, to increase post adoption engagement with Success Coach services. *Reach for Success* was implemented at the Indicated Interval of the QIC-AG Permanency Continuum Framework

The Theory of Change for *Reach for Success* was that adoptive families may experience challenges, but not ask for support because they are unaware of the availability of services, unsure of how to access services, or are not comfortable asking for assistance. Through proactive outreach, adoptive families in need can become aware of available services and participate in services.

## Intervention

*Reach for Success* is located in the **Develop and Test** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. Developed by the QIC-AG project, *Reach for Success* comprised two major components:

1) A survey sent to all adoptive families in order to identify those who reported significant child behavior problems or current service needs (i.e., a *high-score* group of families) and

2) Outreach to families identified for additional contact (i.e., Groups 1 and 3 below) to engage them in Success Coach services, with the goal of preventing post permanency difficulties.

The survey was sent to all adoptive families receiving a subsidy in Catawba County, which also allowed program staff to develop a profile of characteristics for all adopted youth and caregivers in the county who responded to the survey.

## Primary Research Question

The primary research question in Catawba County was:

Will children in Catawba County whose parents are receiving an adoption subsidy and are subsequently identified for outreach who also receive *Reach for Success* experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health as compared to children who do not receive the additional *Reach for Success* outreach?

To answer this research question, a three-group experimental design was employed. After initial survey responses were received for each cohort of potential respondents, an algorithm was applied to survey responses to classify respondents into either a high-score group or a low-score group based on current family service needs and behavior issues of the focal child, which was the oldest adoptive child in the family. Higher scores on the Behavior Problems Index [BPI] reflected more child behavior issues for the focal child.

Once respondents were assigned to one of the two score groups (i.e., high-score or low-score), the high-score group was randomly assigned to either the *Reach for Success* outreach group or to a no outreach group (the comparison group). All low-score respondents were allocated to a third outreach group. Those assigned to the high-score outreach group or the low-score outreach group were offered the Success Coach Services, and those assigned to the high-score no outreach group were not. In summary, there were three groups for comparison:

- Group #1: High-score outreach group

- Group #2: High-score no outreach group

- Group #3: Low-score outreach group

This experimental design allowed the evaluation team to compare the intervention group of interest (Group #1) to two different comparison groups: one that was similar in risk but did not receive the outreach intervention (Group #2) and one that had lower risk than the intervention group but received the outreach intervention (Group #3). All families randomized into the comparison group could still access the Success Coach services if they requested the service or were referred by a professional (these were the services as usual).

## Key Findings and Discussion

During the project period, 240 families in Catawba County were sent surveys. These 240 families represent all adoptive families who had not previously received Success Coach services in Catawba County. Of those 240 families, 128 (53%) completed and returned surveys.

## FINDINGS FROM THE OUTREACH EFFORTS TO ENGAGE FAMILIES IN INTERVENTION:

- Of the 128 families who returned surveys, 94 were designated for outreach (57 in the low score group and 37 in the high-score outreach group)

- Of the 94 families designated for outreach, 39 parents were able to be contacted by CCSS (or 41% of those designated for outreach, with 23 contacted in the low-score group and 16 contacted in the high-score outreach group)

- A significant proportion of the 39 parents who were successfully contacted by CCSS were interested in either learning more about Success Coach services or receiving Success Coach services. Specifically, 21 of the 39 families (54%) who were successfully contacted through outreach were interested in either Success Coach information or services, with seven interested in services and 14 interested in information only.

- Of the seven families who were interested in services, three (43%) entered into a service agreement and actually participated in Success Coach services.

- Of the three families who entered into a service agreement for Success Coach services, two were from the low-score group and one was from the high-score group. It is important to note that with such a low uptake of Success Coach services, it is impossible to discern if low-score or high-score families were more likely to enter into a service agreement.

- Families who were contacted through outreach but declined services largely reported they did not need extra support.

In sum, this study did not find that the additional outreach to families resulted in additional uptake of Success Coach services. Furthermore, the low number of families who engaged in services does not allow us to sufficiently assess the impact of the algorithm to distinguish families who may be interested in services. Perhaps with additional time, CCSS will observe a different level of uptake based on the algorithm and additional analysis can be pursued to understand the characteristics of families in need of Success Coach services.

## FINDINGS FROM THE SURVEY:

- The survey results indicated that most adoptive families were adjusting well to permanence. For example, a large majority of respondents said that they felt extremely positive about the impact of the adoption on their family (71%) and almost all respondents stated that they never thought about ending the adoption (94%). Regarding youth academic performance, most adopted children were reported to be doing "excellent" or "good" in both reading and math (72% and 66%, respectively).

- Only a small proportion of caregivers (10% or less of respondents) reported that youth experienced negative school and legal outcomes, such as in- or out-of-school suspension, skipping school, expulsions from school, runaway behavior, or legal and juvenile justice system involvement.

- In relation to the scales measuring child behavioral health and family wellbeing, the survey results supported the classification of families into high and low-score groups with high-score families who returned surveys ($n$ = 71) having higher scores on the BPI than low-score families who returned surveys ($n$ = 57). Results suggest that the instruments were effective indicators of child and family wellbeing and may be used to identify families at risk for post adoption difficulties and placement instability.

- Respondents were asked about an array of service needs, and if they were able to obtain the services they needed. Overall, less than 35% of respondents indicated that their family needed any of the services asked about the survey. The four most commonly reported services were: mental health, specialized medical or dental care, educational supports, and child developmental services. Most adoptive parents who tried to obtain services reported that they were successful and were typically happy with the services they received.

In sum, the purpose of outreach provided through *Reach for Success* was to engage more adoptive families in Success Coach services, particularly families who may be struggling with unmet service needs, difficult child behaviors, poor family cohesiveness, or other issues related to child and family wellbeing. Although *Reach for Success* was successful in contacting over half of the families eligible for outreach, and a little over a third of those contacted were interested in at least more information about Success Coach, less than 20% of those families contacted were interested in participating in the Success Coach program. It is important to note that most caregivers who did not want services reported that they were doing well and that they did not need or want additional services. Furthermore, families who had previously engaged with Success Coach services were excluded from this study. Low service uptake in *Reach for Success* may have occurred because Catawba County Social Services (CCSS) offers Success Coach services to all adoptive families at the time of finalization, and has a history of implementing proactive, innovative programs to prevent difficulties for adoptive families.

The findings of this study were consistent with previous post adoption literature, which indicates that most children and families adjust well after adoption from foster care, although a small but significant proportion of families (i.e., about 5-20%) also report unmet needs, child behavior problems, placement instability, and other issues, and might benefit from additional services (Rolock, 2015; Rolock & White, 2016; Rolock & White, 2017; White, 2016).

## Cross-Site Summary

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

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

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

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

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

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

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

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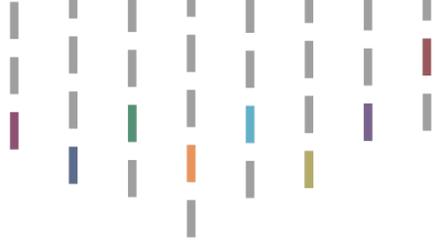
# Chapter 1

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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

Average Monthly Title IV-E Substitute Care Caseload

Average Monthly Title IV-E Adoption or Guardianship Assistance
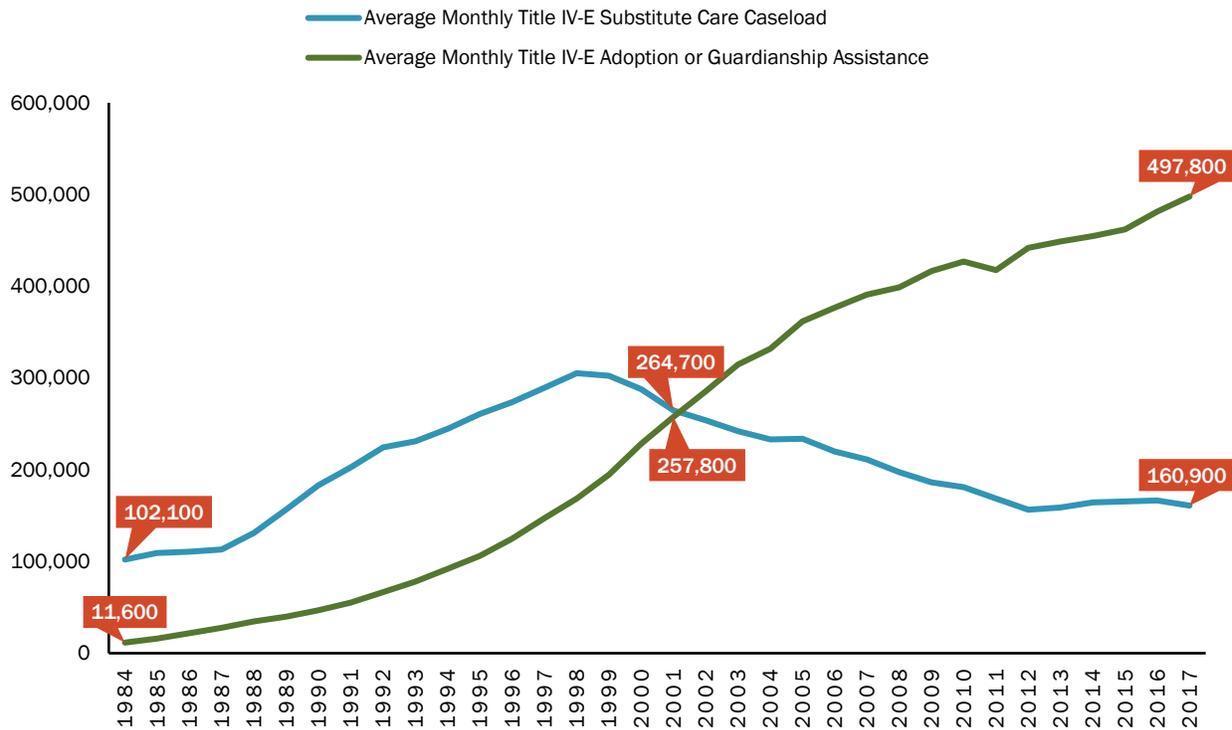


Data sources: The information on federally-funded caseloads are from the Committee on Ways and Means (CWM) of the U.S. House of Representatives and represents the average monthly Title IV-E caseloads.

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).
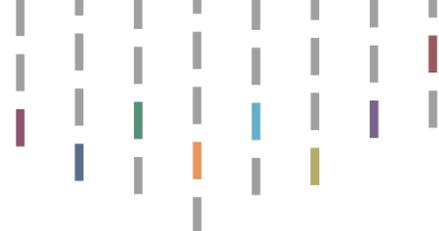
# QIC-AG Target Populations

## 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.

<div align="right">

**RESEARCH QUESTION**

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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)**?

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**THEORY OF CHANGE**

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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
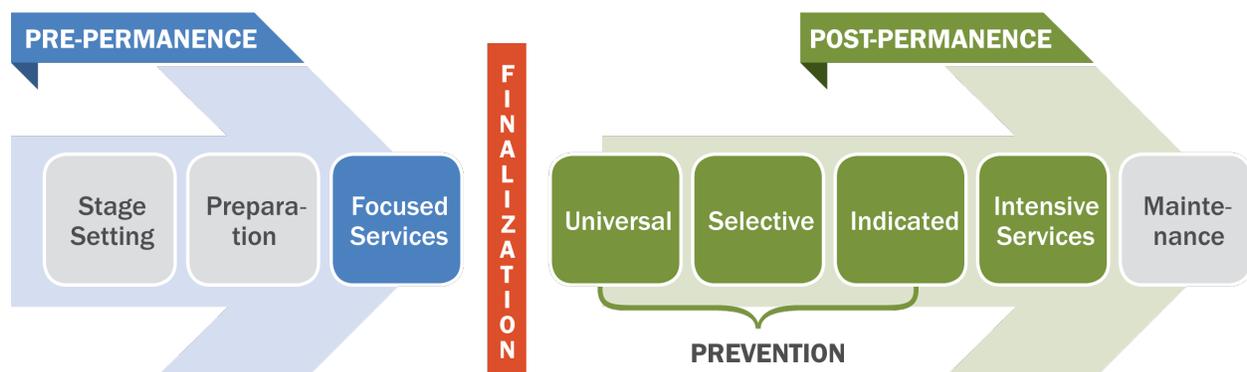


Taken together, the eight intervals serve as an organizing principle that helps guide children within the selected state, county, or tribal child welfare systems transition to adoption or guardianship while supporting families to maintain stability and wellbeing after adoption or guardianship has been 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
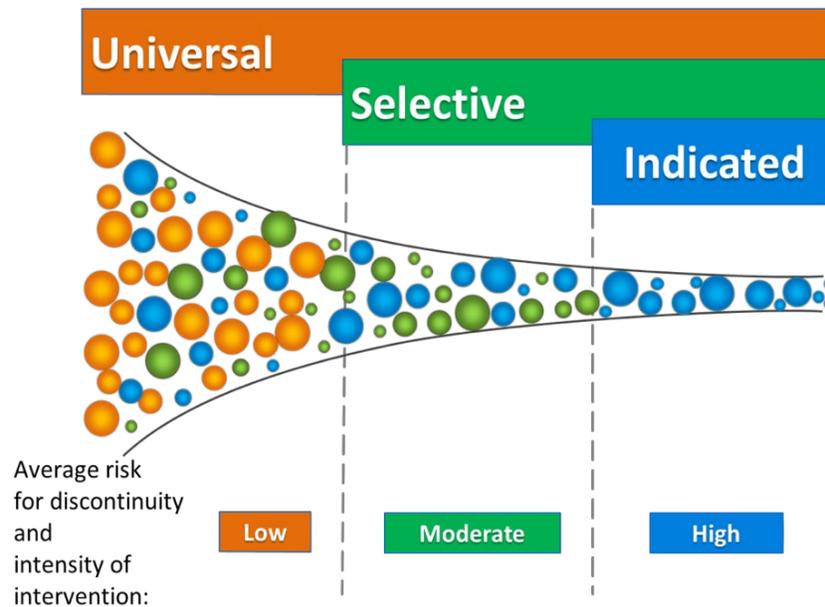


The prevention framework is based on the work of the Institute of Medicine (IOM) prevention planning (Springer & Phillips, 2006).

## 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.
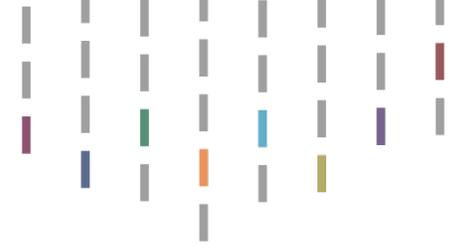
# Site Selection

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
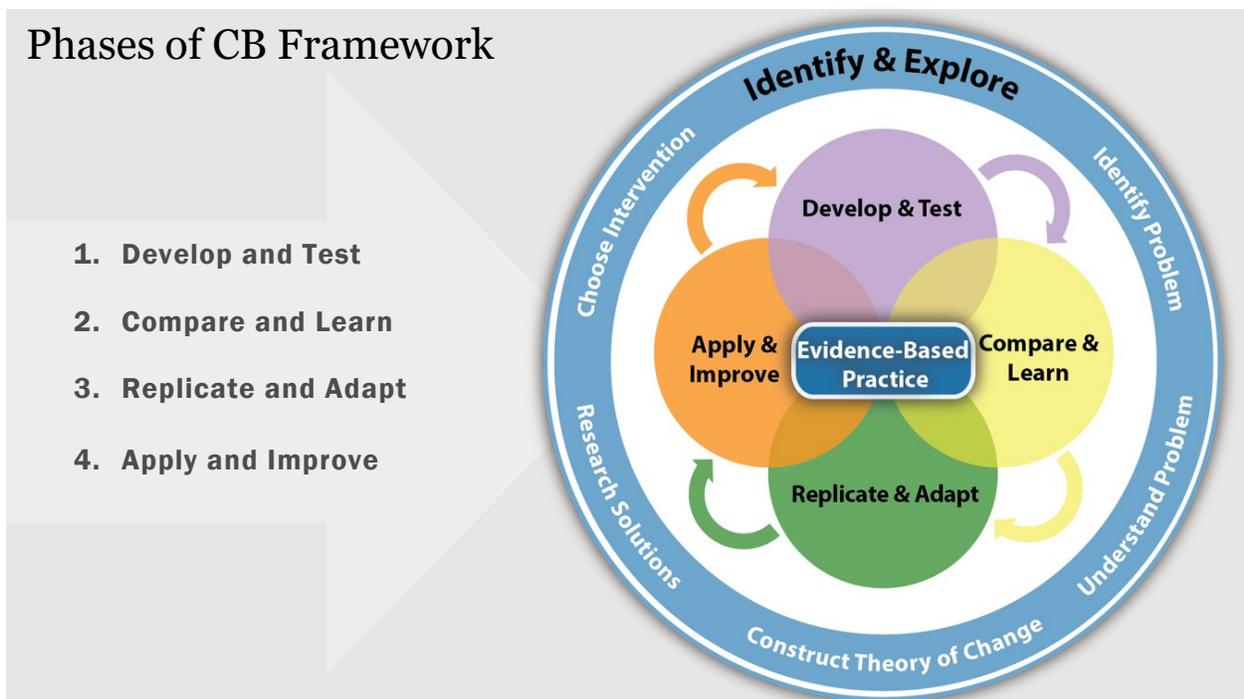
If a site selected an intervention that was well-defined, showed early signs of success, and wanted to compare the intervention's outcome to practice as usual, the site would be in the **Compare and Learn** phase of the CB Framework. An intervention in the **Replicate and Adapt** phase was one that had 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
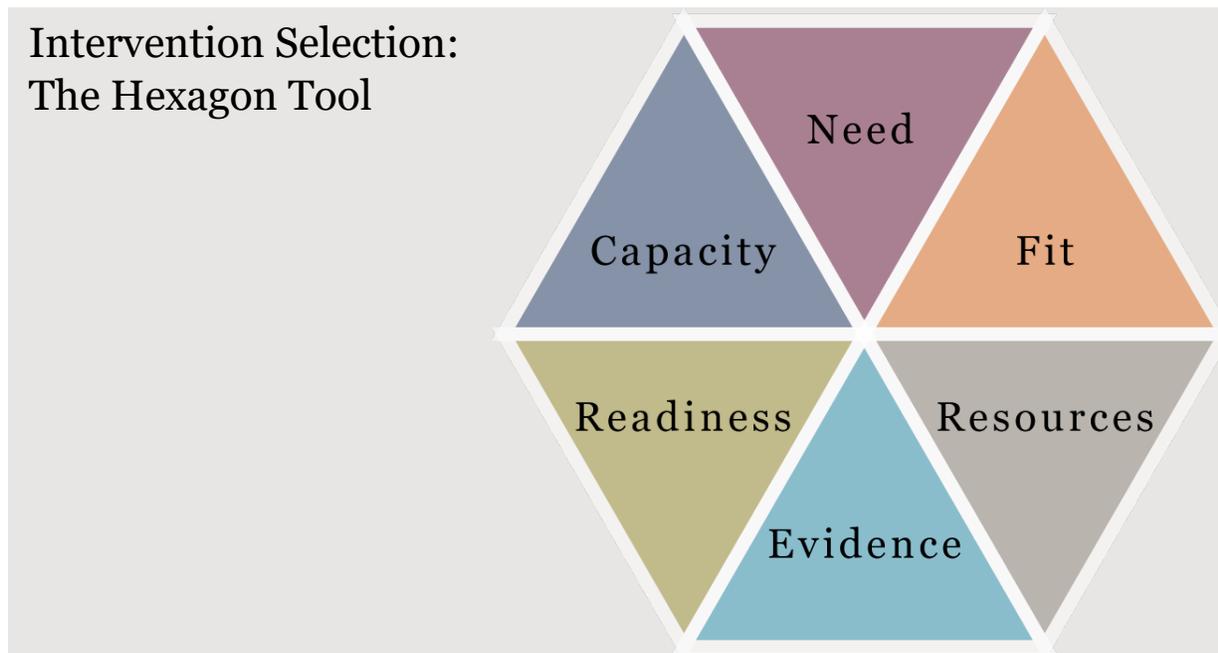
Table 1.1. Site, Target Population, Intervention and Study Design

| 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.
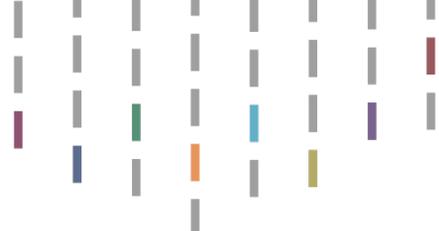
# Summary

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.
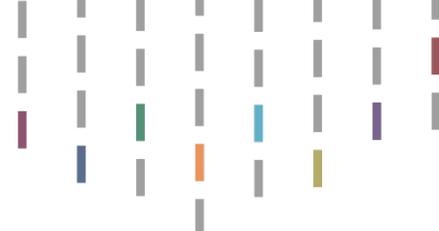
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# Chapter 8

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# Site Background

North Carolina is a county-administered, state-supervised child-welfare system. The North Carolina Department of Health and Human Services (NCDHHS) encourages counties across the state to identify emerging best practices that strengthen families and stabilize placements in child welfare. In that spirit, the Catawba County Social Services (CCSS), in partnership with The Duke Endowment, established the Child Wellbeing Project. The Child Wellbeing Project originally created an intervention called the Success Coach program to support post reunification stability in reunified families. However, Success Coach services were later expanded to address the needs of families who had adopted children through the foster care system. Specifically, Success Coach services were designed to address concerns that current services to families who had adopted children through the foster care system might not be sufficient to prevent youth from reentering state care (Wilson, Brandes, Ball, & Malm, 2012).

In 2010, Success Coach services were made available to all families in Catawba County formed through adoption. Success Coach Services included mentors, or Success Coaches, who engaged with families and provided in-depth assessments; case management; skill-building training; service coordination; advocacy; educational support; and referrals to other support services including mental health services. Of the 72 adoptive families who actively participated in the Success Coach Service during this initial test of the program, 100% maintained permanent placement with no children re-entering foster care (CCSP, 2017).

Despite the initial promising results of Success Coach services in Catawba County, staff reported that by the time many families called to request services, the families were already in crisis. The CCSS staff felt they were missing the opportunity to proactively serve and intervene early with adoptive families who were either unaware of the support services available or reluctant to initiate contact with CCSS.

The Theory of Change in Catawba County suggested that adoptive families may experience challenges but not ask for post adoption support. Families may not ask for services because the families are unaware of the availability of post adoption services, are unsure how to access services, or are not comfortable asking for assistance. Thus, the idea behind *Reach for Success* was that through proactive outreach, families would become aware of available services, and those in need would participate in existing services.

# National Data: Putting North Carolina in Context

The data in this section is provided to put North Carolina in context with national data. Through comparing data from North Carolina to that of the nation we are able to understand if North Carolina is a site that removes more or fewer children than the national average and compare the median lengths of stay of children in foster care in the state to the rest of the U.S. Finally, we also use data to understand the number of children receiving IV-E adoption or guardianship assistance over time (note that North Carolina did not adopt a guardianship assistance program [KinGAP] until 2017). All of these comparisons are provided over the past five years to give a sense of recent trends.

As displayed in Figure 8.1, between Fiscal Years 2013 and 2017, the rate[1] of children entering foster care in both North Carolina and the U.S. increased. Between 2013 and 2017, the state's foster care entry rate increased from 23.2 per 10K (5,300 children) to 25.1 per 10K (5,777 children). This per capita rate is lower than the per capita rates for the U.S. The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. In other words, fewer children, per capita, entered foster care in NC than in the US, although increases over the past five years occurred at both the state and national levels. As a point of comparison, the per capita rate for children entering foster care in Catawba County in 2016 was similar to the state rate and lower than the national rate. For example, in 2016, 25.8 per 10K children entered care in Catawba[2] (Fostering Court Improvement website, 2018).

## Figure 8.1. North Carolina Foster Care Entry Per Capita Rate (2013-2017)
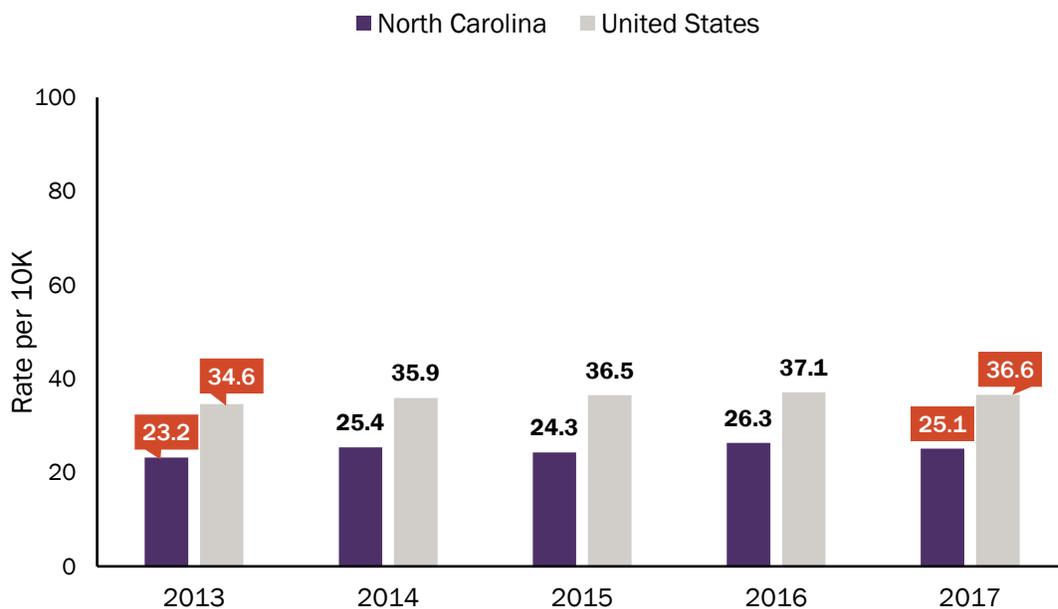


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

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

2 Data on Catawba County from 2016 is the most recent available to the evaluation team

Between 2013 and 2017, the median length of stay for children in foster care as of September 30th of each year (shown in Figure 8.2) was similar and fairly constant for both North Carolina and the U.S. The length of stay increased slightly in North Carolina from 12.3 months in 2013 to 13.1 months in 2017 while in the U.S. it increased slightly from 12.8 months in 2013 to 12.9 months in 2017. The median length of stay for children in care in 2016 Catawba County was 17.9 months[3], which was longer than the state or national rates (Fostering Court Improvement website, 2018).

Figure 8.2. North Carolina Median Length of Stay for Children in Foster Care as Measured in Months (2013 – 2017)
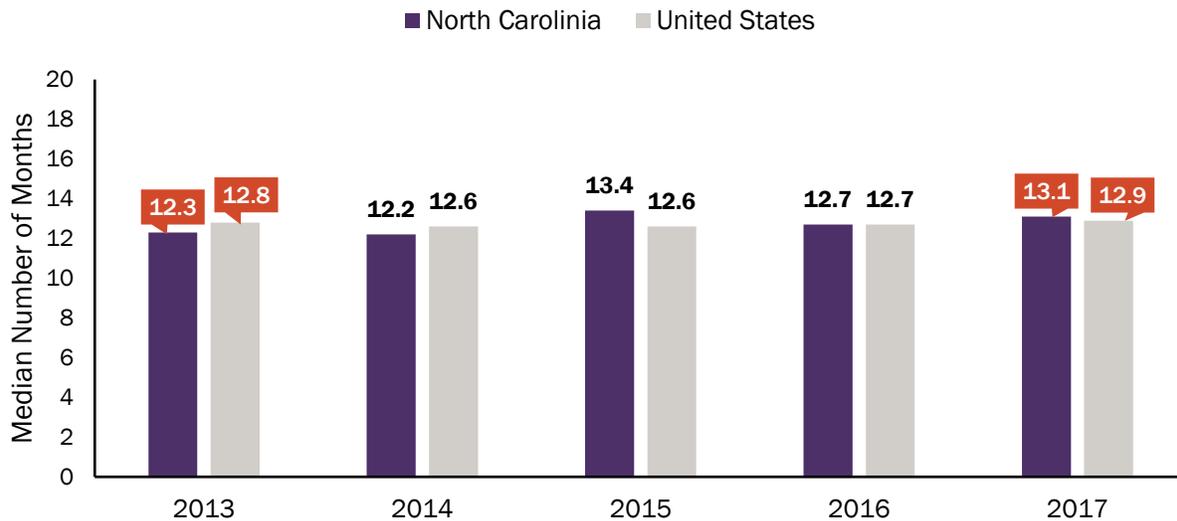


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/.

Nationally, we have seen a shift in the number and proportion of children living in IV-E supported foster care and IV-E funded adoptive or guardianship homes. As shown in Figure 8.3, the number of children in North Carolina in IV-E funded foster care and the number of children in IV-E funded adoptive homes was approximately the same in 2000 (4,118 and 4,214 respectively), yet by 2016 these numbers had diverged. In 2016 there were 3,732 children in IV-E funded substitute care and 10,257 children in IV-E funded adoptive homes.

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[3] Data on Catawba County from 2016 is the most recent available to the evaluation team

## Figure 8.3. North Carolina Caseloads

— Average Monthly Title IV-E Substitute Care Caseload

— Average Monthly Title IV-E Adoption or Guardianship Assistance
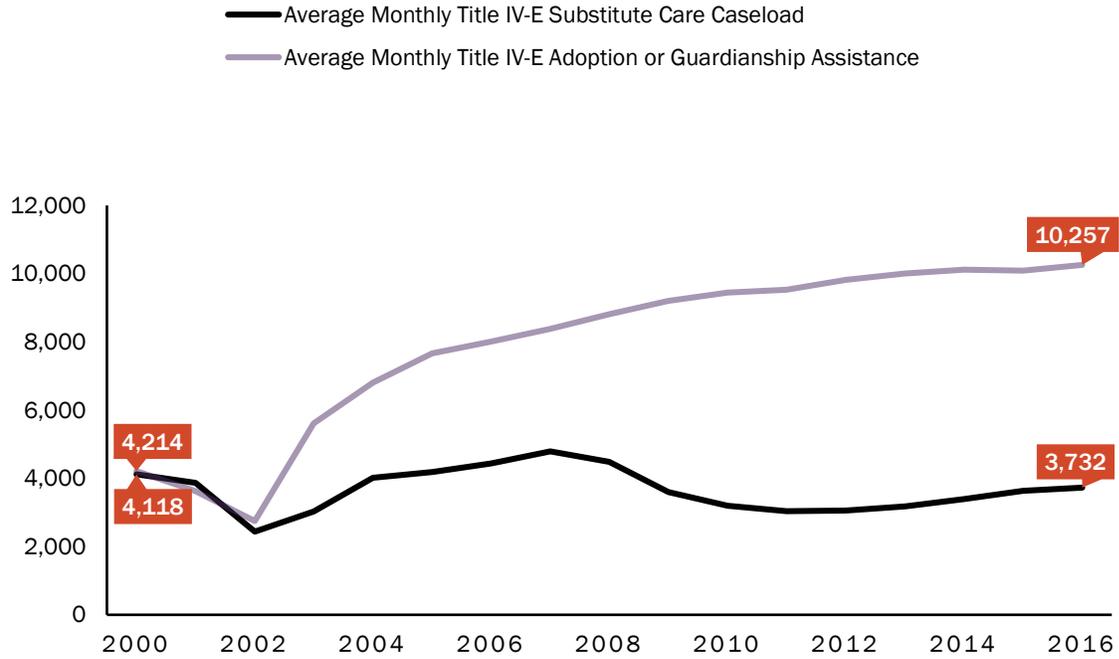


Data sources: Title IV-E numbers: U. S. Department of Health and Human Services / Administration for Children and Families, compiled data from states' Title IV-E Programs Quarterly Financial Reports, Forms IV-E-1 (for years prior to 2011) and CB-496 (for 2011 and later).

# QIC-AG Permanency Continuum Interval

The Catawba County QIC-AG team focused its intervention efforts in the **Indicated Interval** of the QIC-AG Permanency Continuum Framework. **Indicated** prevention efforts focus on interventions that seek to address specific risk conditions; participants are identified based on characteristics they themselves have (Offord, 2000; Springer and Phillips, 2006).

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

*Reach for Success* targeted services to families who were selected for additional outreach, including a group of families who were identified as potentially being at an elevated risk for post permanency discontinuity based on their responses to a post adoption survey.

Figure 8.4. QIC-AG Permanency Continuum-North Carolina
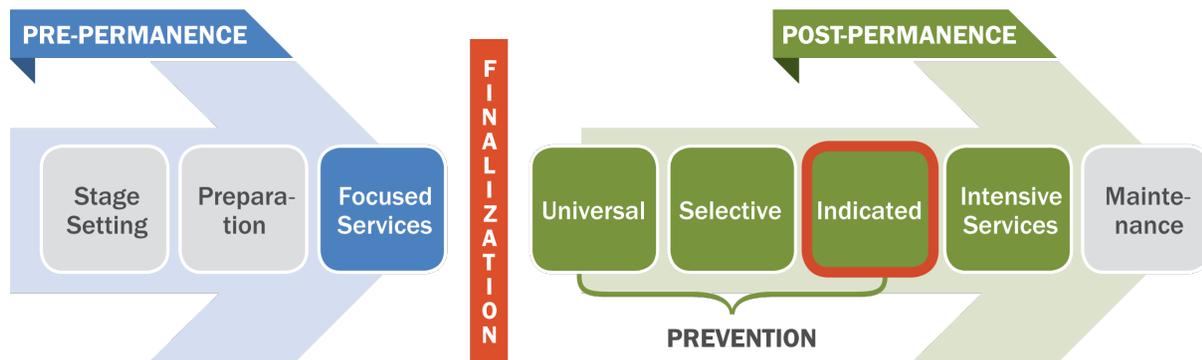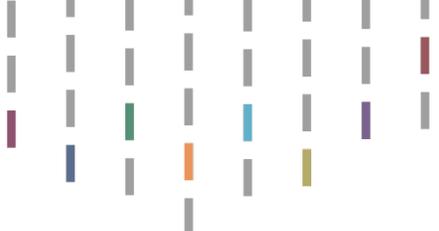
# Primary Research Question

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

Will children in Catawba County whose parents are receiving an adoption subsidy and are subsequently identified for outreach (P) who receive *Reach for Success* (I) experience a reduction in post permanency discontinuity, improved wellbeing, and improved behavioral health (O) as compared to children who do not receive the additional *Reach for Success* outreach (C)?

## Target Population

The target population for the Catawba County QIC-AG team included all the children in the county whose parents were receiving an adoption subsidy and were subsequently identified for outreach. Post permanency discontinuity refers to situations in which children leave their homes after adoption or guardianship, prior to becoming an adult (Rolock, 2015).

Children adopted through international or private domestic channels were also included in the Catawba County QIC-AG project. At the time the project began, Catawba County, North Carolina did not have a subsidy for guardianship, and thus, guardianship was not included as part of the target population. Also, adoptive families were excluded from the target population if: 1) children and youth were not currently residing in the home of their adoptive parent, 2) families had ever received Success Coach services.

# Intervention

Figure 8.5. Map of Catawba County, North Carolina



The target population was **children in Catawba County, NC whose parents were receiving an adoption subsidy** and were subsequently identified for outreach.
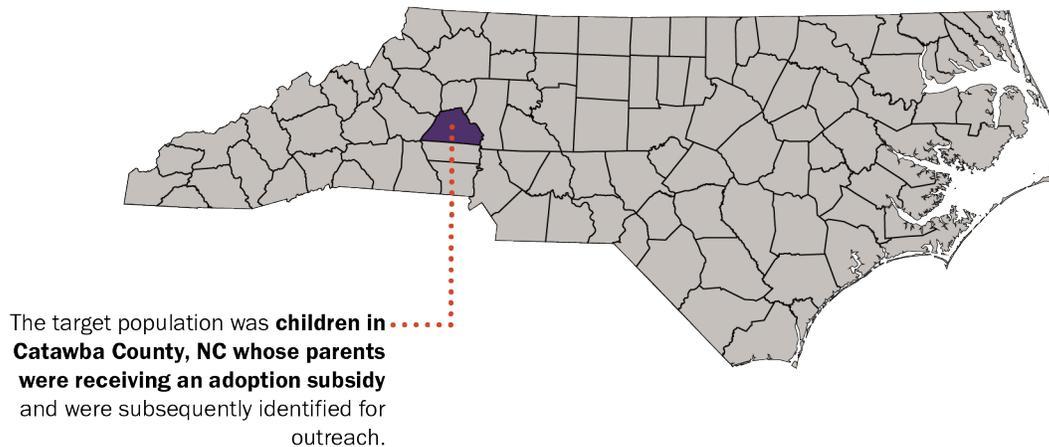
## REACH FOR SUCCESS

In selecting *Reach for Success*, the QIC-AG site team followed the guidance of the National Implementation Research Network (NIRN). During this process, a search for possible interventions occurred. In their search of existing interventions, the Catawba County team did not find an existing intervention that addressed their Theory of Change. As such, the North Carolina QIC-AG team created the *Reach for Success* intervention. *Reach for Success* is located in the **Develop and Test** phase in the *Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare*. The **Develop and Test** phase should result in "a set of specific practices, program components, and intervention guidelines that do not require adjustment, have been defined well enough that others can replicate them, and show an initial improvement in outcomes that can most likely be traced to the intervention" (Framework Workgroup, p. 11).

In order to identify families most in need of support, *Reach for Success* was comprised of two components:

1) A survey sent to all adoptive families in order to develop a descriptive profile of adoptive families in Catawba County, as well as to identify families who reported significant child behavior problems or current service needs (a *high-score* group of respondents). In contrast, those families who responded to surveys but reported low/no child behavior problems and no current service needs were designated as the *low-score* group of respondents.

2) Outreach to families to engage them in Success Coach services, with the goal of preventing post permanency difficulties.

The Success Coach services aligned well with the values of both CCSS and NCDHHS in serving all families who needed post adoption support. CCSS hoped that early identification of, and outreach to, adoptive families would ultimately help families engage in services early (prior to a crisis) and ultimately prevent post permanency discontinuity.

## Comparison

The main comparison group in *Reach for Success* for the group of high-score families who received outreach from CCSS (i.e. the intervention group) was high-score families who did <u>not</u> receive outreach. Higher risk for families was based on current family service needs and more behavior issues of the focal child in the home. An additional comparison group, low-score families who received outreach from CCSS, was also created by allocating all low-score families to receive outreach (see Figure 8.7). The evaluation design was modified after the usability evaluation to include outreach to low-score families because of low uptake among high-score families for the Success Coach intervention (see Methods below).

## Outcomes

The primary outcome for the *Reach for Success* program was increased engagement in the Success Coach Program.

In addition, an analysis of survey responders vs. non-responders was examined. Survey results were used to describe the characteristics of adoptive families in Catawba County.

The project-defined long-term outcomes were:

- Reduction in post permanency discontinuity

- Improved behavioral health

- Improved wellbeing

# Logic Model

The Logic Model (Figure 8.6) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and interventions to the intended proximal and distal outcomes. The model also identifies the core programs, services, activities, policies, and procedures that were studied as part of the process evaluation, as well as contextual variables that may affect their implementation

## Figure 8.6. North Carolina Logic Model

### North Carolina Logic Model

**Program Inputs**

**Population:** Children in Catawba County whose parents are receiving an adoption subsidy who are subsequently identified for outreach

**Intervention:** Reach for Success

**Comparison:** Children who do not receive additional outreach through Reach for Success

**Implementation**

- Components of Early Outreach Model
- Hire Reach for Success Staff
- Educate other County staff as determined necessary
- Develop early outreach protocol/materials
- Develop case flow process and procedure
- Develop/adapt training materials
- Train staff
- Develop early outreach survey
- Design algorithm and randomization
- Submit IRB
- Data base modification
- Develop plan for outreach to international and private domestic adoption families
- Develop early outreach fidelity measures
- Send surveys
- Plan Reach for Success Supervision
- Establish Fidelity tracking system

**Program Outputs**

- Finalized components
- Hired staff
- Educated county staff
- Finalized outreach protocol
- Finalized case flow process
- Training materials adapted
- Staff trained
- Survey developed
- Randomization and algorithm tested
- IRB approved
- Data base modified
- Outreach to international and private families completed
- Fidelity measures created
- Surveys mailed
- Reach for Success supervision sessions attended
- Fidelity activities tracked

**Short-Term Outcomes**

- Increased engagement in Success Coach Program

**Long-Term Outcomes**

**Outcomes:**
- Reduction in post-permanency discontinuity
- Improved behavioral health
- Improved well-being

**Unintended Consequences:**
- Improved coordination of post-permanency services and supports
- Increased capacity of post-permanency staff

**External Conditions**

- Perception of families that needing support services reflects badly on their parenting skills/ability (Shame)
- Lack of phone numbers for families
- Lack of email addresses for families

**Theory of Change**

There are children living in adoptive homes whose families are experiencing challenges, but they have not asked for post-adoption support. Left unaddressed, these children may be at risk for post-permanency discontinuity. As many families who adopt younger children do not experience challenging behaviors for a number of years after permanency has been finalized, adoptive parents who find that they need services may not be aware of available supports or how to access them, or if aware, they may not be ready to engage in services. As a result, families in need of assistance are not taking advantage of available Success Coach Services. If the system were able to identify families who are experiencing post-adoption challenges, the system would be able to offer Success Coach Services to those families at a time when the family would be likely to take advantage of the services. If families take advantage of Success Coach Services, they will be better equipped to address their needs and stable permanencies will increase.

**End Values**

- Awareness that post adoption support services are available
- Improved behavioral health for children
- Improved well-being for children, youth and caregivers related to feelings of commitment, belonging, and a positive view of permanence
- Improved stability in adoptive homes

# Evaluation Design & Methods

*Reach for Success* included reaching out to adoptive families through a survey, and then subsequently inviting subgroups of those who responded to the survey to participate in Success Coach services. After survey responses were returned for each cohort, an algorithm was applied to responses. An algorithm classified respondents into either a high-score group or a low-score group, based on current family service needs and behavior issues of the focal child, which was the oldest adoptive child in the family (higher scores on the Behavior Problems Index [BPI] reflected more child behavior issues). Once respondents were assigned to one of the two score groups (i.e., high-score or low-score), the high-score group was randomly assigned to either the *Reach for Success* outreach group or to a no outreach group (the comparison group). All low-score respondents were allocated to a third outreach group. Thus, through this project three experimental groups were created:

- Group #1: High-score outreach group

- Group #2: High-score no outreach group

- Group #3: Low-score outreach group

Families assigned to the high-score outreach group or the low-score outreach group were offered the Success Coach services, and those assigned to the high-score no outreach group were not. This experimental design allowed the evaluation team to compare the intervention group of interest (Group #1) to two different comparison groups: a group that was similar in risk but did not receive the outreach intervention (Group #2) and a group that had lower risk than the intervention group but received the outreach intervention (Group #3). However, all families randomized into the comparison group could still access the Success Coach services if they requested the service or were referred by a professional.

The evaluation design and protocol for *Reach for Success* were reviewed by the Institutional Review Board (IRB) at the University of Wisconsin-Milwaukee (UWM), the University of Illinois at Chicago (UIC), and East Carolina University (ECU). All researchers associated with the project fulfilled all requirements of their university Institutional Review Boards (IRBs). The project involved two types of data: the paper surveys completed by adoptive families and the electronic data collected by Catawba County and shared with the evaluation team. Consent forms clearly detailed the risks and benefits of participation in the study for participants. Analyses with electronic records involved the use of secondary data only, with no direct contact with human subjects. No identifying information for participants was shared with the Survey Research Labrator (SRL) at the University of Illinois at Chicago, and a study identification (ID) number was assigned by CCSS and used to track participation.

# Procedures

The outreach protocol for *Reach for Success* was initially tested and evaluated for its effectiveness. Questions related to eligibility, engagement/uptake, and survey completion/responses were as follows:

### 1) Did the Algorithm Accurately Differentiate Between High-Score and Low-Score Families?

The metrics used for this question included the proportion of high-score families that allowed a first visit and the proportion of families with high- scores that enrolled in the services. Based on initial findings from responses received during usability, changes were made to the algorithm. In addition to the BPI score, the algorithm was modified to include families with unmet service needs.

### 2) Could the Success Coaches Make the First Calls Within the Required Time Frame?

The metrics used were the number of calls made within the proposed timeframe. Results indicated Success Coaches made the first call within the required timeframe.

### 3) Would the Families Sign the Success Coach Service Agreement and Engage in the Services?

The metrics used included the proportion of families who allowed a home visit and signed the service agreement (with a target goal of 70%) as well as an examination of the disposition codes for those that refused services after a home visit. During the timeframe of the usability testing, only one family out of the 46 who completed surveys were interested in services. The family signed a service agreement and engaged in the Success Coach services.

### 4) Were the Completed Surveys Returned?

The metrics used were the percent of surveys that were returned (with a target goal of 70%) and the percent of surveys returned that were fully completed. For the usability testing phase, the response rate was 37%; all 17 returned surveys were fully completed. Due to the low response rate two changes were made to the survey administration protocol: 1) a follow-up phone call was included after the survey was administered, and 2) a $5 gift card incentive was added to the survey when mailed the first and second time. Response rates increased in subsequent rounds after these two changes were made, and the overall response rate for all five cohorts of surveys was 53% (128 out of 240 valid surveys completed and returned).

## RECRUITMENT



The *Reach for Success* survey was sent to cohorts (groups) of adoptive families, with approximately 50 families in each cohort. Surveys were mailed to families residing in Catawba County who (1) had adopted through the public child welfare system, (2) were receiving an adoption subsidy, and (3) had not received and were not currently receiving Success Coach services. The project also served families who had adopted children through a private domestic or intercountry process. Additional information regarding private domestic and intercountry adoptive families can be found in a separate report conducted by the QIC-AG, but not part of this evaluation report.

Careful consideration was given to which organization should administer the survey, with discussion centering on an outside research firm versus CCSS. Ultimately, the Catawba County site team decided the survey should be sent by CCSS, with survey responses sent directly to the survey firm at the University of Illinois at Chicago (UIC) to ensure respondents' confidentially. Stakeholders and the site team felt that a letter directly from the CCSS would be better received by families than a letter from an organization that was unknown to the families. Once completed surveys were received, SRL sent de-identified survey results to the QIC-AG evaluation team for analysis. During the initial implementation of *Reach for Success*, the outreach protocol included the following steps:

1. Mail a questionnaire packet, including a cover letter, an overview of the study, a survey instrument, and a reply envelope. Included a $5 gift card (with all first mailings after the usability cohort). One week after the initial mailing, mail a postcard reminder to families who have not returned the survey.

2. Two weeks after the reminder postcard was sent, mail a duplicate questionnaire packet with the materials described in Step 1 to families who have not returned a completed survey. Include a $5 gift card (with all second mailings after the usability cohort).

3. Send a $25 gift card to families who completed the survey.
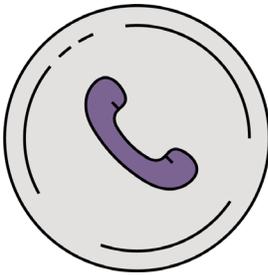


The second outreach component involved contacting families whose survey responses indicated they might benefit from the Success Coach services. These families received a phone call from a Success Coach. The protocol for the Success Coach engagement component included (1) making initial contact via a phone call, (2) mailing an initial contact letter to families the Success Coach was unable to reach by phone, and (3) scheduling a time for the Success Coach to visit the family. During the first visit, the Success Coach introduced the program, described the support services, shared program goals, and expectations, and—if the parents were interested in participating in the program—obtained the parents' signatures on and date on the service agreement.

## PRIVATE DOMESTIC/INTERCOUNTRY ADOPTIONS

Outreach efforts to private domestic or intercountry adoptive families in Catawba County started with agency staff attending community events (e.g., ball games) where they thought adoptive families might attend. Catawba County staff distributed information about Success Coach services and gift bags at these events. Catawba County staff also met with the U.S. State Department to identify a list of Adoption Service Providers (ASPs) or professionals who help families through the private/intercountry adoption process. The ASPs were identified by location, with Catawba specifically reaching out to agencies who were likely to work with families in Catawba's eight county post permanency service regions. After contacting the ASPs, Catawba then developed a curriculum and set up trainings with them to raise awareness about adoption issues and advance adoption-competent practice. Specifically, trainings were designed to raise awareness that families who adopt through a private domestic or intercountry domestic process are eligible for post adoption services in North Carolina. Catawba also provided the ASPs who attended training with materials about Success Coach services which the ASPs could then disseminate to the families they work with through the private adoption process. As a result of these outreach efforts to ASPs, Catawba County had one intercountry family call CCSS to ask for information about post adoptive services, but the family did not enter into a service agreement for Success Coach. Additional information regarding private domestic and intercountry adoptive families can be found in a separate report conducted by the QIC-AG, but not part of this evaluation report.

## Outreach Protocol

Lower than anticipated response rates to the survey among the first cohort precipitated changes to the outreach protocol. These changes included adding a follow-up reminder phone call to determine why the parents had not completed the survey and to encourage survey completion. This phone call was made by the *Reach for Success* staff and scheduled one week after the reminder postcard was mailed. Moreover, the phone call included the family's adoption worker, based on the idea that a call from a familiar person might increase families' buy-in to the program. To ensure consistency across the phone contacts, the calls were guided by a structured script. To accommodate this change in the protocol, the second questionnaire packet was mailed 2 weeks after the reminder call.
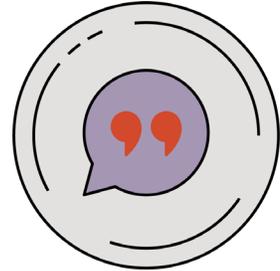
## Incentives

To help increase response rates, the incentive process was changed from a single incentive provided after the survey was completed to a multiple incentive process. As previously indicated, a $5 gift card was included in the first and second questionnaire packets mailed to families, in addition to the $25 gift card families received upon completion of the survey.

## Engagement

Originally, the Success Coach contacted only those families whose survey responses suggested they may be at higher risk for post permanency discontinuity and who may benefit from support services (i.e., high-score families). However, based on responses from the first two cohorts that completed the survey, the site team decided that in addition to contacting families whose response suggested they may need additional services, CCSS staff also reached out to respondents whose responses did not suggest a high need for services. Through these efforts, CCSS learned about the characteristics of families who may benefit from additional post adoption services and supports.

## IMPLEMENTATION

As noted above, the goal for *Reach for Success* was to develop a structured early-outreach program to identify adoptive families who might be experiencing post adoption challenges, are at risk for post permanency discontinuity, and may benefit from Success Coach post adoption services. Developing and administering a survey required careful planning. Catawba County worked in conjunction with the QIC-AG evaluation team and SRL at the University of Illinois Chicago to design the survey and develop the outreach protocol. It was important that the team worked together to capitalize on the expertise of the diverse array of team players. This included practitioners who brought practice wisdom, the project evaluation team who brought the expertise in the area of post adoption research, and SRL who brought survey development expertise. Steps involved in this process included:

## 1. Selection of Survey Questions

General areas of inquiry were discussed among the team. Once general areas were agreed upon, the research team selected standardized measures, as well as developed any additional questions to be included in the survey. Standardized measures (e.g., the Behavioral Problem Index) were selected because previous research showed that they were important intermediate outcomes to understand post permanency discontinuity.

## 2. Mailing Protocol

The second critical element in survey administration was developing a process for getting the highest number of survey responses. Because of their expertise in survey development and administration, the Catawba team followed the suggestion of SRL, who recommended mailing hard copies as opposed to sending an electronic survey. The protocol detailed each step in the survey mailing process as described above. The selection of approximately 50 families for each cohort was based on the number of calls and follow-up that seemed reasonable for the Catawba staff to add to their workload, in addition to all their other typical work-related responsibilities.

## 3. Data Sharing Process

The third aspect of successful survey administration was the creation of a data-sharing process between the state, the county, the SRL, and the QIC-AG evaluation team. This process was developed based on feedback from Stakeholders, who shared they were more likely to respond to a mailing from CCSS than the researchers.

## 4. Tracking of Protocol Steps

The fourth aspect of a successful survey administration was tracking. For each step in the survey protocol, Catawba noted the dates and other important details (such as gift card ID number) in a spreadsheet in order to track protocol adherence and fidelity to the outreach intervention. This allowed evaluators and other QIC-AG leaders to ensure the mailing process was the same for each cohort and did not impact the response rate.

## 5. Follow up with Non-Responders

The fifth and final component of the survey administration process was following up with telephone calls to non-responders to better understand why they chose not to respond to the survey.

## 6. Follow up with Families Identified through the Algorithm

The next part of *Reach for Success* was contacting the families who fell into one of the two outreach groups once the algorithm was applied. After applying the algorithm to survey responses, the evaluation team referred families who obtained a high score (and were assigned to the intervention group) and families who obtained a low score to the *Reach for Success* staff. The *Reach for Success* staff (a Success Coach) called the family within 14 days of the referral. If the Success Coach was unable to reach the family by a telephone call within 14 calendar days, he or she called twice more (at different times of day). A letter and brochure were also sent to the family informing them of the Success Coach service and a number to call if they would like to learn more. When the Success Coach reached the family by telephone, the Success Coach tailored the introduction of the Success Coach service to the needs of the family by indicating how the service could help address the needs they reported on their self-report survey. The Success Coach then scheduled a face to face visit with the family within 2 weeks of the successful outreach call.

### ADHERENCE

For adherence, CCSS tracked by cohort the number of surveys sent for each of the three rounds of mailings, the number, and proportion of survey responses by date of response, and the numbers and dates that thank you letters and gift cards were mailed. Regarding fidelity, CCSS also kept track of the dates of outreach phone calls made for those in the high- score group and notes about the results of each phone call (e.g., the family requested information but not services).

# Measures

## PROCESS MEASURES

Data related to the *Reach for Success* outreach activities were collected by Success Coach staff and shared with the evaluation team. This data allowed the evaluation team to examine adherence to the protocol. Information collected included:

- Number of surveys sent: initial, second, and third mailings (when applicable)

- Dates of survey responses

- Number and dates of thank you and gift cards mailed

- Number and dates of phone calls to families selected for outreach

## DESCRIPTIVE AND OUTCOME MEASURES

### Administrative Data

Administrative data were used to characterize adoptive families in Catawba County from the Adoption and Foster Care Analysis and Reporting System (AFCARS). Federal law and regulation require state child welfare agencies to collect case-level information on all children for whom the agency is responsible for placement, care, or supervision and on children adopted under the auspices of the agency. These data are derived from the bi-annual NC AFCARS submissions to the Administration for Children and Families of the Department of Health and Human Services (ACF). These data allowed us to understand the pre adoption experiences of children and examine how they may impact later outcomes

### Participant Surveys

The QIC-AG contracted with the SRL at the University of Illinois at Chicago (UIC), who assisted with the development of the survey instrument and related protocol. This survey was administered by CCSS to all families who meet the eligibility criteria. The consent forms associated with these surveys also asked permission for the responses to be linked to the administrative and service data. The survey collected information on services families needed and received, and on the measures listed below.

### Behavior Problem Index (BPI)

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

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

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

## Caregiver Strain Questionnaire – FC/AG17

The Caregiver Strain Questionnaire-Adoption/Guardianship Form (CGSQ-FC/AG17) is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger, & Brickman, 1997). This 17-item measure is a self-report measure that assesses the extent to which caregivers experience additional demands, responsibilities, and difficulties as a result of caring for a child who is in foster care, legal guardianship, or who was adopted. The scale includes two subscales that measure objective and subjective strain. Higher scores indicate higher levels of strain.

## Education Outcomes

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

## Illinois Post Permanency Commitment Items

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

## Protective Factors Survey (PFS)

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

the Nurturing and Attachment Subscale, higher scores indicate a higher level of emotional bonding and positive interaction between the parent and child.

## Missing Data

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

# Findings

## Sample Frame and Participant Profile

This section describes the population of adoptive families that received outreach from CCSS in Catawba County, including the number of families who were targeted and who participated. Also, characteristics of the adoptive families who received outreach are described, including a comparison of variables for those who responded to outreach versus those who did not respond to outreach. It is important to note that all of the analyses presented below include the usability cohort in addition to the other four cohorts. The decision was made to include the usability cohort in order to obtain information from as many families as possible, and because the outreach procedure for the survey between usability and formative stages did not change significantly in NC.

### UPTAKE

The tree diagram in Figure 8.7 below displays the number of adoptive families who were initially targeted for outreach, how they were classified as high or low-score, and the results of outreach.

Figure 8.7. Survey and Outreach in Catawba County
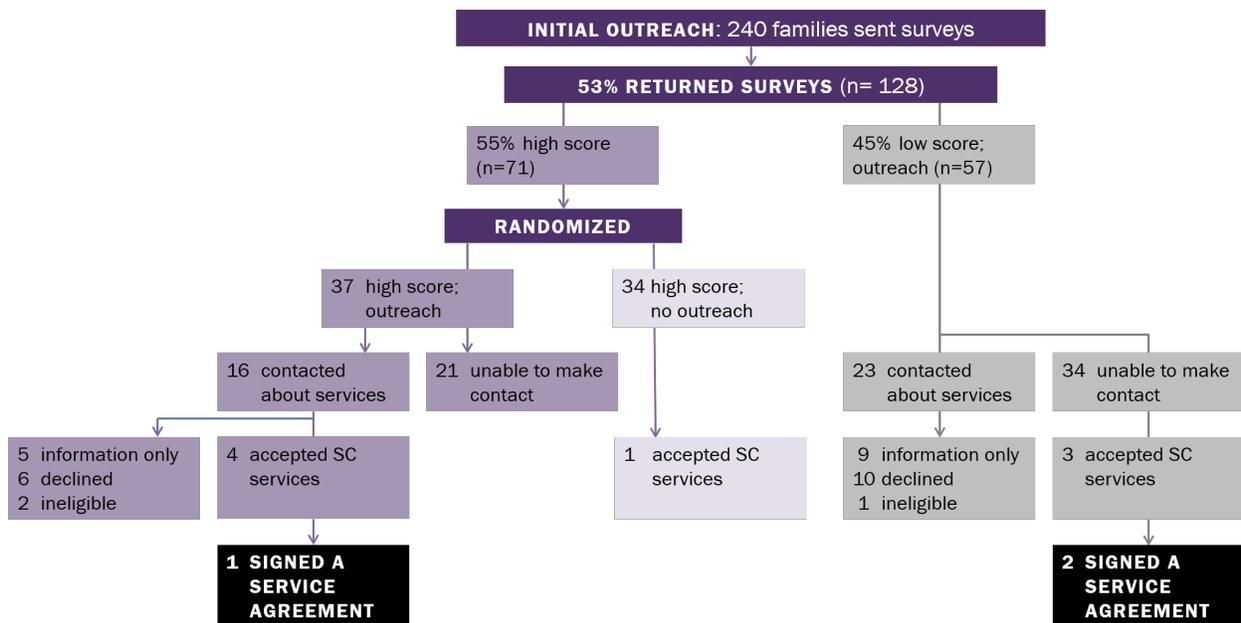
For this study, we were interested in whether there were significant differences between those families who responded to outreach versus those who did not respond to outreach. To examine this, we matched all potential survey respondents (i.e., those who responded and those who did not respond) to administrative records from AFCARS where a match was possible (for 103 cases, or about 43% of the original 240 who were sent surveys). Then we compared those who responded to the survey to those who did not respond to the survey on several demographic and foster care variables shown in Table 8.1 below. One statistically significant difference, for child race, was found between those who responded and those who did not respond to the survey. Specifically, in the sample that matched to AFCARS data, caregivers of White children made up a larger proportion of those who responded to the survey (75%) than those who did not respond to the survey (just 53%). In contrast, only 8% of those who responded to the survey were caregivers of Black children, in comparison to 22% of those who did not respond to the survey. Finally, caregivers of children from other races made up just 17% of those who responded to the survey as compared to 26% who did not respond to the survey. These findings suggest that caregivers of White children were more likely to respond to the survey than caregivers of Black children or caregivers of children from other races.

Table 8.1. Child Characteristics: Comparing Respondents and Non-Respondents

| NORTH CAROLINA | SAMPLE FRAME WHO MATCH TO AFCARS | SURVEY RESPONDENTS WHO MATCH TO AFCARS | NON-RESPONDENTS WHO MATCH TO AFCARS | BIVARIATE COMPARISON (RESPONDENTS VS. NON-RESPONDENTS)[A,B] | | |
|---|---|---|---|---|---|---|
| | 103 OF 240 SURVEYS (42.9%) | 52 OF 103 (50.5%) | 51 OF 103 (49.5%) | $\chi^2$ | df | p |
| CHILD HAS A DISABILITY | 13% | 12% | 14% | 0.00 | 1 | 0.970 |
| 3+ MOVES IN FOSTER CARE | 46% | 46% | 45% | 0.00 | 1 | 1.000 |
| CHILD'S RACE | | | | 6.17 | 2 | 0.046 |
| WHITE | 64% | 75% | 53% | | | |
| BLACK | 15% | 8% | 22% | | | |
| OTHER | 21% | 17% | 26% | | | |
| CHILD IS HISPANIC | 10% | 15% | 4% | N/A | | |
| CHILD IS FEMALE | 50% | 58% | 41% | 2.19 | 1 | 0.139 |
| PARENTS MARRIED OR TWO-PARENTS* | 65% | 69% | 55% | 0.74 | 1 | 0.390 |
| | M | M | M | t | df | p |
| CHILD AGE AT PERMANENCE | 5.81 (4.02) | 6.18 (3.63) | 5.44 (4.38) | 0.88 | 89 | 0.378 |
| MEAN YRS IN FOSTER CARE | 1.83 (.72) | 1.97 (.68) | 1.70 (.73) | 1.85 | 91 | 0.067 |

Notes:
[A] Bivariate comparisons were for the previous two columns in the table only—i.e., those who responded to the survey versus those who did not respond to the survey
[B] Chi-square not valid for comparisons where expected cell sizes are less than 5

# Process Evaluation

A process evaluation "determines whether program activities have been implemented as intended and resulted in certain output" (Centers for Disease Control and Prevention, 2015). Initial implementation of *Reach for Success* first began when the first clients received services. At that time, the evaluators began the formative (process) evaluation and tested whether the early phases of the initiative were associated with the expected program outputs of the intervention. Also, through the rest of implementation, evaluators continued to use the metrics related to adherence described above to keep track of whether processes for each cohort happened as intended.

Adherence variables were measured in terms of the degree of practitioners' adherence to the best practice model of service delivery as intended by the developers and the numbers of children families reached. Adherence variables provided information about the number and proportion of families who received mailings and phone calls to complete surveys as well as the proportion of thank you cards mailed after survey receipt. Table 8.2 below displays the results of adherence measures for all five cohorts, including the first cohort for usability (which had slightly different follow-up procedures as described above). Results indicated that adherence was extremely high across all five cohorts, with 95% to 100% of respondents receiving second mailings as needed, and 100% of respondents who were eligible receiving third mailings and thank you cards. Going into the process, the team was confident that mailing addresses would be high quality (since they were the addresses families used to receive their adoption subsidy), so the team was surprised to find that several surveys were returned because of invalid addresses.

Another aspect of the research protocol was that CCSS staff provided outreach to high and low-score families who were designated for outreach. The staff made 100% of these outreach attempts to designated families. All data related to outreach was collected by the Success Coach team and shared with the evaluation team. Finally, the evaluation team also closely monitored the development and testing of the algorithm that was utilized to determine high- score families to make sure that the algorithm correctly identified families at higher risk for difficulties after adoption (e.g., higher BPI scores, lower BEST scores, more service needs).

**Table 8.2. Adherence Tracking: Reach for Success**

| | COHORT 1 | COHORT 2 | COHORT3 | COHORT 4 | COHORT 5 |
|---|---|---|---|---|---|
| FIRST SURVEY MAILED | 46 | 50 | 52 | 47 | 45 |
| NUMBER OF NON-RESPONDERS (WITHIN 2 WEEKS OF INITIAL SURVEY) | 37 | 32 | 44 | 43 | 45 |
| SECOND MAILING (REMINDER LETTER) TO NON-RESPONDERS* | 95% | 100% | 100% | 100% | 100% |
| NUMBER OF NON-RESPONDERS (WITHIN 4 WEEKS OF INITIAL SURVEY) | 36 | 31 | 18 | 32 | 31 |
| REMINDER PHONE CALLS TO NON-RESPONDERS | N/A | 100% | 100% | 100% | 100% |
| NUMBER OF NON-RESPONDERS (WITHIN 6 WEEKS OF INITIAL SURVEY) | 29 | 22 | 16 | 38 | 26 |
| THIRD MAILING (SURVEY) | N/A | 100% | 100% | 100% | 100% |
| TOTAL NUMBER OF RESPONDERS | 20 | 28 | 36 | 22 | 22 |
| THANK YOU LETTER WITH GIFT CARD SENT (TO THOSE WHO RETURNED SURVEYS) | 100% | 100% | 100% | 100% | 100% |
| TOTAL NUMBER OF FAMILIES IN THE OUTREACH GROUP WHO RECEIVED PHONE CALLS | 100% | 100% | 100% | 100% | 100% |

*Note: The process for retrieving addresses was updated after Cohort 1

# Outcome Evaluation

There was one short-term outcome in Catawba County: Engagement in Success Coach Services. This was measured in two ways, the number of families who expressed interest in services, and the number of families who participated in Success Coach services.

## ENGAGEMENT IN SUCCESS COACH SERVICES

Findings from the outreach efforts to engage families in intervention:

- Of the **128** families who returned surveys, **94** were designated for outreach (**57** in the low score group and **37** in the high-score outreach group).

- Of the **94** families designated for outreach, **39** parents were able to be contacted by CCSS (or **41%** of those designated for outreach, with **23** contacted in the low-score group and **16** contacted in the high-score outreach group).

- A significant proportion of the **39** parents who were able to be contacted by CCSS were interested in either learning more about Success Coach services or receiving Success Coach services. Specifically, results showed that **21** of the **39** families (**54%**) who were successfully contacted through outreach were interested in either Success Coach information or services, with **7** interested in services and **14** interested in information only.

- Of the **7** families who were interested in services, **3** (**43%**) entered into a service agreement and actually participated in Success Coach services.

- Of the **3** families who entered into a service agreement for Success Coach services, **2** were from the low-score group and **1** was from the high-score group. It is important to note that with such a low uptake of Success Coach services, it is impossible to discern if low-score or high-score families were more likely to enter into a service agreement.

In sum, this study did not find that the additional outreach to families resulted in additional uptake of Success Coach services. Furthermore, the low number of families who engaged in services does not allow us to sufficiently assess the impact of the algorithm to distinguish families who may be interested in services. Perhaps with additional time, CCSS will observe a different level of uptake based on the algorithm and additional analysis can be pursued to understand the characteristics of families in need of Success Coach services.

An additional area of inquiry related to families in Catawba County, NC was whether the target population of interest, adoptive families, was participating in and receiving the Success Coach intervention as intended. This study found that families who were contacted through outreach but subsequently declined services largely reported they were adjusting well and did not need extra supports (see the discussion below regarding how CCSS front-loads supportive services for adoptive families). For example, among the five high-score families who received outreach but explicitly declined Success Coach services, three caregivers reported that their family was doing fine, one caregiver did not provide further information, and one caregiver reported that their family was not adjusting well. Thus, it may be that in Catawba County, most families who do not receive Success Coach services are those that feel they are doing fine and do not need more services or supports.

In regard to barriers for families to obtain Success Coach services, a significant proportion of the families in this study who were contacted through outreach requested information about the program (36%). Therefore, one barrier to service engagement may be a lack of information about the availability of Success Coach services, eligibility criteria, or even the potential benefits of services for families. Related, outreach efforts were unsuccessful for over half of those eligible for outreach in this study (55 out of 94 families, or 59%). Thus, another barrier to service engagement may be that adoptive parents change addresses, phone numbers, and/or living arrangements after adoption and lose contact with CCSS. Outreach efforts to families after adoption, such as a general survey, may help adoptive parents both remain in contact with the agency and stay aware of potential supportive programs like Success Coache services.

## COMPARING LOW VS. HIGH-SCORE RESPONDENTS

### Behavioral Health and Wellbeing

In regard to child behavioral health and child/youth and family wellbeing, the results of the scales used in the survey are summarized in Table 8.3 below. These scales provide information about levels of child behavior problems (BPI: higher values indicate more reported behavior problems in the home); child belonging and emotional security (BEST-AG: higher values indicate more belonging and emotional security), protective factors in the family (PFS: higher values indicate higher family functioning, nurturing, and attachment), and caregiver stress or strain (STRAIN: higher values indicate higher caregiver stress or strain).

These scales also provide information about differences in these scale scores between those families who were identified as "high-score" (i.e., caregivers reported more behavior problems and unmet needs) and those families identified as "low-score" (i.e., caregivers reported fewer behavior problems and unmet needs). However, please note that because total BPI score was a primary factor used in the algorithm to classify families as high or low-score, differences between the two groups on the BPI would be expected.

The scale results presented in Table 8.3 below support the classification of families into high and low-score groups, with high-score families having not only higher scores the BPI scale and subscales, but also higher average scores on the STRAIN scale and subscales, lower average scores on the PFS-Nurturing and Attachment scale, and lower total scores on the BEST scale and subscales. These results suggest that the families who were classified as high-score have a lower level of child, caregiver, and family functioning as compared to those families classified as low-score. These findings suggest that these scales and subscales may be used to identify families who are struggling. However, as noted above, uptake for Success Coach services was low overall, with only 21 families reporting an interest in Success Coach information or services (12 in the low-score group and 9 in the high-score group) and just 3 families actually entering into a service agreement for Success Coach services (2 in the low score group and 1 in the high score group), Therefore, with such a small number of participants in Success Coach, this study was unable to provide information about whether low- or high-score families were more likely to engage in the program, and more research is needed in this area.

**Table 8.3. Measures of Wellbeing: Comparing Low vs. High-Score Respondents**

| MEASURE | RANGE | OVERALL MEAN (SD) | LOW-SCORE GROUP MEAN (SD) | HIGH-SCORE GROUP MEAN (SD) | BIVARIATE COMPARISON (LOW-SCORE VS. HIGH-SCORE) | | |
|---|---|---|---|---|---|---|---|
| | | | | | *t* | *df* | *p* |
| *ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN* | | | | | | | |
| BEHAVIOR PROBLEM INDEX | 0-56 | 9.75 (10.42) | 2.96 (3.17) | 15.32 (10.99) | -8.77 | 79 | < .000 |
| BPI EXTERNALIZING | 0-38 | 7.48 (8.08) | 2.30 (2.45) | 11.68 (8.61) | -8.57 | 80 | < .000 |
| BPI: INTERNALIZING | 0-22 | 2.96 (3.74) | 0.75 (1.24) | 4.76 (4.12) | -7.55 | 80 | < .000 |
| CAREGIVER STRAIN (CGSQ-FA22) | 1-5 | 1.61 (0.64) | 1.34 (0.31) | 1.83 (0.75) | -4.91 | 96 | < .000 |
| OBJECTIVE STRAIN | 1-5 | 1.47 (0.76) | 1.16 (0.29) | 1.72 (0.91) | -4.91 | 86 | < .000 |
| SUBJECTIVE STRAIN | 1-5 | 1.71 (0.67) | 1.47 (0.43) | 1.90 (0.76) | -4.00 | 112 | < .000 |
| *ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN* | | | | | | | |
| PFS FAMILY FUNCTIONING | 1-7 | 6.12 (0.86) | 6.26 (0.83) | 6.01 (0.87) | 1.65 | 120 | .102 |
| PFS NURTURING AND ATTACHMENT | 1-7 | 6.19 (0.91) | 6.50 (0.53) | 5.95 (1.06) | 3.74 | 108 | < .000 |
| BEST-AG | 20-100 | 95.49 (6.50) | 97.54 (2.98) | 93.85 (7.95) | 3.61 | 93 | < .000 |
| BEST-AG EMOTIONAL SECURITY | 13-65 | 61.18 (5.11) | 62.84 (2.65) | 59.84 (6.14) | 3.70 | 100 | < .000 |
| BEST-AG CLAIMING | 7-35 | 34.32 (1.61) | 34.71 (0.71) | 34.01 (2.03) | 2.71 | 90 | .008 |

Note: Bivariate relationships between BPI total scale and subscales were expected because total BPI scores were used in the algorithm to classify families as high or low-score.

PROFILE OF ADOPTIVE PARENTS IN CATAWBA COUNTY

The survey responses provided an opportunity to also examine the characteristics of adoptive families in Catawba, County. These results are summarized below.

## Caregiver Commitment:

The survey results from caregiver commitment questions, shown below, indicate that most adoptive families are adjusting well to permanence. A large majority of respondents said that they felt positive about the adoption, that they understood their children most of the time, and that they could meet their child's needs. In addition, almost all respondents stated that they never thought about ending the adoption. Finally, most adopted children were reported to be doing "excellent" or "good" in school for both reading and math.

Overall, how would you rate the impact of your child's adoption on your family?

- **71%** of respondents felt extremely positive about the impact of the adoption.

During the past month, how often have you felt that you just did not understand your child?

- **73%** of all respondents responded 'never' or 'less than once a week.'

How often do you think of ending the adoption?

- **94%** of respondents reported that they never thought about ending the adoption,

How confident are you that you can meet your child's needs?

- **84%** of respondents reported being "extremely" or "very" confident that they could meet their child's needs.

How would you describe your child's school performance in reading and language arts?

- **72%** responded "excellent" or "good."

How would you describe your child's school performance in math?

- **66%** responded "excellent" or "good."

## School and legal involvement:

Table 8.4 below shows the percentage of adopted children who were reported to have experienced specific negative school or legal outcomes. Results were generally positive, with 10% or less of caregivers reporting that students experienced in- or out-of-school suspension, skipping school, and expulsions from school. Also, only 1% of caregivers reported that their child had run away and 3% reported legal and juvenile justice system involvement.

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Table 8.4. School Experiences

| CHILD'S EXPERIENCES | % |
|---|---|
| SKIPPED SCHOOL OR CUT CLASSES WITHOUT YOUR PERMISSION | 7% |
| RECEIVED AN IN-SCHOOL SUSPENSION | 10% |
| RECEIVED AN OUT-OF-SCHOOL SUSPENSION | 5% |
| BEEN EXPELLED FROM SCHOOL | 2% |
| BEEN IN TROUBLE WITH THE LAW OR JUVENILE JUSTICE SYSTEM | 3% |
| RUN AWAY FOR A PERIOD OF MORE THAN 7 DAYS | 1% |

## After-School Activities:

Survey respondents indicated that many of the adopted children were involved in after-school activities. Table 8.5 below shows the percentage of survey respondents who indicated their children were involved in various activities. The highest proportions were for religious instruction/youth groups and sports (60% or more of respondents). The activity with the lowest participation among adopted children/youth was a part-time job or internship (only 15%). These results provide evidence that most adopted youth are adjusting to their placement enough to become involved in activities outside of the home.

Table 8.5. Extracurricular Activities

| EXTRACURRICULAR ACTIVITIES | % |
|---|---|
| RELIGIOUS INSTRUCTION OR YOUTH GROUP | 66% |
| SPORTS OR ATHLETIC ACTIVITIES | 60% |
| LESSONS IN ART, PERFORMING ARTS, MUSIC, OR DANCE | 42% |
| ACADEMIC SUPPORT OR TUTORING | 28% |
| CLUBS OR ORGANIZATIONS | 48% |
| VOLUNTEER ACTIVITIES | 40% |
| PART-TIME JOB OR INTERNSHIP | 15% |

## Services families need and use

Families who responded to the survey indicated whether they needed a variety of individual services and if they tried to obtain those services. Among those who tried to obtain services, they were asked if they were successful in obtaining them. Finally, among those who obtained services, they were asked about their level of satisfaction with those services. Table 8.6 below summarizes the results of these questions for the four most commonly needed services: mental health, specialized medical or dental care, educational support, and child developmental services. Overall, 35% or less of respondents indicated needing any of the services, with less than 15% of caregivers reporting a need for three other individual services not shown in the table below—respite, adoption support groups, or summer enrichment. Results indicated that the majority of those who tried to obtain services were successful (83% or more for the four services shown in the table) and that those who obtained services were typically happy with the services provided. However, a significant minority of respondents (20-32% for the four services shown in the table) did not report being satisfied with services (i.e., they found services "slightly helpful," "not at all helpful," or they did not respond to this follow-up question).

Table 8.6. Service Needs and Use

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

## Limitations

There are several limitations to keep in mind regarding the QIC-AG evaluation in Catawba County. First, Catawba is an innovative county, often an early adopter of innovative practices. CCSS has developed an agency culture and infrastructure that supports evidence building. It has a long history of partnering with local, state, federal partners, both public and private, to advance child welfare practice. CCSS has a proactive social service system that provides post permanency services and has experimented with new programs that have the potential to benefit families both before and after adoption. Thus, Catawba County may not be representative of other county social service agencies in NC or other social service agencies in the U.S. For example, Catawba County offers mental health services to all families in foster care, provides coordinated child welfare services using clinical teams, and has a Success Coach program already in place for adoptive families (that started prior to the QIC-AG project). Thus, it may be that front-loading child welfare services in Catawba prevents issues after adoption and/or lowers the reported needs of adoptive families.

Another limitation to consider is that the types of caregivers and families who responded to the outreach survey in Catawba may be different from those caregivers and families who do not respond in ways that were not captured in analyses presented above. Indeed, one statistical test found child racial differences between respondents versus non-respondents, with caregivers of White children more likely among respondents than non-respondents (see Table 8.1 above). Therefore, care should be used in interpreting the results for those families who responded to the survey—for example, they may have more (or less) needs and/or challenges than other adoptive families.

Finally, the results of statistical tests presented above should be interpreted with some caution because the sample sizes used in analyses were somewhat small (i.e., 103 cases possible for comparisons of respondents versus non-respondents and 128 cases possible for comparisons of low versus high- score families). Also, many statistical tests were estimated, so statistically significant findings may be obtained simply due to chance.

## Thoughts from Parents

At the end of the survey, parents were asked, *"Is there anything else about your experience of adoption of your child that you would like to share?"* Their responses reflected a wide variety of experiences within the narrow target population that we defined.

The following are direct quotes from participants about the experience of being an adoptive parent:

"I thoroughly enjoyed raising my granddaughter. I would do it all over again! She is a joy to have around!"

"Our children are our children, loved no different than biological children. They are loved and cared for. They are our life. Thanks to Catawba County, it has been an awesome journey."

"My daughter makes me happy and proud. At times it has been a little difficult because she's going through puberty, but she's still a joy. She makes straight A's at school and is liked by all her teachers. She is very motivated and has been a cheerleader for 6 years."

"Our adopted child has been a bundle of joy in our lives. We are so grateful!"

"Our daughter has been with us since her birth. She is our daughter and we love her as if she were our own because she truly is our little girl. We would not want our family to have happened any other way."

"Love her to the moon and back!"

The following are direct quotes from participants about the challenges with their adopted child:

"He is my son now. I would never leave him for anything in this world. He has problems but we are trying to take care of them with his counselors, psychiatrists, school."

"Very demanding yet very rewarding."

"Adoption has definitely enriched my life in ways I never imagined. But often I feel there's more I should be doing for my child - but don't have time, energy or patience to do it. So, I just do what I can and hope for the best."

"I have had to learn a lot about trauma attachment, and sensory issues in order to meet my daughter's needs. I strongly believe adopted or biological, that all parents need to rise up and meet their child's needs."

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

"We maintained limited birth family connections. I feel this has helped (child's name)."

"Honestly, the best experience that we have ever had as far as the child is concerned. Really frustrating trying to handle birth families though."

The following are direct quotes from participants regarding services that could be improved:

> **"If the parents are on drugs or have mental issues, they should let the adoptive parents know. They should stay on Medicaid till at least 21. And also receive a check."**

> **"Fighting for mental health services is exhausting."**

> **"I feel like my child's needs were not assessed properly while in foster care due to the foster parents being extremely neglectful."**

> **"It really depends on your social worker as to how your experience will be."**

> **"We allowed birth mom to visit and have access to our child. This was a mistake. We work with a counselor to help control the situation. We would not recommend trying to work with birth parents."**

In sum, most parents noted a strong bond to their children, as well as maintaining the adoption, even in the face of challenges. Some specific difficulties were noted that related to inadequate or inconsistent services and the mental health and behavioral needs of children, However, parents indicated that timely, supportive services have the potential to mitigate difficulties that adoptive families face (e.g., better communication with the school and adoption-competent mental health services).
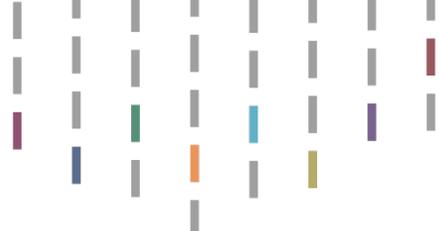
# Cost Evaluation

The Catawba County, North Carolina QIC-AG project implemented and tested the effectiveness of *Reach for Success*, a service-engagement intervention. The project reached 128 families formed by adoption and guardianship through a survey to identify families with elevated risk for post permanency discontinuity. Seven families were in need of and agreed to participate in Success Coach Services.

## Cost Evaluation Approach

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

## Assumptions, Conditions, and Constraints

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

### ASSUMPTIONS

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

We also assume multiple positive outcomes are likely impacted by the QIC-AG site programs. For the North Carolina site, the desired impact of the programs is to improve behavioral health and wellbeing. However, other positive outcomes may not be necessarily captured by the intervention.

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

### CONSTRAINTS

Constraints are factors that have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For Catawba County, constraints may include the fact that North Carolina does not have a unique child ID that is used across counties, and possibly that the counties are run as independent systems in North Carolina, with less central support than a state-run system might have.

Conditions are factors that may influence system processes but are not necessarily constraints. For Catawba County, conditions may include recent policy changes in North Carolina, including the availability of subsidized guardianship as a permanency option, and the availability to extend foster care to the age of 21.

## Cost Estimation

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

### KEY POINTS IN COST ESTIMATION

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

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. Prior to implementation, North Carolina's intervention site, Catawba County Social Services, had substantial infrastructure as a county agency. Infrastructure costs specific to the agency were not estimated for this cost evaluation. Additionally, Catawba County had already implemented the Success Coach model with substantial support from the Duke Endowment. Thus, sites wanting to implement the Success Coach model would need to budget for additional costs during their installation phases. The sites also received substantial technical support from consultants and evaluators during implementation. Although the consultation was crucial to moving sites into implementation, the costs associated with the consultation will only be noted in the conclusion as additional costs for future programs to consider. Evaluation costs are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates.

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

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

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

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

The steps involved in the cost estimation of this analysis are described below. All QIC-AG sites used a standardized budget form and cost reimbursement form. Costs for Catawba County were taken from monthly budget forms and summarized into Table 8.7. It should be noted that North Carolina ended up providing outreach on its own due to issues with payments and accounting procedures. Some of those efforts may have resulted in increased costs.

Table 8.7. Costs for North Carolina

| | IMPLEMENTATION | | | TOTAL |
|---|---|---|---|---|
| | FY 2019* | FY 2018 | FY 2017** | |
| **PERSONNEL COSTS** | | | | |
| SIM SALARY | $3,837 | $7,390 | $10,950 | $22,178 |
| SIM FRINGE BENEFITS | $1,049 | $2,163 | $2,867 | $6,079 |
| SUCCESS COACH | $8,103 | $53,036 | $30,542 | $91,681 |
| PROJECT MANAGER | $3,323 | | | $3,323 |
| FRINGE | $7,300 | $16,431 | $8,968 | $32,699 |
| **NON-PERSONNEL COSTS** | | | | |
| CONTRACTED SERVICES: U OF ILLINOIS | | $14,597 | $16,579 | $31,176 |
| FACILITIES/OFFICE SPACE | | $487 | $837 | $1,324 |
| GIFT CARD INCENTIVES | $50 | $3,185 | $1,710 | $4,945 |
| POSTAGE | | | $522 | $522 |
| PRINTING/DUPLICATION | | $32 | | $32 |
| PROGRAM SUPPLIES | | $72 | $224 | $296 |
| TELEPHONE | | $758 | $389 | $1,147 |
| TRAVEL | | $4,291 | $3,664 | $7,955 |
| OTHER: CERTIFIED MAIL | | $1,296 | | $1,296 |
| OTHER: MATERIAL SUPPORT FUNDING | | $30 | $3,666 | $3,696 |
| OTHER: NON-SPECIFIED | | $7,902 | | $7,902 |
| **NON-PERSONNEL INDIRECT COSTS** | | | | |
| BOOKS | $1,636 | | | $1,636 |
| TRAVEL | | | $414 | $414 |
| **TOTAL** | $25,298 | $111,670 | $81,332 | $218,300 |

*FY 2019 through 3/31/19 only
**FY 2017 started 3/1/29

## Collect data on Resource Costs

In order to collect accurate information, monthly expense forms were used to track actual costs. All QIC-AG sites developed an annual budget. The actual costs billed to QIC-AG were provided to the evaluation team via monthly expense reports. These expense reports contained a year to date summary of expenses. Expenses for each fiscal year were then compiled into Table 8.7.

## Collect data on Resource Allocation

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

## Estimation of Direct Costs

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

### Personnel

Personnel costs totaled $117,182 for staff time allocated to the project. Personnel costs included the salary of the SIM which was $22,178; salary of the Success Coach $91,680; and $3,323 for the salary of the Project Manager.

### Fringe

Overall fringe for all employees totaled $38,777. Fringe was calculated based on guidelines set by Catawba County.

### Contractual expenses

North Carolina contracted for services with the University of Illinois/Survey Research Lab for $31,176 for all survey related tasks and technical assistance to assist with a protocol on the engagement of adoptive families.

### Gift cards

$4,944 were provided to caregivers who completed the survey.

### Materials and supplies

Over the implementation period, $295 was spent on program supplies that were specific to the operation of the intervention.

### Travel

Over implementation and installation, $8,369 was paid for travel. Travel costs included travel to the state Family Preservation Meeting.

### Facilities/Office space

$1,324 was spent for office and/or facility space.

## Other direct charges

Other direct charges include all non-personnel direct costs that do not fit into the categories listed above such as postage ($1,817), phones ($1,146), printing and duplication ($31), and funds for material support of families ($3,696).

## Estimation of Indirect Costs

Descriptions of all indirect costs billable to Spaulding were defined by Spaulding. These same descriptions are used in this cost estimation. Only one indirect cost was billable to the project. The purchase of books was $1,635 were billed to the project as general overhead costs. Travel was billed at $414.

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

## Summary of Costs

Total implementation costs for North Carolina were $218,299.

# Cost Calculations

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

### COST PER PARTICIPANT

North Carolina conducted a survey to find families who may have needed extra support. They identified 240 families and had 128 families respond. Based on the total costs of $218,299, each survey cost $910 to send.

### COST-EFFECTIVENESS ESTIMATION

For North Carolina, the survey was intended to identify families who might be needing assistance. Given that so few families reported needing assistance, there were no significant outcomes related to the Success Coach intervention.

However, an effective outcome is a completed survey which can be used in a cost-effectiveness estimation. In total, 128 caregivers completed a survey. Thus, the cost per positive outcome or cost-efficiency ratio is:

$$\textbf{COST-EFFECTIVENESS RATIO} = \frac{\text{Cost of mailing surveys}}{\text{Number of completed surveys}}$$

which results in a cost of $1,705 per completed survey.

## Sensitivity Analysis

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

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

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

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

2. The costs for the site coordinator were removed. As with the Site Implementation Manager's role, administrative tasks directly related to the intervention could be absorbed by the Success Coach.

3. Gift cards were removed from the cost calculation. Gift cards were provided to thank people for their time in completing survey materials so that they could be identified to program staff. In other agencies, recruitment would likely occur differently.

4. Program supplies were excluded as there was no specification that these were directly related to the intervention.

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

6. Fees related to office space rental were excluded. Other agencies would likely have the office space available for the Success Coach. Additionally, rental space varies significantly by area and other agencies would need to adjust for their own community and agency needs.

7. Contracted costs for the University of Illinois were also removed because those expenses related to survey costs and data collection. Some sites could opt to do the survey and collect the data with in-house resources.

8. Other non-intervention related charges were excluded including other non-specified costs and material support. These expenses were not necessary for the implementation of the intervention.

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

Costs that remain include telephone and postage charges. These were included because the intervention model called for outreach to families who may need services but were not receiving them. Based on these exclusions, Table 8.8 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $127,376 which amounted to $530 per participant or $995 per completed survey.

Table 8.8. Sensitivity Analysis: Adjusted Costs for North Carolina

| | IMPLEMENTATION | | | TOTAL |
|---|---|---|---|---|
| | FY 2019* | FY 2018 | FY 2017** | |
| **PERSONNEL COSTS** | | | | |
| SUCCESS COACH | $8,103 | $53,036 | $30,542 | $91,681 |
| FRINGE | $7,300 | $16,431 | $8,968 | $32,699 |
| **NON-PERSONNEL COSTS** | | | | |
| POSTAGE | | | $522 | $522 |
| PRINTING/DUPLICATION | | $32 | | $32 |
| OTHER: CERTIFIED MAIL | | $1,296 | | $1,296 |
| **TOTAL** | **$15,403** | **$71,552** | **$40,421** | **$127,376** |

*FY 2019 through 3/31/19 only
**FY 2017 started 3/1/29

## Cost Evaluation Summary

Total implementation costs for North Carolina were $218,299. North Carolina conducted a survey to find families who may have needed extra support. They identified 240 families and had 128 families respond. Based on the total costs of $218,299, each survey cost $910 to send.

For North Carolina, the survey was intended to identify families who might be needing assistance. Given that so few families reported needing assistance, there were no significant outcomes related to the Success Coach intervention. However, a measurable outcome for North Carolina was a completed survey. The site achieved a 55% response rate with 128 surveys returned. Thus, the cost per returned survey was $1,705.

A sensitivity analysis demonstrates that many costs could be reduced or eliminated in a replication of the site activities. Based on that analysis, the reduced total cost of the project was $127,376 which amounted to $530 per participant or $995 per completed survey.
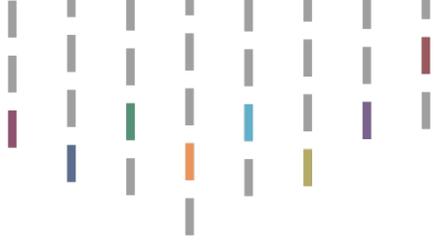
# Discussion

The purpose of outreach provided through *Reach for Success* was to engage more adoptive families in Success Coach services, particularly families who may be struggling with unmet service needs, difficult child behaviors, poor family cohesiveness, or other issues related to child and family wellbeing. The Theory of Change suggested that early outreach and intervention would increase participation in Success Coach services, resulting in improved child and family wellbeing and decreased post adoption instability. Through *Reach for Success*, 94 families were selected for additional outreach based on survey responses (57 in the low-score group and 37 in the high-score group). CCSS was able to make contact with just 39 of these 94 families (41%). Then of these 39 who were contacted, only seven (18%) were interested in participating in the Success Coach program (three in the low-score group and four in the high-score group). Finally, follow-up by CCSS indicated that three of these seven families (43%) who were interested in Success Coach services actually entered into a service agreement and subsequently participated in services. Given the low number of families who engaged in services, it is difficult to know if *Reach for Success*, either through the survey or subsequent outreach, was successful in identifying families who may be in need of Success Coach services. Additional time and tracking of who contacts the Success Coach program would help understand this question better. However, one positive finding of outreach was that low uptake was largely the result of most caregivers feeling that families were doing well and did not need or want additional services.

Low uptake in Catawba County may also have occurred because Catawba County Social Services (CCSS) front-loads adoption services and has a history of implementing proactive, innovative programs to support adoptive families. However, the findings of this study are consistent with previous post adoption literature which indicates that most children and families adjust well after adoption from foster care, although a small but significant proportion of families (i.e., about 5-20%) also report unmet needs, child behavior problems, placement instability, and other issues, and might benefit from additional services (Rolock, 2015; Rolock & White, 2016; Rolock & White, 2017; White, 2016). The most commonly needed services reported by caregivers in Catawba County were mental health, specialized medical or dental care, educational support, and child developmental services. However, typically less than a third of families reported needing each service. In fact, only a few families reported needing several other services, including respite, adoption support groups, and summer enrichment. Another positive finding of this study was that most caregivers and youth who tried to obtain services were successful and that those who obtained services were typically happy with the services provided.

Many of the measures used in this study were effective in both identifying youth and families who may be at-risk for poor adjustment after adoption (e.g., caregivers who report high parenting strain) and showing high reliability in statistical tests (i.e., Cronbach's alphas greater than .70; DeVellis, 2003). Reliable and valid measures are needed in post adoption research, so the scales used in this study could be used and/or adapted in future research studies, including the BPI, BEST, STRAIN, and PFS scales and subscales.

Finally, the results from surveys obtained in this study provided a descriptive profile of adoptive families in Catawba County who responded to the survey. Although those who responded to the survey may not be representative of all adoptive families in Catawba (e.g., younger adoptive children in multi-adoption homes would not be included), the survey results may be useful to policy-makers and practitioners in child welfare. For example, the average age of adopted children and youth at the time of the survey was about 13, and the pre-teen and teenage years have been identified in previous literature as high-risk ages for post adoption instability (Rolock & White, 2016). Further, the age of primary caregivers was 52, 80% of families had a racial match between the caregiver and child, and 43% of adoptive caregivers had a kinship relationship to the child. Thus, descriptive results suggest strategies for post adoptive intervention, such as providing education for adoptive

caregivers to effectively parent high-risk adolescents, or engaging families to process their new kinship roles after adoption.

As noted above, we asked families to share additional thoughts with us when we surveyed them. Of the 128 survey respondents, 51 (40%) provided comments, and the majority of those respondents (35) reported something positive about their adoption experiences. For example:

> "My adoption experience has been a positive nature. I would not have it any other way. Love my daughter so much and I will be her mother forever. I appreciate the foster adoption process."

> "Our lives are complete now because of our kids. I would never change a thing! They are perfect. Our DHSS staff was wonderful during our process."

In many comments, the parents described a deep love and appreciation for their adopted children. However, for some adoptive parents, their child also presented unanticipated challenges including attachment issues from past trauma experienced, problems at school, and identity concerns. Difficulties interacting with birth families were also problematic for some families. Challenges were compounded when parents could not obtain the services their children needed. Therefore, culturally sensitive, developmentally-appropriate, trauma-informed services that are requested and delivered in a timely fashion have the potential to help avert difficulties that adoptive families experience after legal permanency.
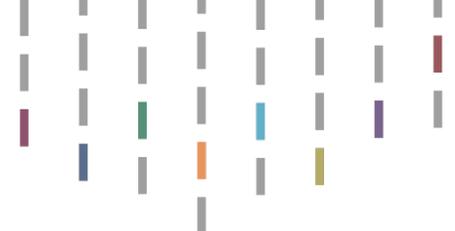
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# Chapter 10

## Table of Contents

## Tables and Figures

# Overview

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

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

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

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

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

# Cross-Site Results

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

## Engagement with Adoptive and Guardianships Families

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

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

### SERVICE ENGAGEMENT FOR SELECTIVE PREVENTION SITES

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

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

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

**CENTRAL REGION, IL**

577 families assigned to the intervention group

53% successfully contacted

12% participated in the intervention

**NEW JERSEY**

769 families assigned to the intervention group

57% successfully contacted

12% participated in the intervention

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

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

- Less confident that they could meet the needs of their child

- More likely to struggle to effectively manage their child's behavior

- More likely to struggle to appropriately respond to their child

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

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

**CATAWBA COUNTY (NC)**

240 families were sent surveys

128 (53%) took the survey

94 designated for outreach

41% successfully contacted

3 participated in Success Coach services

In Catawba County, the working hypothesis was that there were families in need of post adoption services who either did not know about the services or were unable to access the services. During the project period, 240 families in Catawba County were sent surveys. Of those 240 families, 53% (128) completed and returned surveys. Of the 128 families who returned surveys, 94 were designated for outreach. Of the 94 families designated for outreach, 41% (39) parents were subsequently successfully contacted by Catawba County staff to assess their interest in Success Coach services. A total of 3 families signed service agreements and participated in Success Coach services. Families who were contacted through outreach but declined services largely reported they did not need extra support.

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

## Survey Response Rates

Surveys were sent to families in Vermont, Catawba County (NC), Illinois and New Jersey[1]. In Vermont, the survey could be completed electronically or by pen and paper. In all the other sites, the surveys were pen and paper only. In Catawba, Illinois, and New Jersey a pre-paid cash incentive was also included. A variety of methods were used to encourage participants to return the surveys: sites sent emails, made phone calls, and followed up with non-responders in a series of assertive outreach efforts. The sites also engaged a look-up service to acquire the most recent contact information for families. Surveys were sent to adoptive parents and guardians who were asked to respond to the survey focusing on one target child per family. Surveys assessed caregiver's experiences related to adoption or guardianship (for example, respondents completed standardized measures, such as the Caregiver Strain scale, the Behavior Problem Index, and questions related to caregiver commitment, familial relationships, and service needs and use).

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

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[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
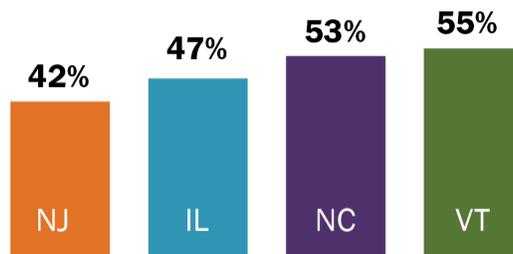


Overall Response Rates

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.

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

## Service Needs and Use

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

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

### SURVEYS IN VERMONT AND CATAWBA COUNTY (NC)

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

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

Table 10.2. Vermont Service Use in Past 6 Months

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## SERVICE NEEDS AND USE SUMMARY

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

# Outcomes

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

- In Vermont, the project was able to provide a robust assessment of the needs, characteristics, and strengths of families formed through adoption and guardianship. The Vermont site developed an understanding of families who are struggling and those who seem to be doing well. Caregivers who would definitely adopt or assume guardianship of their child again had higher levels of resilience, open communication, perseverance in times of crisis, and more positive parent-child interaction compared to caregivers who indicated they were uncertain or definitely would not adopt or assume guardianship again. The "definitely adopt or assume guardianship again" group had less strain attributed to parenting their child and more confidence in knowing how to meet their child's needs. Additionally, they felt more prepared at the time of their child's finalization and used fewer services in the past six months than those who expressed hesitancy to adopt or assume guardianship again.

- In Illinois, intervention participants were struggling more than families who did not participate in the intervention. Yet, this study did not find that TARGET participants fared better than children in the comparison group on the outcomes measured (e.g., child behavioral issues and wellbeing measures). It is possible that no intervention effects were observed due to the limited observation window of about 6 months post intervention. With additional time, perhaps differences between the intervention participants and families assigned to the comparison group will emerge. It is also possible that families in Illinois needed something different than TARGET. Additional research is needed to develop next steps in Illinois.

- In New Jersey, no statistically significant differences were found between the TINT intervention participants and the overall comparison group and between the TINT participants and a sample of the matched comparison group on the key measures of child and family wellbeing. However, promising trends suggest that with additional time, statistically significant differences may emerge. Specifically, caregivers who participated in the intervention tended to feel better able to manage their child's behavior, which is a key factor related to post permanency stability and family wellbeing. An extended observation period in New Jersey would enhance our understanding of these issues.

- In Wisconsin, parents and guardians reported that service providers often did not listen to them or believe how bad it could be at home. Results indicated that families felt supported when the AGES workers made home visits, listened to families' concerns, and provided support and advocacy with other service providers or systems. The AGES workers were

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

- In Catawba County (NC), families who needed post adoption services and supports were largely already engaged in services through the existing outreach methods and service delivery systems. Few additional families requested Success Coach services as a result of Reach for Success. However, through the outreach survey sent to adoptive families, a profile of family characteristics, services sought and received, and responses to key measures related to post adoption stability provided valuable information to the child welfare agency to design future post adoption and guardianship interventions and supports.

- In Tennessee, compared to neuro-typical children their age, children and youth who participated in the intervention saw an increase, over baseline, of their functioning on key domains measured through the NMT Metrics. Importantly, a decrease in BPI scores from pretest to posttest, stronger for the intervention group compared to the comparison group, was observed. Trends found in this study are promising, but more research using a larger sample and a longer observation window is needed. Post adoption services should be designed to help children and families cope with prior experiences of trauma and placement instability.

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

## Limitations

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

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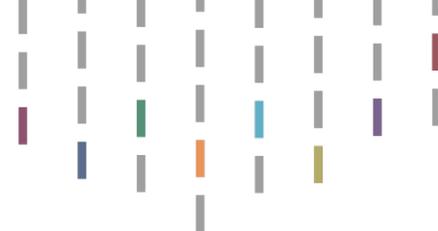
# Examining Post Permanency Discontinuity

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

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

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

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

# Post Permanency Discontinuity

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

- Children aged six or older at the time of finalization were 2.9 times more likely to reenter foster care compared to children whose adoption or guardianship was finalized prior to the age of six.

- Children who had three or more moves in foster care were 66% more likely to reenter foster care, compared to children who had less than three moves while in foster care.

- Children of color (compared to White children) were 6% more likely to reenter foster care.

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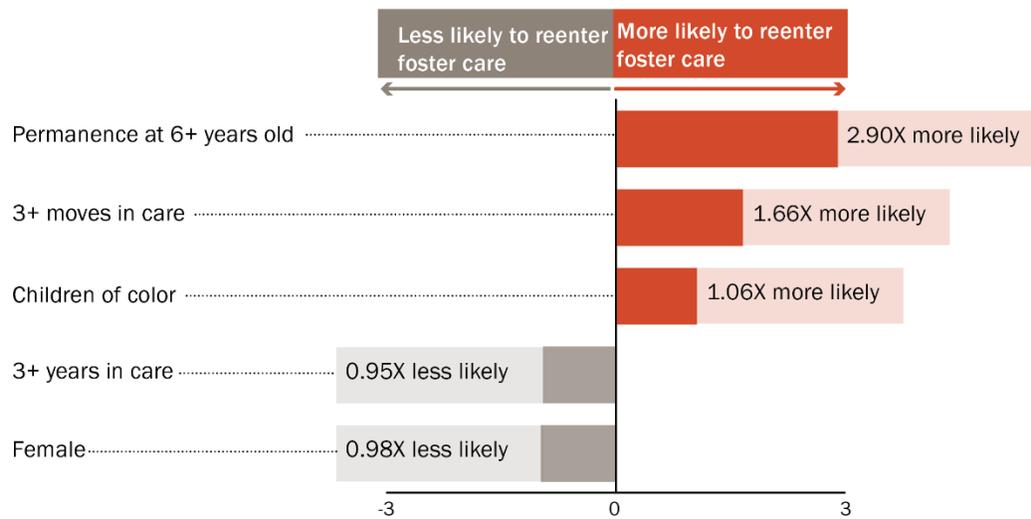


Note: The graph above shows hazard ratios. They are plotted on a logarithmic scale for ease of interpretation. Hazard ratios less than 1.0 represent decreased odds relative to the comparison group, while values greater than 1.0 represent increased odds relative to the comparison group. In this graph,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

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

# Analysis Along the Prevention Continuum

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

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

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

- For this section of the report, Vermont and Catawba County (NC) are classified as Universal outreach. Although the Catawba intervention (Reach for Success) was an Indicated intervention, the initial survey sent to all adoptive families in the county who had not been previously engaged in post adoption services was a Universal outreach effort. This section grouped Vermont and Catawba results to examine Universal outreach data.

- For the analysis of data from Illinois and New Jersey, intervention participants were removed because we did not want to confound these findings with the effect of the intervention. In other words, for this section we are analyzing the characteristics of families identified in the Selective interval, not describing the impact of the intervention.

- In Wisconsin data were collected at **intake**, prior to participation in the intervention. This baseline data was used to understand the profile of families who indicate that they may be having some difficulty, and to compare their outcomes to families who responded to surveys in the other sites.

- The number of respondents varied by site. There is greater confidence in the results of sites where there are more respondents. In particular, caution should be exercised in the interpretation of the Wisconsin findings, given the lower number of respondents and the wide variety of types of adoptions or guardianships served in that site (please see the Wisconsin report for additional information).

- Not all sites collected the same information; therefore, some sites will not be represented in the graphs showing site-specific results.

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

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

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

## Behavioral Problem Index (BPI)

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

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

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

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

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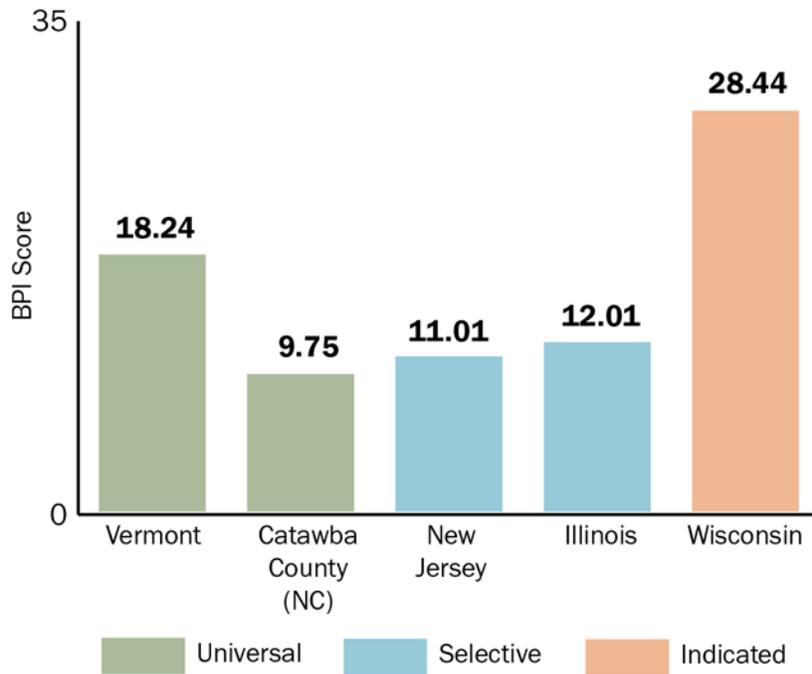


Figure 10.2 note: It should be noted that we expect to see higher levels of behavior problems in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are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

## Caregiver Strain

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

Figure 10.3. Mean Caregiver Strain Scores by Site
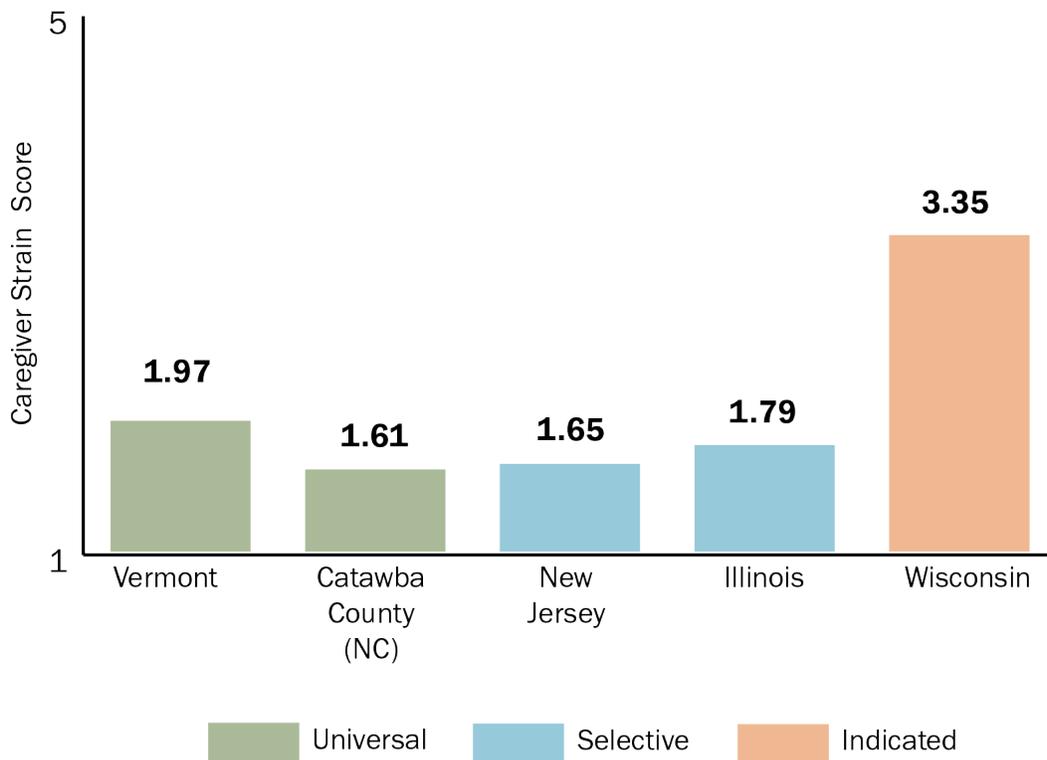


Figure 10.3 note: It should be noted that we expect to see higher levels of caregvier strain in the site that is serving families who reach out to request assistance (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin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

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

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

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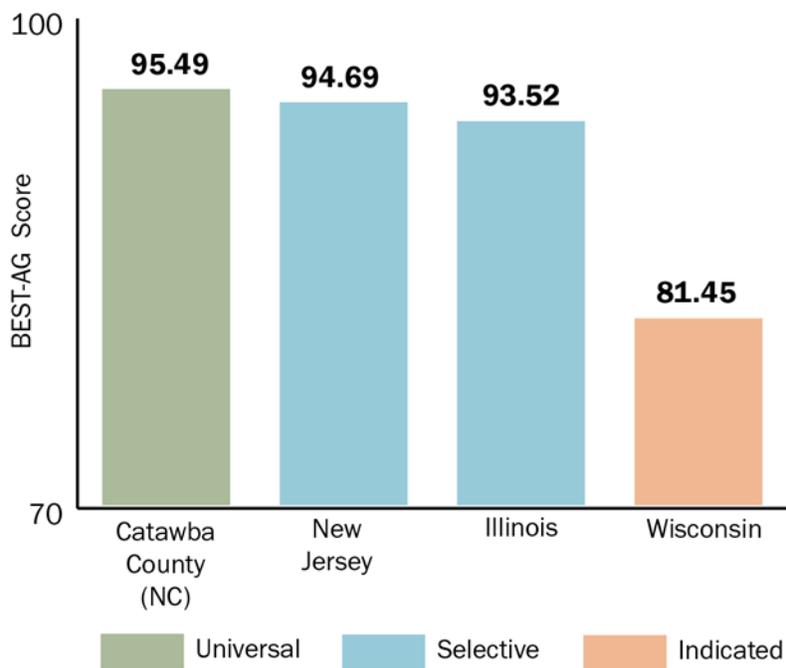


Figure 10.4 note: It should be noted that we expect to see lower levels of belonging and emotional security in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families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

# Impact of Caregiver Commitment on Key Measures

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

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

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

**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?**

| Definitely would have | | Probably would have | Might or might not have | Probably would not have | Definitely would not have |

Definitely would
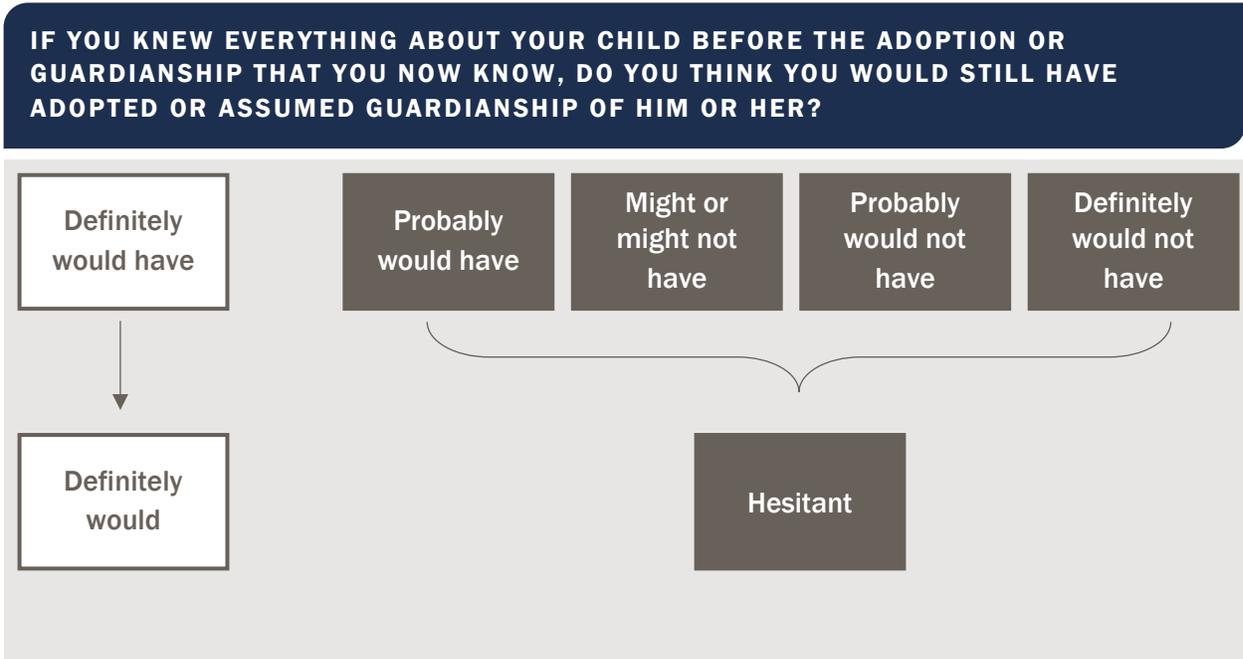
Hesitant

Results (depicted in Figure 10.5), show that between 19% and 24% of respondents from the prevention-related sites (Vermont, New Jersey and Illinois) expressed some level of hesitancy to adopt or assume guardianship again[3]:

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

- In New Jersey, 19% of families expressed hesitancy to adopt or assume guardianship again.

- In Illinois, 24% of families expressed hesitancy to adopt or assume guardianship again.

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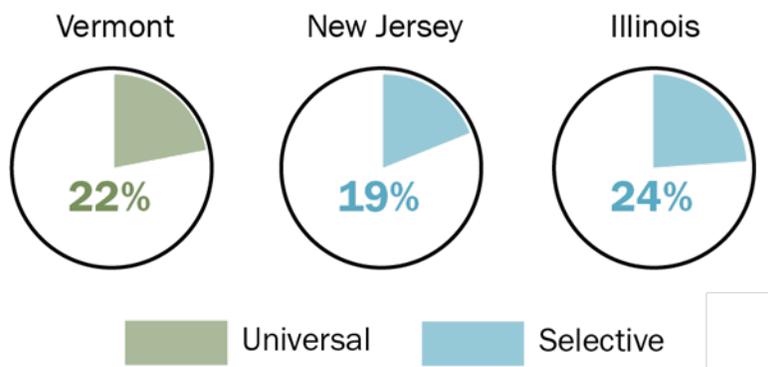


These results do not align exactly with the theory behind the continuum. Through this theory, one would expect a lower proportion of families to express hesitancy in Vermont (Universal) than in New Jersey or Illinois (Selective). It is possible that external factors (e.g., level and type of post permanency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

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

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

## GUIDE TO FIGURES 10.6 – 10.8

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

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

- Families who were hesitant to adopt or assume guardianship again.

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

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

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

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

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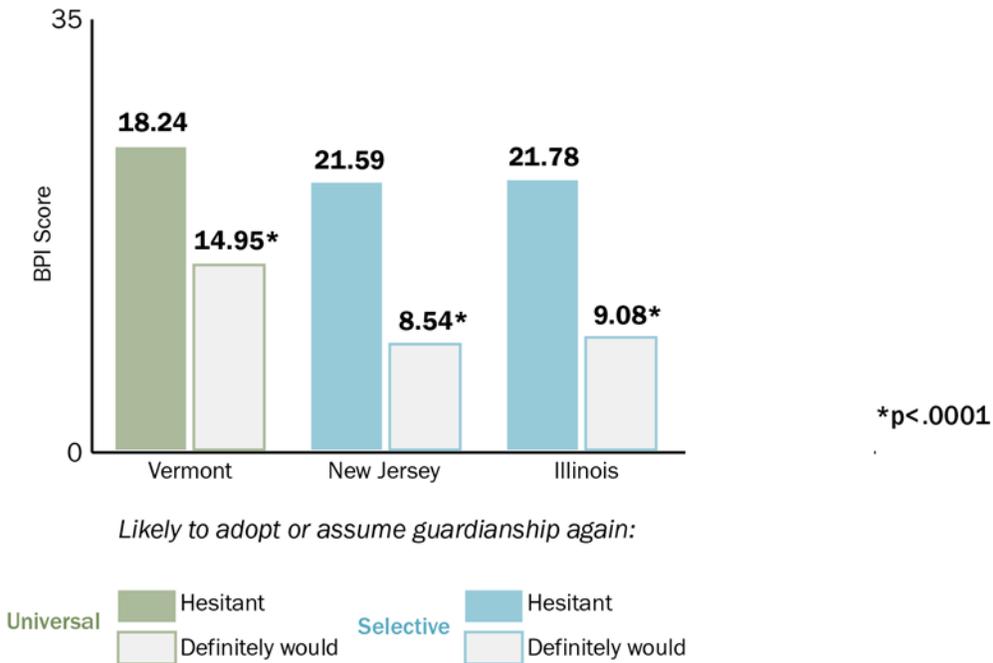


The BPI was selected as a standardized measure of child behavior problems based on previous research with adoptive and guardianship families (Liao & Testa, 2016; Testa et al., 2015; White, 2016). Higher scores on the BPI mean more behavioral issues. As shown in Figure 10.6, there is a statistically significant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

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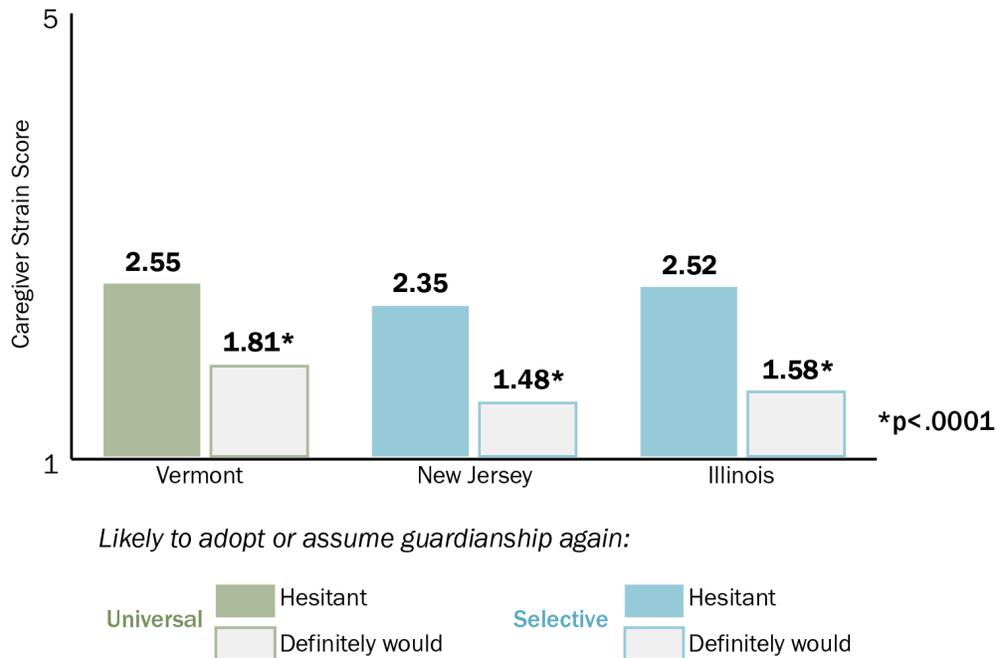


The Caregiver Strain Questionnaire-Adoption/Guardianship (CGSQ-AG) used in this project is an adapted version of the Caregiver Strain Questionnaire (Brannan, Helfinger, & Brickman, 1997), a measure to assesses the extent to which caregivers experience additional demands, responsibilities, and difficulties as a result of caring for a specific child. Caregiver strain, similar to parenting stress or burden, has been found in the previous literature to be associated with lower child and family satisfaction and wellbeing after adoption or guardianship (White et al., 2018). The same analysis was conducted with the caregiver strain measure (see Figure 10.7), and similar patterns emerged. Again, keeping in mind that this analysis focused on the differences highlighted in Figure 10.5 (that 22% of families in Vermont, 19% in New Jersey, 24% in Illinois expressed hesitancy to adopt or assume guardianship again).

With the Caregiver Strain measure, higher scores mean higher levels of strain. Results found a statistically significant difference in the level of strain reported by caregivers who expressed hesitancy to adopt or assume guardianship again in all three sites where data was available. These families also reported much higher rates on caregiver strain than families who were not hesitant to adopt or assume guardianship again.

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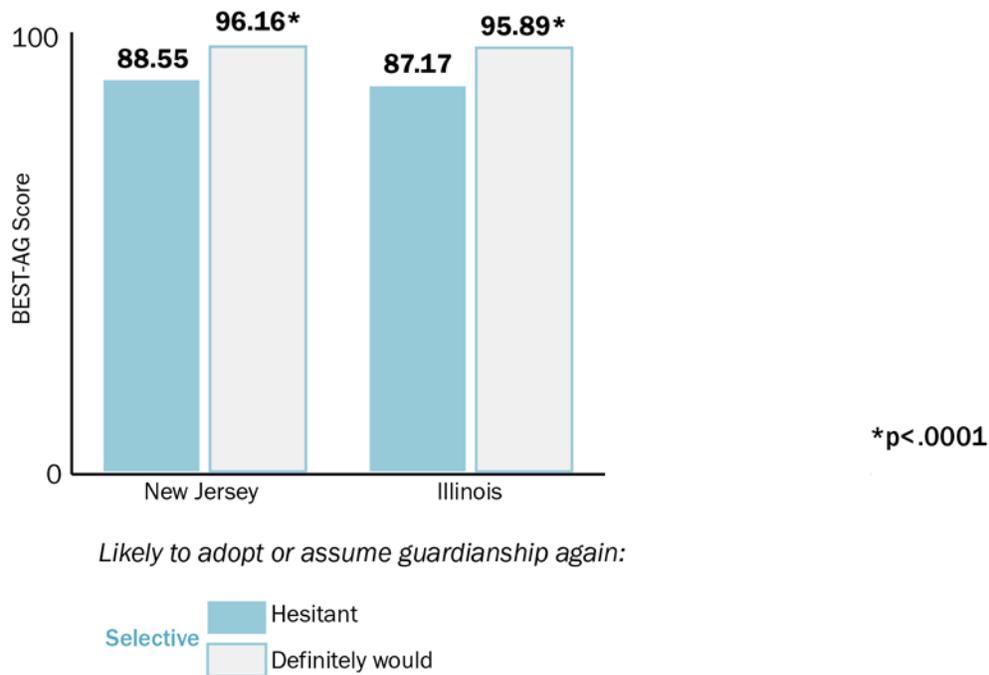


The BEST-AG, developed by Casey Family Services (Frey, Cushing, Freundlich, & Brenner, 2008), was originally designed to help social workers frame conversations about emotional and legal commitment with foster parent and youth who are unable to reunify with their family of origin. For this study, the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

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

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

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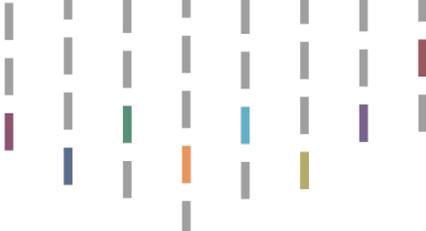
# Discussion

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

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

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

## SERVICE UPTAKE DID NOT OVERWHELM POST PERMANENCY SERVICE PROVIDERS

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

## ONGOING SERVICE NEEDS

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

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

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

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

In sum, some suggestions moving forward:

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

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

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

- Encourage child welfare jurisdictions to develop systems to track and update families' addresses and contact information so that families receive the information that agencies send.

- Increase the availability of service providers experienced in working with families formed through adoption or guardianship, particularly for child and family mental health support.

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

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

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

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

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

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

## IDENTIFYING FAMILIES AT RISK FOR POST PERMANENCY DISCONTINUITY

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

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

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

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

## MULTI-PRONG APPROACH TO OFFERING SUPPORT AND SERVICES

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

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

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

## ADOPTIVE PARENTS AND GUARDIANS REPORT ON THEIR POST PERMANENCY EXPERIENCES

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

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

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

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

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

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

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

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

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

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

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

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

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

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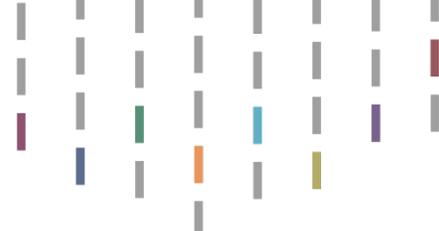
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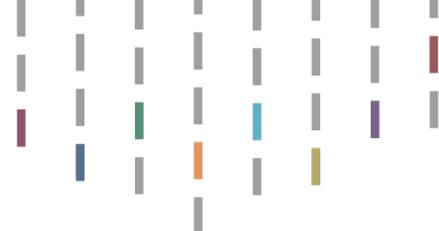
# Appendices

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

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

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

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

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

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

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

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

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

# Appendix B. Data Tables

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

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

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

| | 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.