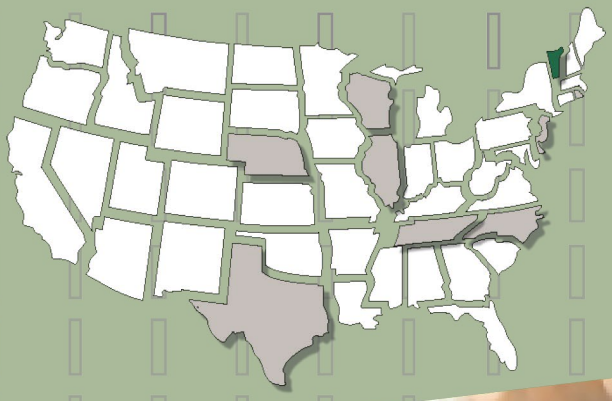
Evaluation Results from

Vermont



Final Evaluation Report



September 2019

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

Chapter 4: Vermont

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 (Vermont is Chapter 4), and a cross-site evaluation (Chapter 10). The chapter numbers reflect the chapters designated in the full report.

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



Funded through the Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Grant #90CO1122. The contents of this presentation do not necessarily reflect the views or policies of the funders, nor does mention of trade names, commercial products or organizations imply endorsement by the U.S. Department of Health and Human Services. This information is in the public domain. Readers are encouraged to copy and share it, but please credit the QIC-AG.

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

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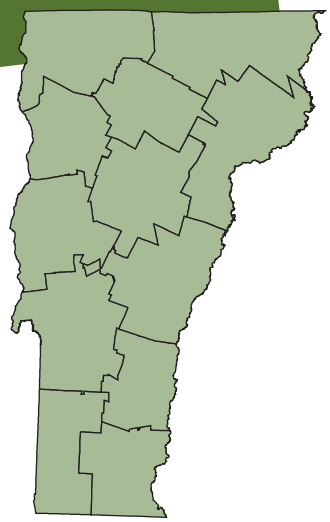
The QIC-AG evaluation team would like to extend our sincerest thanks to all of the adoptive and guardianship families who participated in the project.

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

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

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

Evaluation Results from Vermont



PROJECT PARTNERS

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

CONTINUUM PHASE

Universal

INTERVENTION

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

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

STUDY DESIGN

Descriptive

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

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

809
PARTICIPANTS
(55% OF FAMILIES RESPONDED)

RESEARCH QUESTION

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

Findings

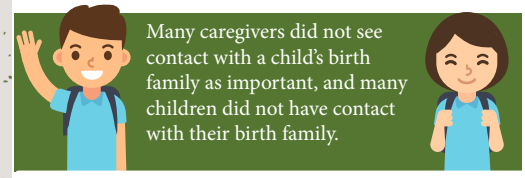
FAMILY WELLBEING

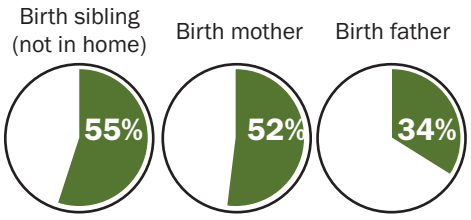
98% of caregivers were committed to their child for life

91% had never thought about ending adoption or guardianship

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

BIRTH FAMILY CONTACT

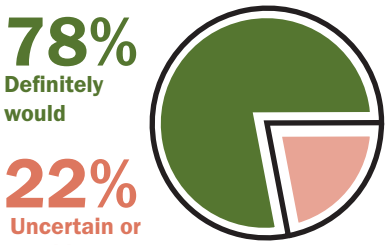




% WITH CONTACT IN LAST 6 MONTHS WHEN CONTACT WAS POSSIBLE

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

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



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

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

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

RECOMMENDATIONS

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

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

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

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

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



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Executive Summary

Overview

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

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

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

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

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

Intervention

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

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

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

Primary Research Question

The primary research question for this study was:

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

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

Key Findings and Discussion

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

Caregivers who reported that they would definitely adopt their child again had higher levels of resilience, open communication, perseverance in time of crisis, and more positive parent-child interactions compared to caregivers who indicated they were uncertain or definitely would not adopt again. They also had less strain attributed to parenting their child and more confidence in knowing how to meet their child's needs. Additionally, they felt more prepared at the time of their finalization and used fewer services in the past six months

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

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

Cross-Site Summary

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

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

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

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

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

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

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

Chapter 1

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QIC-AG Overview

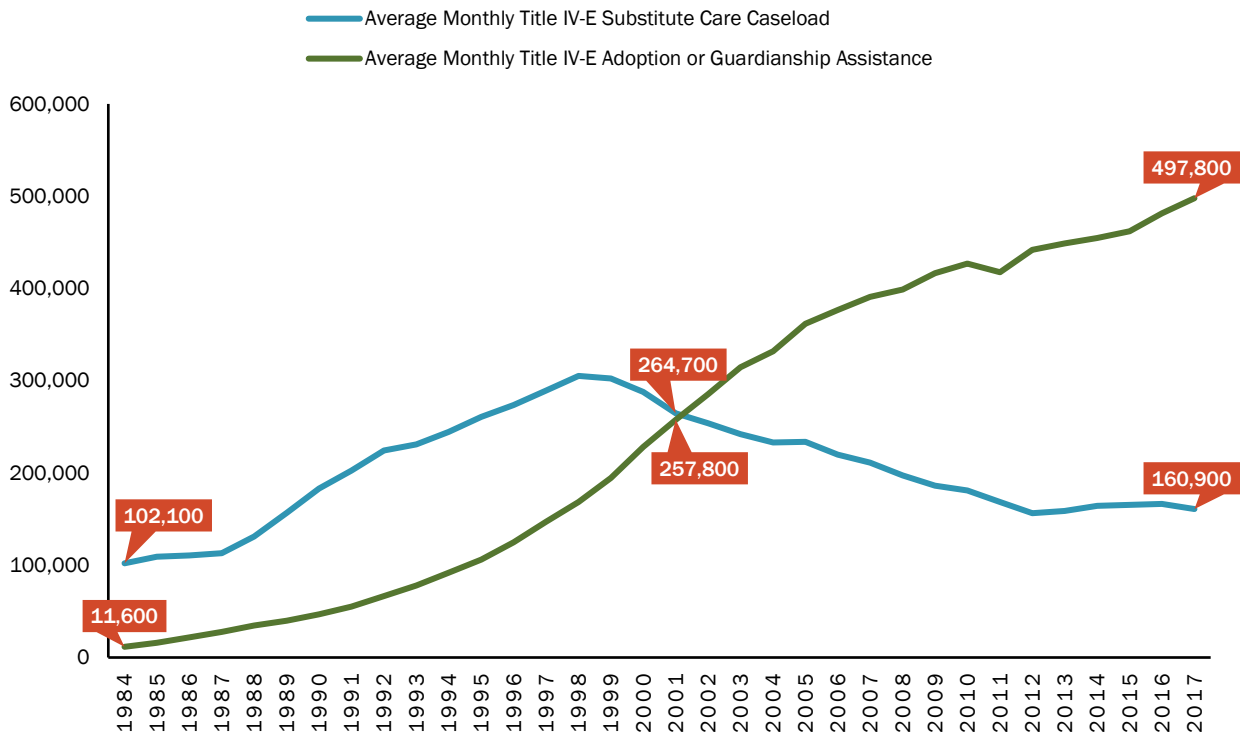
The Children's Bureau, Administration for Children and Families, and Department of Health and Human Service established the National Quality Improvement Center for Adoption and Guardianship Support and Preservation (QIC-AG). In October 2014, the QIC-AG was awarded to Spaulding for Children in partnership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

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

Background

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

Figure 1.1. National Average Monthly IV-E Funded Caseloads



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

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

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

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

QIC-AG Target Populations

Target Group 1

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

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

PICO RESEARCH QUESTION

The PICO question for Target Group 1 was:

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

THEORY OF CHANGE

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

Target Group 2

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

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

RESEARCH QUESTION

The PICO question for Target Group 2 was:

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

THEORY OF CHANGE

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

Private Domestic and Intercountry Adoptive Families

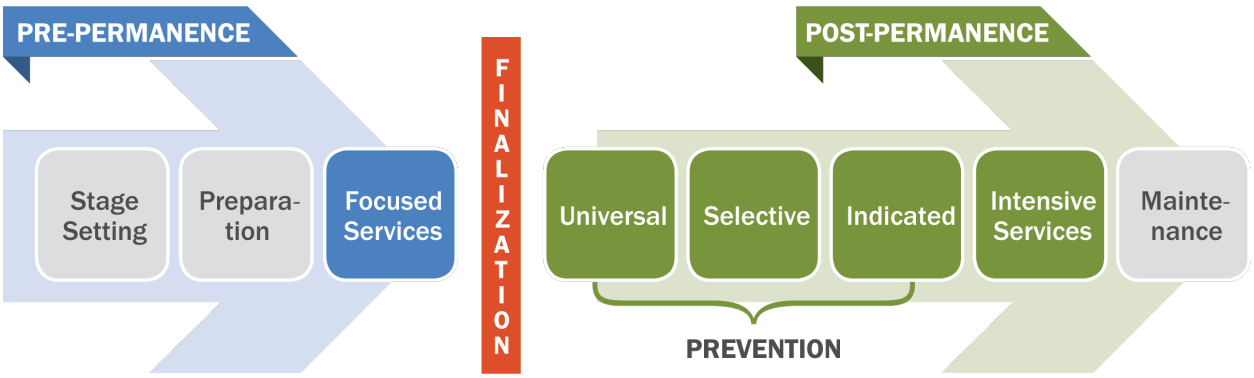
The challenges associated with providing a stable, long-term and permanent home are not consigned to adoptions and guardianships that occur through the child welfare system. Private domestic and intercountry adoptive families can also encounter post permanency disruptions and discontinuity. Children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

QIC-AG Continuum of Services

Pre Permanence

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

Figure 1.2. QIC-AG Permanency Continuum



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

Stage Setting

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

Preparation

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

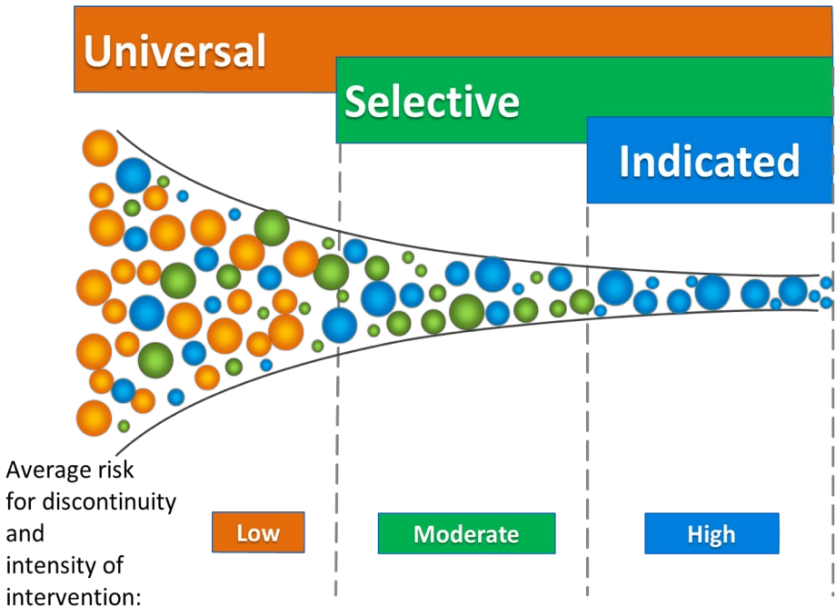
Focused Services

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

Post Permanence

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

Figure 1.3. Prevention Framework



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

Universal

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

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

Selective

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

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

Indicated Services

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

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

Intensive

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

Maintenance

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

Site Selection

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

Pre Assessment

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

Initial Assessment

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

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

Full Assessment

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

Tribal Selection Process

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

Implementation & Evaluation

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

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

Evaluation

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

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

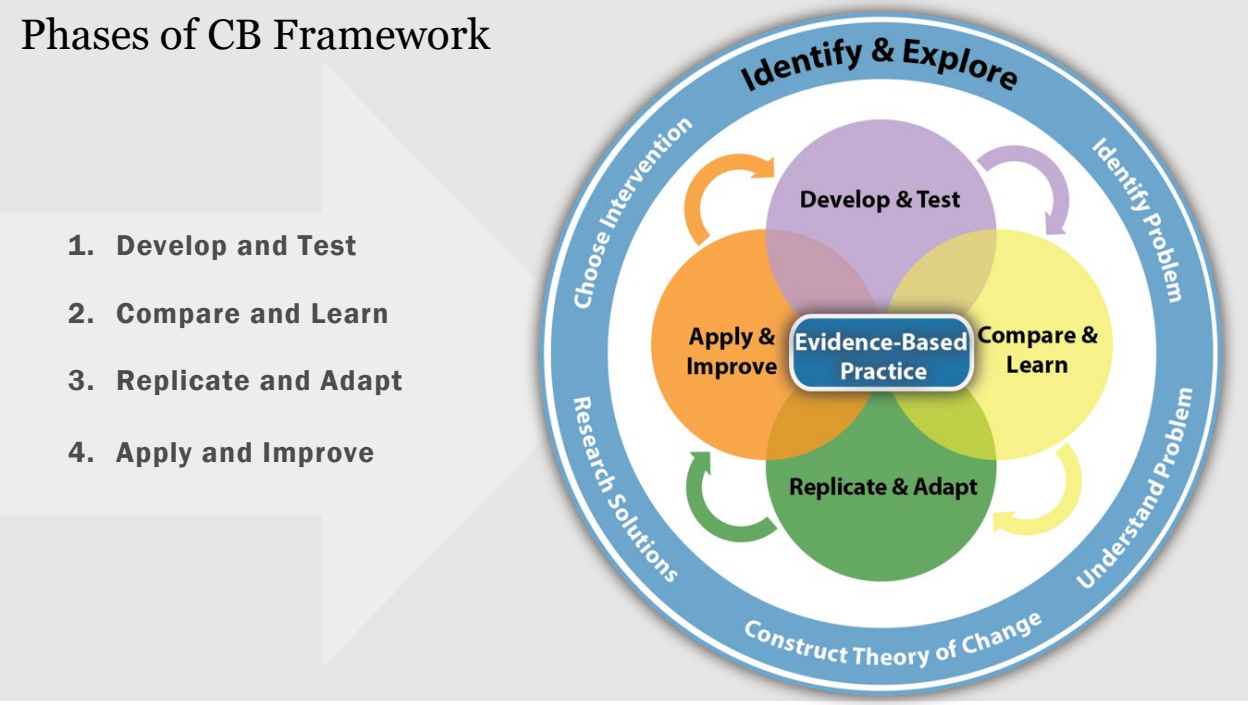
Guiding Frameworks

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

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

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

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



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

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

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

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

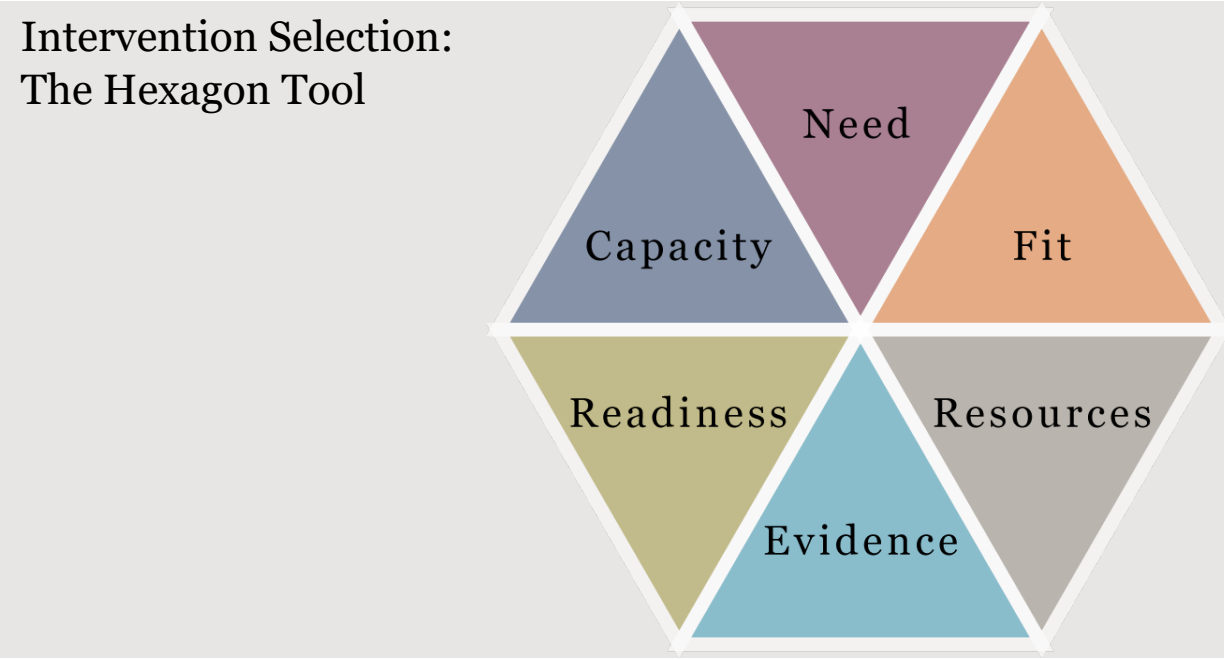


Table 1.1. Site, Target Population, Intervention and Study Design

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

Process Evaluations included the following types of information:

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

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

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

Summary

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

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

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Chapter 4

VERMONT PERMANENCY SURVEY

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Site Background

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

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

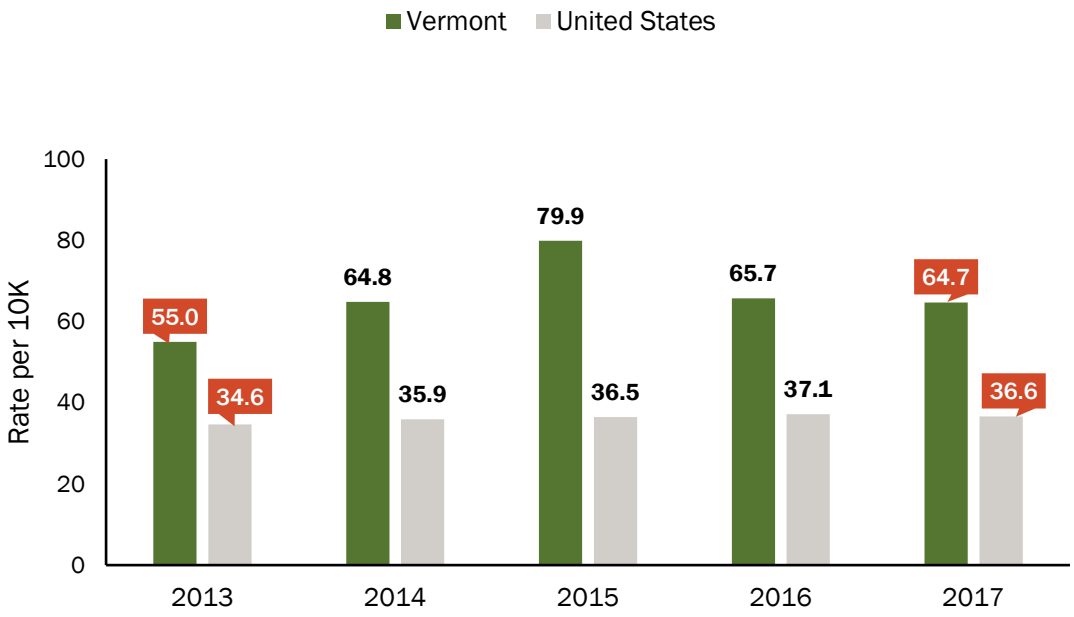
1. Identify and understand the strengths of families who are doing well;
2. Develop a valid process that allows for the early identification of families who are struggling or may be at increased risk of discontinuity;
3. Develop a better understanding of the profile of those adoptive and guardianship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

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

National Data: Putting Vermont in Context

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

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

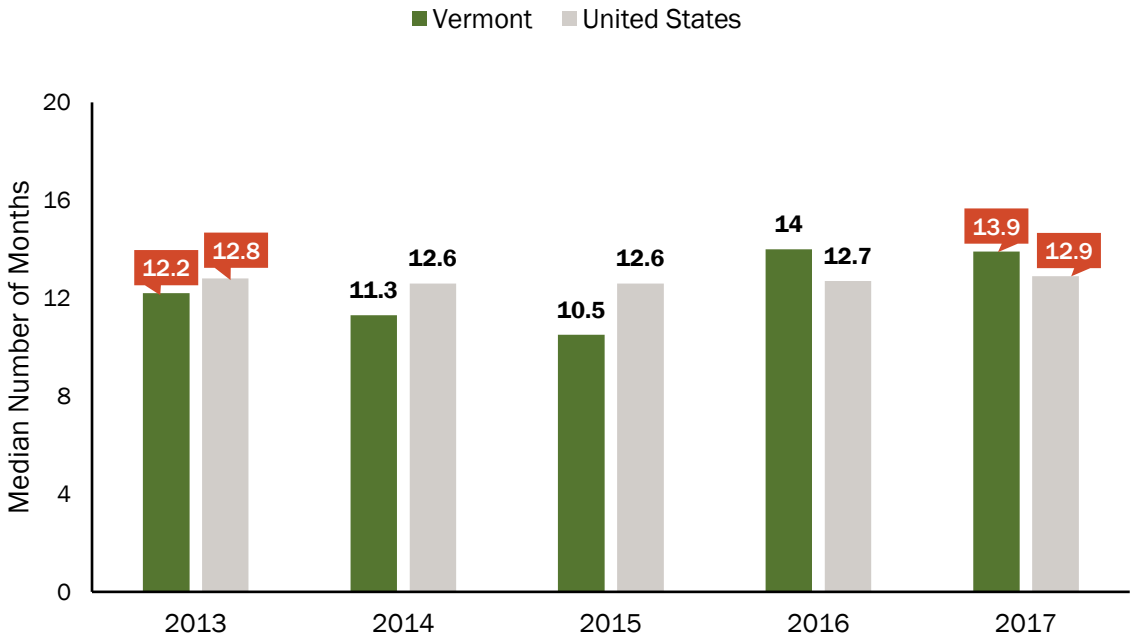


Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

As displayed in Figure 4.1, between Fiscal Years 2013 and 2017, the rate[1] of children entering foster care in Vermont and the U.S. increased. Between 2013 and 2017, the state's foster care entry rate increased from 55.0 per 10K (677 children) to 64.7 per 10K (756 children). This per capita rate is higher than the per capita rates for the U.S. The foster care entry rate in the U.S. was 34.6 per 10K in 2013 and 36.6 per 10K in 2017. In other words, although increases over the past five years occurred at both the state and national levels, a greater number of children, per capita, entered foster care in Vermont than in the U.S.

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

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



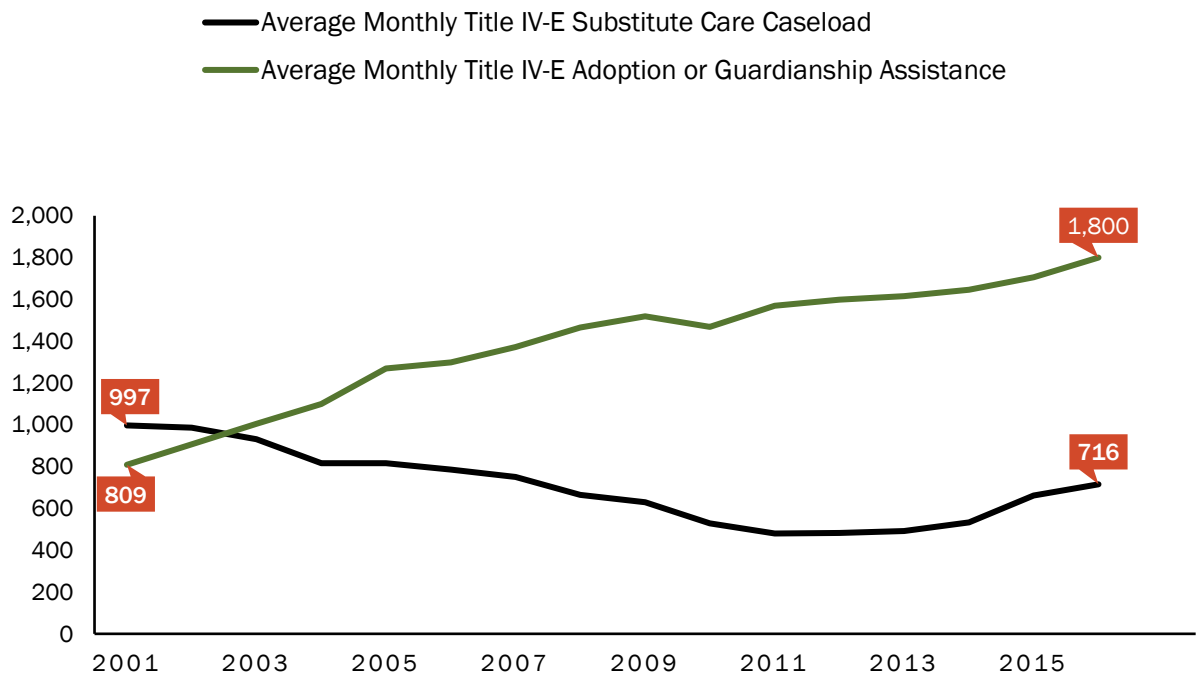
Data Source: United States Department of Health and Human Services, Administration for Children and Families (ACF), Administration on Children, Youth and Families Bureau, https://cwoutcomes.acf.hhs.gov/cwodatasite/

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

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

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

Figure 4.3. Vermont Caseloads



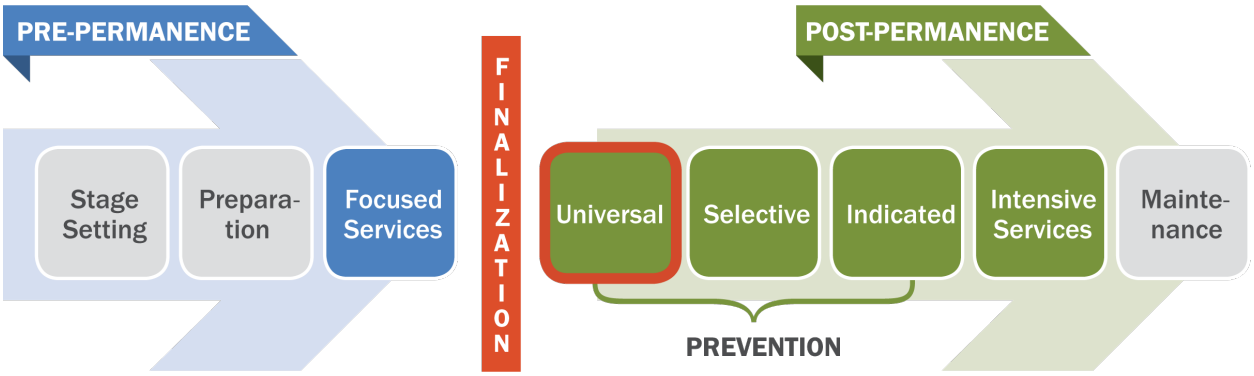
Data sources: Title IV-E numbers: U. S. Department of Health and Human Services / Administration for Children and Families, compiled data from states' Title IV-E Programs Quarterly Financial Reports, Forms IV-E-1 (for years prior to 2011) and CB-496 (for 2011 and later).

QIC-AG Permanency Continuum Interval

Vermont implemented an intervention within the **Universal** Interval of the QIC-AG Permanency Continuum Framework. **Universal** prevention is defined as strategies that are delivered to broad populations without consideration of individual differences in risk (Springer and Phillips, 2006).

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

Figure 4.4. Vermont QIC-AG Permanency Continuum



Primary Research Question

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

Target Population

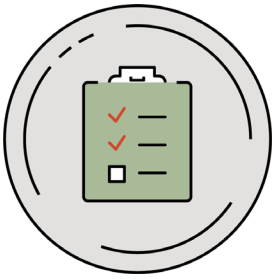
All families with children in the state of Vermont whose parents or guardians received an Adoption or Guardianship Assistance Agreement Subsidy were included in the target population. These families were identified using the Vermont Adoption and Guardianship Assistance Subsidy Database. Families formed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

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

Intervention

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

VERMONT PERMANENCY SURVEY



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

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

The Vermont intervention comprised five core components:

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

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

Survey Development

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

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

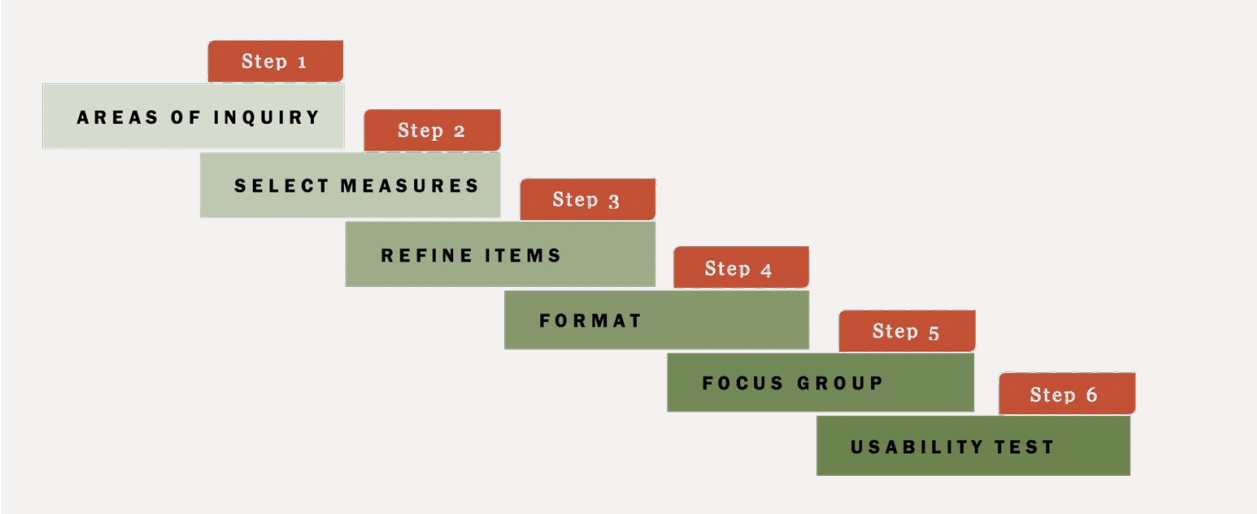
3. **Refine/select questions.** All questions and measures under each area of inquiry were reviewed by the Vermont site team and stakeholders. Key questions and measures were selected to keep in the survey while others were removed to make the survey a manageable length for caregivers. Additionally,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

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

5. **Conduct a focus group.** A focus group was conducted to help with the adaptation of some scales.

6. **Pilot test and finalize survey.** The survey was piloted with stakeholders, some families, and students to test the length, clarity, and relevance of the survey. Lastly, the Vermont site ran a stress test on the electronic version of the survey to ensure skip patterns and questions were displayed as intended.

Figure 4.5. Vermont Survey Development Process



Assertive Outreach

In order to increase survey response rates and engage families with post permanency services, the Vermont team established assertive outreach methods (methods used to reach and connect with families). Assertive outreach methods were reviewed and adapted after each cycle of survey implementation. Outreach strategies were based on previous research (Dillman, Smyth & Christian, 2014) and on the capacity of the State of Vermont to reach families.

In 2010, Fan & Yan conducted a meta-analysis on factors influencing response rates in web surveys and found:

- Response rates are influenced by factors including topics, length, ordering, and format of the web survey during survey design and development;
- Response rates are impacted by survey delivery factors such as sampling methods, contact delivery modes, invitation designs, informed consent methods, pre-notification letters, reminders, and incentives;
- Survey completion and response rates are impacted by factors such as an individual's level of computer knowledge or web-use and whether an alternative method to take the survey is available; and
- Survey return will impact response rates if various technical failures occur.

Based on this research, the Vermont site included an introductory letter and multiple contact attempts in their initial assertive outreach method. The introductory letter clearly stated the purpose of the survey, asked participants for their help, provided organizational logos and letterhead to establish trust, and used pieces of social exchange theories to decrease the cost of participation to participants while increasing potential benefits.

Outcomes

The following short-term outcomes were evaluated using the Vermont Permanency Survey in addition to the tracking of post permanency services through the Vermont Department for Children and Families- Family Service Division.

- Earlier identification of families post permanency who are struggling and/or who may be at risk of discontinuity
- Increased identification of post permanency service needs by region and system of care provider type
- Improved ability to share information on post permanency needs, risks and protective factors within the Vermont system of care
- Improved capacity to deliver data-driven, relevant and timely prevention and intervention services to families post permanency
- Increased understanding of the profiles of families who respond with varying degrees of assertive outreach

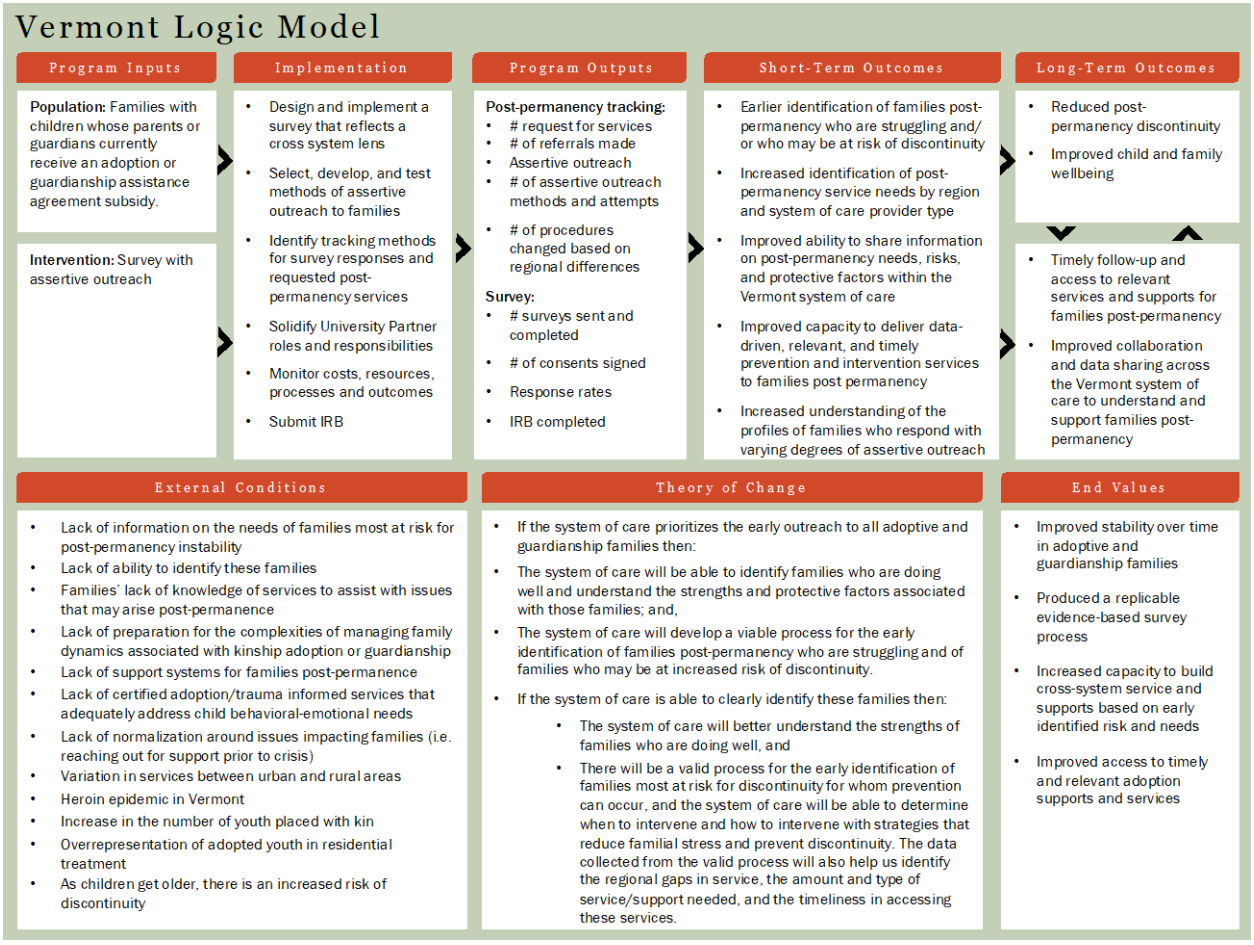
The following outcomes were evaluated using the Vermont post permanency survey linked to the tracking of post permanency services through FSD and AFCARS data:

- Reduced post permanency discontinuity;
- Improved child and family wellbeing;
- Timely follow-up and access to relevant services and supports for families post permanency; and
- Improved cross-system collaboration and data sharing to understand and support families post permanency.

Logic Model

The logic model (see Figure 4.6) elaborates on the PICO question and illustrates the intervening implementation activities and outputs that link the target population and core developmentally informed interventions to the intended proximal and distal outcomes. The model identifies the core programs, services, activities, policies, and procedures that were studied as part of the process evaluation, as well as contextual variables that may affect their implementation.

Figure 4.6. Vermont Logic Model



Evaluation Design & Methods

A descriptive cross-sectional design was conducted to understand and gather information on the needs, risks, and strengths of families formed through adoption and guardianship. All families in the target population were invited to participate in this study. Families were identified using the Vermont Adoption and Guardianship Assistance Agreement Subsidy database. Parents and guardians were asked to answer questions about one child in their home, referred to as the "identified child." The identified child was randomly selected by the evaluators when parents or guardians were receiving a subsidy for more than one child.

The evaluation design and protocol were reviewed by the Institutional Review Board (IRB) at The University of Texas at Austin, University of Vermont and Vermont Agency of Human Services.

Procedures

USABILITY

As the first step in implementation, a usability test was conducted in Vermont. During usability (Cycle 1), the survey was distributed to a random sample 51 families (36 families with emails and 15 families without emails) in order to test the survey and initial assertive outreach strategy. Findings from usability indicated a need to make small adjustments to the way variables were labeled in the survey, determine a better process to randomly selecting the "identified child" when a family had multiple children who were adopted or in guardianship, fix minor errors in how families were tracked and increase Vermont's capacity to outreach to families electronically.

RECRUITMENT



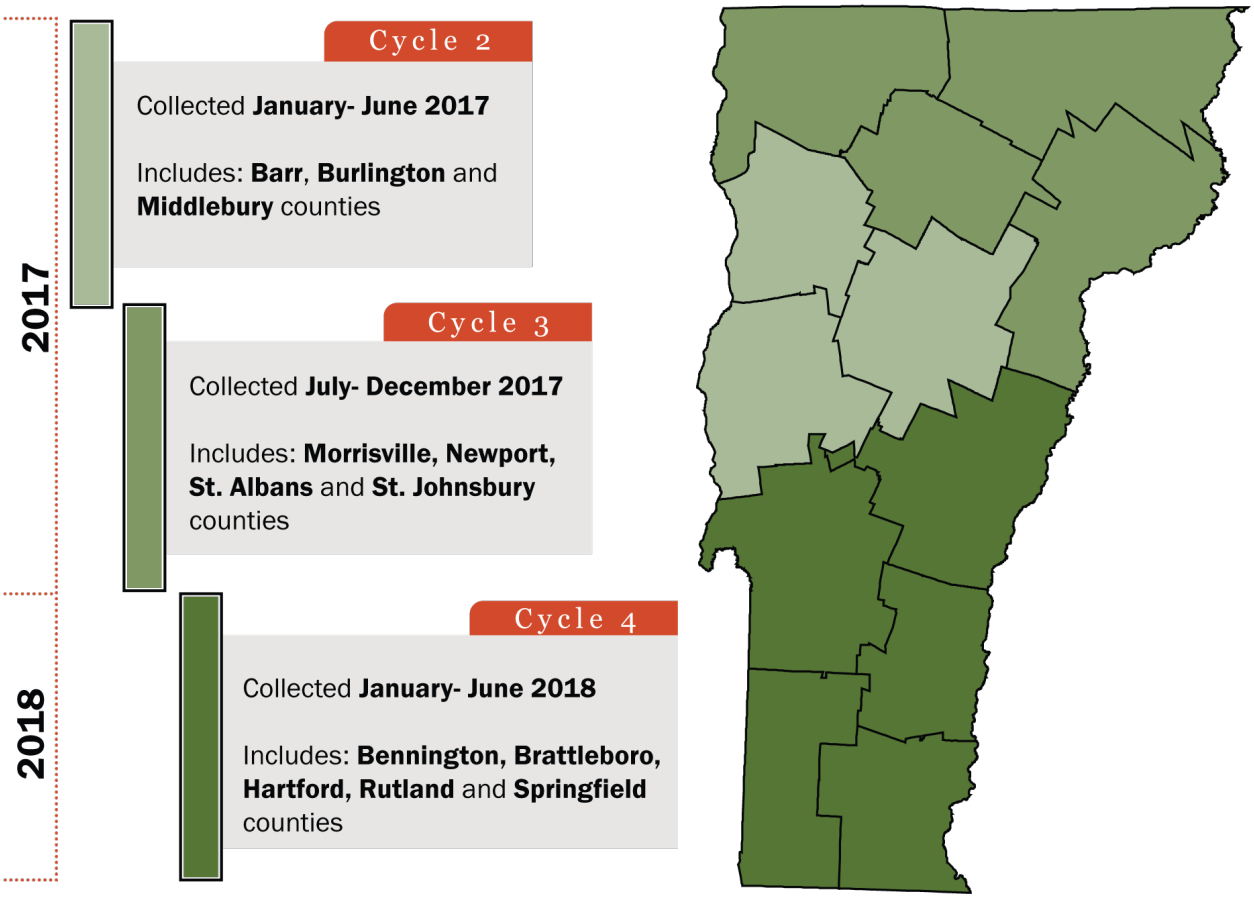
After completing usability testing in Cycle 1, the Vermont site chose to implement the survey over four recruitment cycles (Cycles 2-5) where each cycle occurred approximately six months apart. Implementing cycles in this way allowed for the Vermont team to disseminate findings between cycles to the participating districts. Additionally, a question at the end of the survey asked families if they wanted to be contacted about post permanency services. Initially, the Vermont site team was worried that they might not have the capacity to respond if too many caregivers indicated they did want to be contacted by post permanency services. Therefore, families were recruited in cycles.

At the beginning of each cycle, families were identified using the Vermont Adoption and Guardianship Assistance Subsidy database. Family contact information was pulled from this database and placed into a Family Tracking Workbook. All families with children in the state of Vermont whose parents or guardians received an adoption or guardianship assistance agreement subsidy were included in the target population. Families formed through non-subsidized guardianship were excluded from this study.

Cycles 2-4

In the first three cycles following usability (Cycles 2-4), recruitment was based on the FSD district in which a family lived. Between three and five districts were grouped together into three cycles based on their geographical proximity and total number of children in the target population. In grouping this way, the groups were roughly equivalent in size. Families with children in the target population who resided in those selected group of districts during a cycle were sent the post permanency survey through assertive outreach.

Figure 4.7. Cycles 2-4 District Recruitment Areas



Cycle 5

Cycle 5 was the last survey implementation cycle implemented. It began in July 2018 and closed in September 2018. There were two distinct samples targeted in this cycle (5A and 5B). Families who were not included in previous cycles but eligible for the survey in June 2018 were included in Cycle 5A. These families included 1) families who finalized their adoption or guardianship after the survey has been implemented in their area, and 2) families who moved into a district after the survey has been implemented in their area. These families received the survey with assertive outreach.

Cycle 5B included non-responders (any caregivers living in a previously surveyed district who did not begin the survey). Non-responders were provided with one additional opportunity to complete the survey. Please note that partial responders, or participants who began the survey but did not complete it, and participants who declined to take the survey were not included in this sample.

Lastly, caregivers who did not respond to survey during cycle 5 received an email or postcard asking them to indicate any reasons they were not interested in taking the survey at that time (see the Appendix).

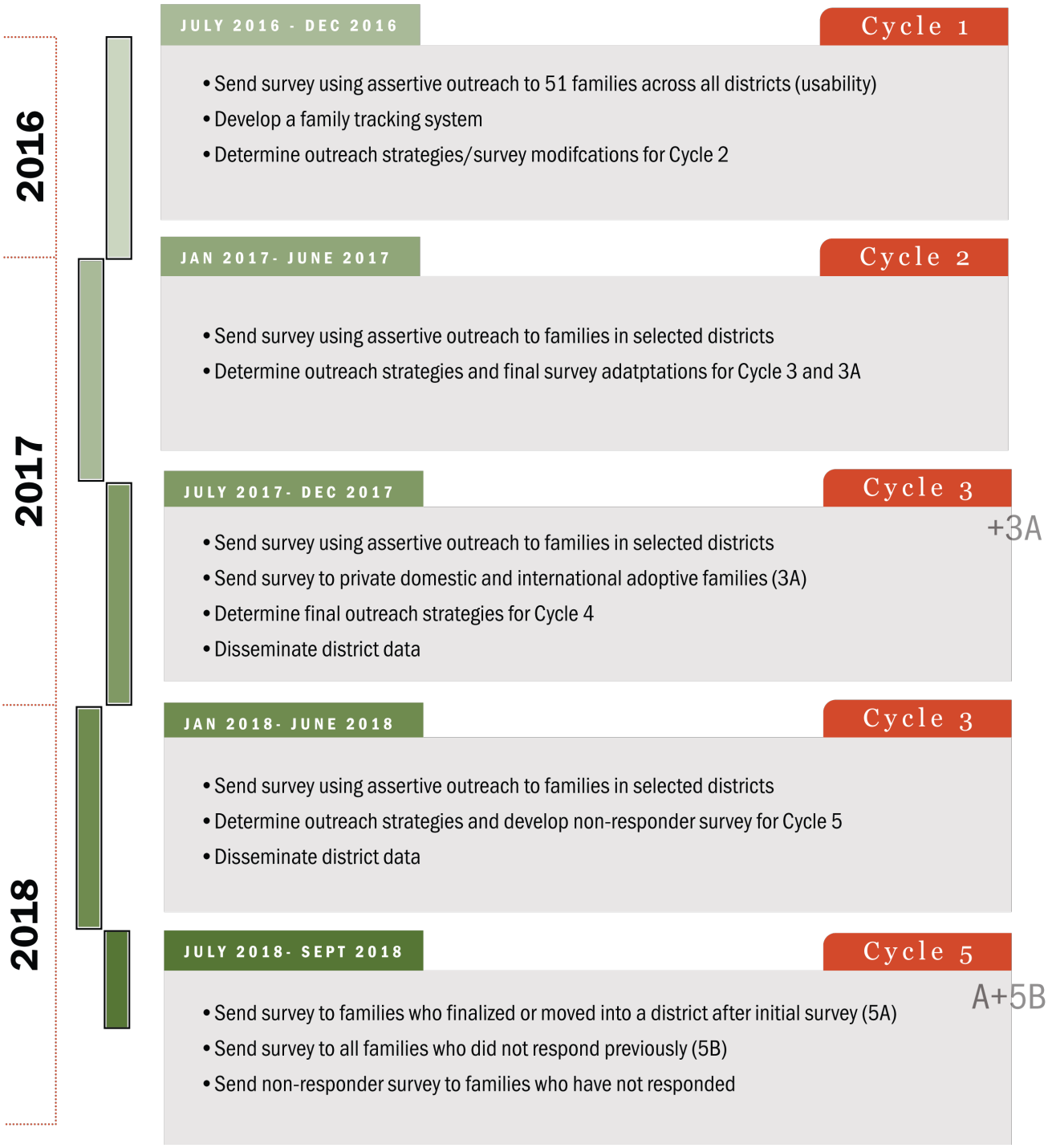
Overall, a total of 1470 families were asked to participate and answer questions about an "identified child," a child for whom they were receiving an adoption or guardianship agreement subsidy. When a family had more than one child in their home, evaluators randomly assigned the "identified child,"

Private Domestic and Intercountry Adoptions

In addition to implementing the survey with families in the target population, the Vermont site team decided to implement the survey with families formed through private domestic and intercountry adoption. Implementation of the survey with this population occurred at the same time as cycle 3 and was referred to as cycle 3A. In cycle 3A, the Vermont site team outreached to agencies and organizations who served families formed through private domestic or intercountry adoption. Agencies sent a letter to families in this population to inform them about the study and requested they provide their contact information to the FSD if they were interested in participating.

Figure 4.8 displays the timeframe and tasks completed for each cycle.

Figure 4.8. Cycle Timeframe and Implementation Tasks



During the initial implementation of the Vermont Permanency Survey, the Vermont site mailed introductory letters about the survey to all participants. For families with emails, an introductory email with the survey link, two reminder emails, and a paper copy of the survey were sent. For families without emails, the first paper survey was sent one week after the introductory letter and the second was sent almost three weeks after the initial survey.

Table 4.1. Initial Assertive Outreach Strategy in Cycle 1

DAY	DATE	TIME	GROUP	TASK
1	Tues 10/25		Electronic & Paper	Mail an intro letter to all families in cycle
8	Tues 11/1	9:30 AM	Electronic	Send an email with the survey link
8	Tues 11/1		Paper	Send a paper survey to families without emails
17	Tues 11/10	2:00 PM	Electronic	Send a reminder email to non-respondents
24	Thurs 11/17		Electronic & Paper	Send a paper survey to non-respondents
38	Thurs 12/1	1:00 PM	Electronic	Send a final email to non-respondents
45	Fri 12/9		Electronic & Paper	Close survey

Adaptations to Assertive Outreach



From the initial cycle to cycle 4, assertive outreach strategies were adjusted slightly to increase overall participation. By cycle 4, Lexus Nexus was being used to identify additional email addresses because caregivers with emails were responding to the survey at a higher rate. Two outreach periods by phone were added, one to families with emails and one to families without emails. This strategy was added to create another connection point with families, collect new contact info when needed, and resend the survey based on the preference of the family. Lastly, an additional reminder email and letter were added to the assertive outreach protocol (see Table 4.2.).

Table 4.2. Final Assertive Outreach Strategy in Cycle 4

DAY	DATE	TIME	GROUP	TASK
PRIOR TO STARTING THE CYCLE LEXUS NEXUS WAS USED TO FIND EMAILS				
1	Mon 1/22		Electronic & Paper	Mail an intro letter to all families in cycle
8	Mon 1/29	9:30 AM	Electronic	Send an email with the survey link
10	Wed 1/31		Paper	Send a paper survey to families without emails
18	Thurs 2/8	2:00 PM	Electronic	Send a reminder email to non-respondents
24-30*	Wed 2/14 – Tues 2/20		Electronic	Call non-respondents with emails. Send an email or paper survey depending on the caregiver's preference. If not able to contact, send a paper survey.
31- 38*	Wed 2/21 – Mon 2/26		Paper	Call non-respondents without emails. Send an email or paper survey depending on the caregiver's preference. If not able to contact, send a second paper survey.
45*	Wed 3/7	2:00 PM	Electronic	Send a reminder email to non-respondents
50	Mon 3/12		Paper	Send a paper reminder letter to non-respondents
59	Wed 3/21	6:30 AM	Electronic	Send a final reminder email to non-respondents
78	Fri 4/9		Electronic & Paper	Close survey

*These assertive outreach steps were added to increase response rates

Incentives

All families who participated and completed the survey received a $20 gift card.

Adherence

A survey protocol was developed to address all communication with survey participants, follow-up requests, and tracking to ensure assertive outreach was followed with fidelity. REDCap was programmed to automatically send out reminder emails to non-responders based on assertive outreach protocols. Lastly, the survey itself also built in validation checks to ensure the quality of data entry.

Measures

PROCESS MEASURES

For each cycle, we assessed adherence to the assertive outreach protocols. The following information was tracked:

- Number of surveys sent via email and mail
- Number of caregivers who responded to initial outreach and number who responded to additional follow up
- Number of respondents called
- Number and dates of survey responses

DESCRIPTIVE AND OUTCOME MEASURES

The Vermont site included the following measures in the Vermont Permanency Survey:

Administrative Data

The Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) databases dated back to 2000 were used to assess differences in families who responded to the survey and those who did not. Federal law and regulation require state child welfare agencies to collect case-level information on all children for whom the agency is responsible for placement, care, or supervision and on children adopted under the auspices of the agency. These data are derived from the Vermont AFCARS and NCANDS submissions to the Administration for Children and Families of the Department of Health and Human Services (ACF). Some of the information in these reports includes demographic information, the number of removal episodes a child has experienced, the number of placements in the current removal episode, as well as the current placement setting.

Adverse Childhood Experiences (ACEs)

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

Behavior Problem Index (BPI)

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

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

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

Brief Resilience Scale (BRS)

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

Caregiver Strain Questionnaire – FC/AG22

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

Education Outcomes

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

Illinois Post Permanency Commitment Items

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

Protective Factors Survey (PFS)

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

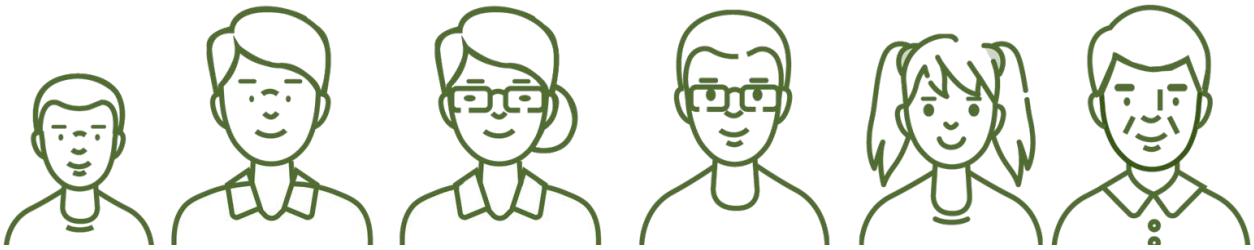
Service Items

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

Findings

Sample Frame and Participant Profile

This section describes the population of Vermont families formed through adoption and guardianship. First, response rates by cycle and assertive outreach method (either paper or email) are provided. Next, the characteristics of respondents and non-respondents are discussed. Lastly, the general characteristics of the 809 survey respondents are reported.



UPTAKE

The sample size and overall response rates by assertive outreach method are displayed in Table 4.3. Response rates for families who received the survey electronically were higher than those who were mailed the survey with the exception of cycle 5A, families who were recently formed through adoption or guardianship. Cycle 5B represents families who did not respond to assertive outreach efforts in an earlier cycle. By sending the survey once more to non-respondents at a later time, an additional 49 surveys were collected. Overall, a total of 809 (55%) participants completed the survey across all cycles. The lowest rates were obtained in cycle 3 when the survey was sent in July.

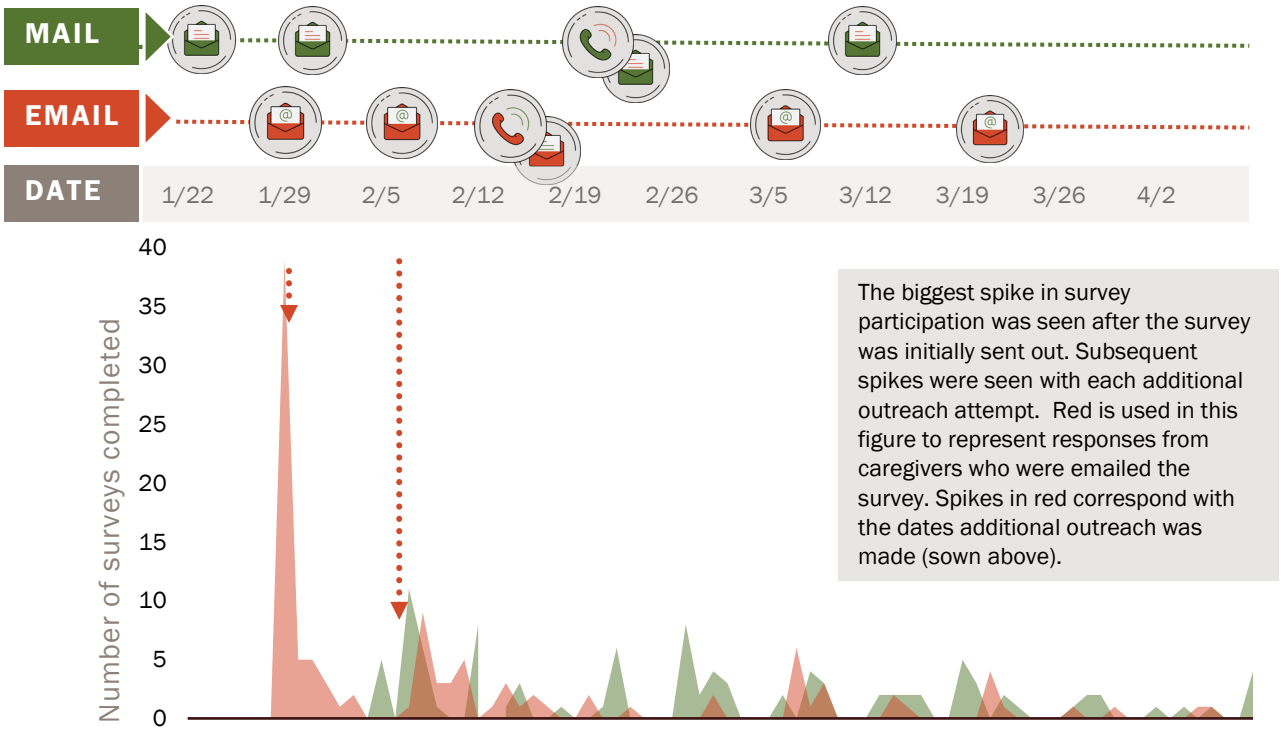
Table 4.3 Response Rates for Families Who Received the Survey

	SAMPLE			PARTICIPANTS			RESPONSE RATES		
	Total	Email	Paper	Total	Email	Paper	Total	Email	Paper
CYCLE 2	454	188	266	255	121	134	56%	64%	50%
CYCLE 3	369	138	231	166	74	92	45%	54%	40%
CYCLE 4	429	205	224	220	111	109	51%	54%	49%
CYCLE 5A	210	168	42	119	93	26	57%	55%	62%
CYCLE 5B	520	158	362	49	20	29	9%	13%	8%
ALL	1470	699	763	809	419	390	55%	60%	51%

We know from prior research that sending a pre-notification letter and making multiple assertive outreach attempts improves response rates (Fan & Yan, 2010). This finding was supported in the current study as well. Other factors may have also impacted response rates, including a participant's familiarity with the agency sending the survey, time of year at which the survey is distributed, whether the area being surveyed is primarily urban or rural, and whether the survey is sent electronically or by mail. Response rates were lower in June compared to January, most likely because children go on summer break in June. Response rates were highest in cycle 2, which included Burlington, Barre, and Middlebury. These districts were more urban compared to districts in other cycles. Additionally, Lund, the agency who sent the survey, is located in Burlington, so families may have been more familiar with this agency. Lastly, response rates were higher for families who received the survey electronically.

Figure 4.9 represents how participants in cycle 4 (finalized assertive outreach strategy) responded over time and by response type.

Figure 4.9. Cycle 4 Response Rates over Time by Type of Outreach



ADHERENCE

Adherence to the assertive outreach protocols was tracked to see if strategies were implemented as intended. Adherence variables provided information on the type and timing of the assertive outreach strategies used each cycle. Adherence to outreach protocols was high, particularly for caregivers who received the survey via email because REDCap was programmed to automatically send out reminder emails on specific dates. Assertive outreach protocols for caregivers receiving the survey by mail was also typically followed across the cycles. Occasionally, dates were shifted to adjust for holidays and/or to provide additional time to get all materials together.

Using Administrative Data: Characteristics of Respondents and Non-Respondents

We matched AFCARS administrative data to all families we asked to participate in the survey. By matching these families, we were able to determine if there were any differences in the characteristics of families who responded to the survey and those who did not. For instance, were families more likely to respond if they had a child with a specific characteristic (e.g., gender, race) or if their child had a different experience in foster care (multiple placements, long lengths of stay)? There were 809 families who completed the survey, and 556 (69%) of these families were able to match to AFCARS data. There were 661 families who did not complete the survey, and 501 (76%) of these families were able to be matched to AFCARS data. Please note that the AFCARS data was pulled around the same time cycle 5A (finalized after the survey had been sent in their district) was collected. Therefore, these families may not yet be represented in AFCARS data.

Results, summarized in Table 4.4, found statistically significant differences between those caregivers responded to the survey and those who did not in the number of times a child moved while in foster care and whether the child had a disability. Caregivers of a child with a disability (identified child) made up a smaller proportion of those who responded to the survey (5%) than those who did not respond to the survey (8%), $\chi^2(1, N=1057) = 6.71, p=.010$. Similarly, caregivers with a child who had moved three or more times in foster care made up a smaller proportion of those who responded to the survey (30%) than those who did not respond to the survey (36%), $\chi^2(1, N=1057) = 3.91, p=.048$. There were no significant differences in a child's race, ethnicity, gender, age at permanence, or mean time in foster care for caregivers that responded and those that did not. There were also no significant differences in a caregiver's age at permanence for caregivers that responded and those that did not.

Table 4.4. Characteristics of Respondents and Non-Respondents Matched to AFCARS Data

	RESPONDENTS 556 of 809 (69%) matched AFCARS	NON-RESPONDENTS 501 of 661 (76%) matched AFCARS	BIVARIATE COMPARISON (Respondents vs non-respondents)		
	%	%	χ^2	*df*	*p*
CHILD HAS DISABILITY	5%	8%	6.71	1	0.010**
3+ MOVES IN FOSTER CARE	30%	36%	3.91	1	0.048*
CHILD'S RACE			5.48	5	0.360
WHITE	98%	96%			
BLACK	1%	2%			
OTHER	1%	2%			
CHILD IS HISPANIC /LATINO	1%	1%	0.70	1	0.403
CHILD IS FEMALE	50%	47%	1.16	1	0.282
	M (SD)	M (SD)	*t*	*df*	*p*
CHILD'S AGE AT PERMANENCE	5.87 (3.97)	6.28 (4.22)	1.60	1055	0.109
CAREGIVER'S AGE AT PERMANENCE	46.46 (10.46)	45.96 (10.05)	-0.77	993	0.440
MEAN YEARS IN FOSTER CARE	2.51 (2.51)	2.51 (1.79)	-0.06	1055	0.950

Using Survey Data: Characteristics of Survey Respondents

The Vermont Permanency Survey was sent to 1470 caregivers, in which 809 (55%) caregivers responded. The 809 caregivers who completed the survey represent 809 unique family households. Most households (76%) had two adult caregivers living at home. Additionally, 175 households were single-parent homes (22%) and twenty-eight households had more than two adult caregivers (3%). Caregivers reported between zero and seven children under 21 who were currently living at home. Table 4.5 provides an overview of the demographic information of the participating caregivers. Most caregivers were female (90%), White (92%), attended at least some college education (78%) and were married (76%). The average age of participating caregivers was 49.69 years old.

Table 4.5. Characteristics of Survey Participants

CAREGIVER CHARACTERISTICS				
			N	%
MARRIED OR LIVING WITH A PARTNER			772	76%
CAREGIVER IS HISPANIC OR LATINO			764	1%
CAREGIVER IS FEMALE			775	90%
CAREGIVER'S RACE			762	
WHITE				92%
BLACK				3%
OTHER				5%
CAREGIVER IS HETEROSEXUAL			523	89%
ATTENDED AT LEAST SOME COLLEGE			774	77%
HOUSEHOLD INCOME			754	
$30,000 OR LESS				15%
$30,001 TO $40,000				16%
$45,001 TO $60,000				19%
$60,001 TO $75,000				12%
$75,001 TO $90,000				13%
$90,001 TO $105,000				10%
MORE THAN $105,000				15%
	Total N	Min	Max	M (SD)
MEAN AGE OF CAREGIVER (YEARS)	754	25	85	49.69(10.10)

For families formed through adoption and guardianship with more than one child in their home, a specific child was randomly selected and was referred to as the "identified child" for the purposes of the survey. Caregivers were asked to think about their "identified child" as they answered the survey. Table 4.6 provides an overview of these children. The majority of caregivers (96%) fostered their child prior to finalization, 27% were related to their child, and 34% had a relationship with their child prior to that child being removed from their birth parents home. For caregivers who were related to their child, the majority were grandparents (67%) and aunts/uncles (38%). The average age of the identified child was 10.81 years old. The average age at the time of finalization was 5.29 years old, and the mean number of years a child was in a caregiver's home prior to finalization was 1.73 years.

Table 4.6. Characteristics of Identified Child

IDENTIFIED CHILD CHARACTERISTICS				
			N	%
CAREGIVER FOSTERED CHILD PRIOR TO ADOPTION OR GUARDIANSHIP			797	96%
CHILD HAD RELATIONSHIP WITH CAREGIVER PRIOR TO REMOVAL			796	34%
CHILD IS RELATED TO CAREGIVER			800	27%
CHILD HAD PREVIOUSLY BEEN ADOPTED OR IN LEGAL GUARDIANSHIP			801	8%
CHILD IS ADOPTED			805	98%
CHILD IS HISPANIC OR LATINO			786	3%
CHILD IS FEMALE			803	49%
CHILD'S RACE			792	
WHITE				88%
BLACK				3%
OTHER				9%
RACIAL MATCH BETWEEN CAREGIVER AND CHILD			762	92%
CHILD IS HETEROSEXUAL			539	63%
	Total N	**Min**	**Max**	**M (SD)**
MEAN AGE OF CHILD (YEARS)	807	1	21	10.81(5.21)
MEAN AGE OF CHILD AT TIME OF FINALIZATION	791	0	17	5.29 (3.95)
MEAN YEARS IN HOME PRIOR TO FINALIZATION	788	0	15	1.73 (1.5)

Table 4.7. Child's Age by Time since Finalization

	TIME SINCE FINALIZATION				
CHILD'S AGE	<2 Years	2-4 Years	5-9 Years	10+ Years	Total
0-3 YEARS OLD	70	9	0	0	79
4-7 YEARS OLD	74	64	19	0	157
8-12 YEARS OLD	51	63	78	19	211
13 OR OLDER	37	43	83	170	333
TOTAL	232	179	180	189	780*

* Twenty-nine caregivers did not provide information on the date of their adoption finalization.

Outcome Evaluation

In this section, we first provide the overall findings on the wellbeing of families formed through adoption and guardianship. Next, we assess the following short-term outcomes (STO):

- Outcome 1: Earlier identification of families post permanency who are struggling and/or who may be at risk of discontinuity
- Outcome 2: Increased identification of post permanency service needs by region and system of care provider type
- Outcome 3: Improved ability to share information on post permanency needs, risks and protective factors within the Vermont system of care
- Outcome 4: Improved capacity to deliver data-driven, relevant and timely prevention and intervention services to families post permanency
- Outcome 5: Increased understanding of the profiles of families who respond with varying degrees of assertive outreach was already discussed under the Participant section of Findings.

Lastly, we explore a subset of questions that focus on communication around adoption and guardianship and birth family contact.

This section summarizes family wellbeing, caregiver wellbeing and child wellbeing across all participants. Overall, survey data indicated that the majority of families formed through adoption and guardianship are doing well. However, some families may be experiencing challenges that place them at greater risk for discontinuity. These families may benefit from timely, relevant services.

Family Wellbeing

We asked caregivers about several family, caregiver and child wellbeing indicators. In terms of family wellbeing, we focused on the relationship between caregivers and children, a caregiver's commitment to their child for life, their overall adoption or guardianship experience, and family functioning.

- **98%** agreed or strongly agreed they are committed to their child for life, no matter what
- **95%** said their relationship with their child has either stayed the same or improved over the past 6 months
- **91%** have never thought about ending their adoption of guardianship
- **86%** rated the impact of adoption on their family as positive (60% rated it as extremely positive)
- **78%** would definitely adopt or assume guardianship of their child again if they knew then what they know now
- **77%** would recommend adoption or guardianship to others

We measured family functioning and attachment using two subscales from the Family Protective Survey (PFS): 1) Family Functioning/Resilience and 2) Nurturing and Attachment. Higher scores on the Family Functioning/Resilience Subscale indicate more open communication within the family and a greater ability to persevere or manage problems in times of crisis. On the Nurturing and Attachment Subscale, higher scores indicate a higher level of emotional bonding and positive interaction between the parent and child. Mean scores for both subscales are reported in Table 4.8.

Lastly, we used the Belonging and Emotional Security Tool (BEST) to assess the shared sense of belonging and the degree to which a caregiver has claimed their child either emotionally or legally. Higher scores are protective and indicate a greater sense of belonging and a higher level of caregiver commitment. Total scale and subscale scores are reported in Table 4.8.

Table 4.8. Family Wellbeing Indicators

MEASURE	SCALE RANGE	N	MIN	MAX	M	SD
PFS FAMILY FUNCTIONING	1 – 7	805	2.40	7.00	5.97	0.79
PFS NURTURING ATTACHMENT	1 – 7	807	1.00	7.00	5.98	0.96
BEST-AG	20 –100	808	20	100	95.61	7.69
BEST-AG EMOTIONAL SECURITY	13 – 65	808	13	65	61.61	5.60
BEST-AG CLAIMING	7 – 35	808	7	35	34.00	2.37

Caregiver Wellbeing

Caregivers were asked about their history of adverse experiences in childhood (ACEs) and how those experiences impact parenting their child now. On average, caregivers reported having two ACEs before the age of 18. The two most common ACEs were living with someone who had a problem with alcohol or substance use, having parents who separated or divorced, and/or living with a parent or adult who often insulted them or put them down. When caregivers reflected on how ACEs impacted their parenting now, there was no consistent response. A few example quotes that reflect a range of responses are listed below:

> **"The negative experiences I had as a child have made me a stronger, kinder, more loving parent. My top priority since I have become a parent is to make sure my children feel supported, important, worthy, safe and loved."**

> **"My mother made it clear that she did not want me and offered me little affection and never considered my thoughts or feelings. I try to listen; I understand childhood resentment and anger; I never want my child to feel insignificant or unwanted. I was not allowed or was not given the opportunity to do many things (sports, camp, music) so I work hard so my son has opportunities to try things and to learn new things."**

> **"I can relate to the loss of a parent and a craving to know more about my origins."**

> **"I sometimes respond in anger rather than taking time to calm down before addressing a situation."**

> **"I may be a little overprotective."**

We also looked at the ability of caregivers to cope and respond to stressful events in their lives. Mean scores on the Brief Resilience Scale (BRS) are reported in Table 4.9. Scores between 1.00 and 2.99 indicate low resilience, scores between 3.00 and 4.30 indicate normal resilience, and scores ranging from 4.31 to 5.00 indicate high resilience (Smith et al., 2013, p.177). The mean BRS score indicated the majority of caregivers had normal (62%) or high (31%) resilience.

We asked caregivers about their confidence in meeting the needs of their child and their ability to understand their child. Overall, 81% of participating caregivers reported being "very confident" or "extremely confident" that they could meet the needs of the identified child. A total of 68% of caregivers reported that in the past month they either "never" or "less than once a week" felt they just did not understand their child.

Lastly, we assessed a caregiver's level of strain, or the extent to which a caregiver experiences additional demands, responsibilities, and difficulties, as a result of parenting their child for whom they have legal guardianship or who was adopted. The mean overall strain, subjective strain, and objective strain scores are reported in Table 4.9. Scores can range from one to five, and higher scores indicate higher levels of strain. The mean caregiver strain score (1.97) was relatively low. The mean objective strain score (1.75) was lower than the subjective strain score (2.15) experienced by caregivers.

Table 4.9. Mean Caregiver Resilience and Caregiver Strain Scores

MEASURE	SCALE RANGE	N	MIN	MAX	M	SD
CAREGIVER STRAIN (CGSQ-FA22)	1 – 5	802	1.00	4.50	1.97	0.71
OBJECTIVE STRAIN	1 – 5	801	1.00	5.00	1.75	0.82
SUBJECTIVE STRAIN	1 – 5	802	1.00	4.58	2.15	0.73
CAREGIVER RESILIENCE	1 – 5	802	2.00	5.00	3.96	0.67

Child Wellbeing

Social, Emotional and Behavioral Wellbeing

In addition to caregiver wellbeing and family wellbeing, we also assessed child wellbeing. We used the Behavior Problem Index to examine the frequency, range, and type of childhood behavior problems children ages four and older may exhibit (Peterson & Zill, 1986). Higher scores indicate more challenges. (See Table 4.10 below.) Overall, the average total BPI score was 18.24 out of 56.

Table 4.10. Child Behavioral Wellbeing

MEASURE	SCALE RANGE	N	MIN	MAX	M	SD
BEHAVIOR PROBLEM INDEX (BPI)	0 – 56	722	0	53	18.24	12.57
BPI EXTERNALIZING BEHAVIORS	0 – 38	722	0	37	13.16	9.26
BPI INTERNALIZING BEHAVIORS	0 – 22	722	0	21	6.07	4.59

Using the CANS as a reference point, the Vermont team developed ten items to measure the social and emotional wellbeing of children (see Table 4.11 below). These items, when summed together, strongly correlated with the BPI, had good internal consistency (Cronbach's alpha=.91) and may be a potential tool to evaluate social and emotional wellbeing in the future. Further evaluation should be conducted to evaluate these items as a scale.

Table 4.11. Social and Emotional Wellbeing

ITEM	N	%	%
HOW MUCH…		Not at all, a little, moderately	A lot or a great deal
DOES YOUR CHILD GET ALONG WITH OTHER ADULTS?	804	24%	76%
IS YOUR CHILD LIKED BY OTHER CHILDREN?	788	48%	52%
HOW EASY OR HARD IS IT FOR YOUR CHILD TO…		Somewhat hard, very hard	Somewhat easy, very easy
FIND THINGS THEY LIKE ABOUT THEMSELVES?	757	35%	65%
MAKE FRIENDS?	791	39%	61%
ASK FOR HELP?	798	43%	57%
BOUNCE BACK QUICKLY WHEN THINGS DON'T GO THEIR WAY?	797	45%	55%
STAY CALM WHEN FACED WITH A CHALLENGE?	796	63%	37%
HOW OFTEN DOES YOUR CHILD…		Never to about half of the time	Most of the time, always
HELP OTHERS?	785	44%	56%
SHOW INTEREST OR CURIOSITY IN LEARNING NEW THINGS?	802	33%	66%
HOW…		Not at all, a little, moderately	Very, extremely
OPTIMISTIC IS YOUR CHILD ABOUT THEIR FUTURE?	677	44%	66%

Educational Wellbeing

In terms of educational wellbeing, schools provide a source of support through crucial relationships with teachers and peers (Sandoval-Hernandez & Cortes, 2012). Strong, supportive relationships with adults and peers in an academic setting allow children to explore different activities and identify areas they might excel. There were 617 of the 809 children in school at the time of the survey (Kindergarten through 12th grade/no assigned grade level), and according to caregivers, **83% of these children had at least one teacher at school who really understood their child's needs.** Additionally, we found that youth were involved in afterschool activities, in particular sports or athletics (64%), art, dance or music class (49%) and academic tutoring and support (45%). About one third (36%) of children were involved in volunteer work (see Table 4.12 below).

Table 4.12. Participation in Afterschool Activities

AFTERSCHOOL ACTIVITY	N	%
ACADEMIC TUTORING/SUPPORT	598	44.6
SPORTS OR ATHLETIC ACTIVITIES	601	64.1
MARTIAL ARTS	586	7.8
ART, DANCE, OR MUSIC CLASS	595	48.6
CLUBS OR ORGANIZATIONS	595	40.0
RELIGIOUS YOUTH GROUP	590	17.8
RELIGIOUS INSTRUCTION/SUNDAY SCHOOL	589	24.8
VOLUNTEER WORK	593	35.9
PART-TIME JOB	586	16.4
UNPAID INTERNSHIP	576	3.5

While children had supportive relationships at school and participated in afterschool activities, there were also some children who struggled more than others. According to caregivers, about half of the children were performing "good" or "excellent" in math (52%), 26% were performing "fair," and 22% were performing "poor" or "very poor." Similarly, 58% of children were performing "good" or "excellent" in reading and language arts, 27% were performing "fair," and 22% were performing "very poor," or "poor." About half (44%) of the children had an IEP (see Table 4.13).

During the past six months, 18% of children repeated a grade and 9% changed schools for reasons other than grade promotion. In terms of discipline, 12% of children had received an in-school suspension over the past six months, 8% had received an out of school suspension, and 2% had been expelled (see Table 4.13).

In terms of school services, 63% of caregivers reported that schools met the needs of their child over the past six months. When asked to identify the most important and most needed services, caregivers mentioned the following school-based services: special education, mentoring and increased awareness or competency of school staff as being critical to families formed through adoption and guardianship. Barriers mentioned specific too schools included schools and teachers not being trauma-informed and system-level barriers including challenges navigating the school system to get needed supports.

Table 4.13. Special Education, School Performance and Discipline

EDUCATIONAL WELLBEING	N	%
HAS 504 PLAN	576	21%
HAS AN IEP	592	44%
HAS AT LEAST ONE TEACHER WHO REALLY UNDERSTANDS THEIR NEEDS	603	83%
"GOOD" OR "EXCELLENT" PERFORMANCE IN MATH	605	52%
"GOOD" OR "EXCELLENT" PERFORMANCE IN READING & LANGUAGE ARTS	604	58%
HAS REPEATED A GRADE	587	18%
HAS CHANGED SCHOOLS FOR REASONS OTHER THAN GRADE PROMOTION	601	9%
RECEIVED AN IN-SCHOOL SUSPENSION	601	12%
RECEIVED AN OUT-OF-SCHOOL SUSPENSION	604	8%
BEEN EXPELLED FROM SCHOOL	600	2%
HAS RECEIVED AWARDS, CERTIFICATES OR MADE HONOR ROLL	601	43%
HAS HELD A LEADERSHIP POSITION IN A CLUB OR ORGANIZATION	601	13%

Health Issues that Impact Daily Functioning

Initially, we asked caregivers if their child had a physical health issue that impacted his or her daily functioning. Caregivers included other types of health issues in their responses, including but not limited to, mental health, food challenges, and disabilities. As a result, several items were added to the survey beginning in cycle three. Most commonly, caregivers reported their child had a mental health issue (38%), sibling conflicts (24%), and food issues (23%). (See Table 4.14.) When asked about prenatal exposure to substances, about one-third of parents were unsure. Of the caregivers who knew, the majority (81%) indicated their child had been prenatally exposed. This finding is particularly relevant because prenatal drug exposure can have a negative, long-term impact on child behavior, cognition, and achievement. In school-age children and adolescence, in utero exposure has been linked to negative, externalizing behaviors, impulsivity, hyperactivity, problems with cognition and executive functioning, disrupted school experiences, and mental health outcomes (Behnke et al., 2013).

Table 4.14. Health Issues that Impact Daily Functioning

HEALTH ISSUE	N	%
PHYSICAL HEALTH	800	19%
MENTAL HEALTH	549*	38%
SIBLING CONFLICTS	469*	24%
FOOD CHALLENGES	548*	23%
PHYSICAL DISABILITY	547*	8%
SUBSTANCE USE	548*	3%
PRENATAL EXPOSURE TO ALCOHOL OR OTHER SUBSTANCES	357*	81%
INTELLECTUAL DISABILITY	540*	17%

Relationship between Family, Caregiver and Child Wellbeing Indicators

Because prior research has shown that the Behavior Problem Index and six Illinois Commitment Items play a role in understanding post permanency discontinuity (Liao & Testa, 2016; Liao & White, 2014; Testa, Snyder, Wu, Rolock, & Liao, 2015), we looked at the relationship of these variables with the following measures: Protective Factors Survey, Belonging and Emotional Security Tool, Brief Resiliency Survey, and the Caregiver Strain Questionnaire – (adapted for Foster and Adoptive Families).

All relationships between items and measures were significant; however, some were stronger than others. We found a strong relationship between behavior problems and caregiver strain and moderate relationships between commitment, and 1) emotional bonding and positive child interactions, and 2) a shared sense of family belonging. A negative moderate relationship was found between commitment and strain. (See Table 4.15).

Table 4.15. Correlations of BPI and Commitment Items with Other Measures

MEASURE OR ITEM	CGSQ-FA22	BRS	PFS-NA	PFS-FF	BEST
BEHAVIOR PROBLEM INDEX	0.62**	-0.34**	-0.43**	-0.21**	-0.31**
IN THE PAST MONTH, HOW OFTEN DID YOU JUST NOT UNDERSTAND YOU CHILD?	0.49**	-0.29**	-0.51**	-0.32**	-0.36**
HOW CONFIDENT ARE YOU THAT YOU CAN MEET YOUR CHILD'S NEEDS?	-0.49**	0.33**	0.54**	0.36**	0.41**
HOW WOULD YOU RATE THE IMPACT OF ADOPTION ON YOUR FAMILY?	-0.48**	0.26**	0.57**	0.32**	0.53**
GIVEN YOUR EXPERIENCE, WOULD YOU RECOMMEND ADOPTION TO OTHERS?	-0.44**	0.23**	0.37**	0.26**	0.37**
IF YOU KNEW THEN WHAT YOU KNOW NOW, DO YOU THINK YOU STILL WOULD HAVE ADOPTED OR ASSUMED GUARDIANSHIP OF YOUR CHILD?	-0.45**	0.21**	0.50**	0.18**	0.50**
HOW OFTEN HAVE YOU THOUGHT ABOUT ENDING THIS ADOPTION OR GUARDIANSHIP?	0.32**	-0.14**	-0.39**	-0.17**	-0.43**

**p<.001

CORRELATION	STRENGTH AND DIRECTION OF RELATIONSHIP
-0.6 to 1.0	Strong, negative
-0.40 to -0.59	Moderate, negative
-0.20 to -0.39	Weak, negative
0.20 to 0.39	Weak, positive
0.40 to 0.59	Moderate, positive
0.6 to 1.0	Strong, positive

Reliable and valid measures are needed in post permanency research. By looking at the relationship between variables we know are connected to post permanency discontinuity and other wellbeing measures, we begin to identify potential measures that may help us understand the characteristics of families at risk for discontinuity. In addition, all measures used in this study showed high internal consistency (i.e., Cronbach's alphas greater than .70; DeVellis, 2003). The Cronbach's alpha for each scale is shown in Table 4.16 below.

Table 4.16. Reliability of Survey Measures

SCALE	CRONBACH'S ALPHA
BEHAVIOR PROBLEM INDEX	0.95
BELONGING AND EMOTIONAL SECURITY TOOL	0.94
CAREGIVER STRAIN QUESTIONNAIRE – FOSTER CARE AND ADOPTION (22 ITEMS)	0.93
PROTECTIVE FACTORS SURVEY - NURTURING ATTACHMENT	0.89
PROTECTIVE FACTORS SURVEY - FAMILY FUNCTIONING	0.87
BRIEF RESILIENCE SCALE	0.87

ADOPTION AND GUARDIANSHIP SPECIFIC FINDINGS

Communication around Adoption and Guardianship

We asked caregivers, "How comfortable or uncomfortable are you answering your child's questions about his or her birth parents history?" and "In the past 6 months, how often did you bring up adoption or guardianship with your child?" The majority of caregivers indicated they were very comfortable (67%) or somewhat comfortable (25%) answering questions about their child's birth family history. However, most caregivers never (32%) or rarely (41%) talked about adoption or guardianship with their child (See Table 4.17.)

Table 4.17. Caregiver's Level of Comfort by How Often They Brought up Adoption or Guardianship

		LEVEL OF COMFORT TALKING ABOUT A CHILD'S BIRTH FAMILY HISTORY				% PARENT
		Very Uncomfortable	Somewhat uncomfortable	Somewhat comfortable	Very comfortable	
% PARENT BROUGHT UP ADOPTION OR GUARDIANSHIP WITH CHILD	Never	1%	2%	7%	22%	32%
	< Monthly	1%	2%	10%	28%	41%
	Monthly	0%	1%	4%	12%	18%
	Weekly	0%	0%	2%	4%	7%
	Daily	0%	0%	0%	1%	1%
% LEVEL OF COMFORT		2%	5%	25%	67%	100%

We also looked at the comparison between how often parents bring up adoption or guardianship and how often children initiate that conversation. Findings showed that both caregivers and children were not initiating conversations around adoption and guardianship. A total of 37% of parents indicated they never initiated conversation and 38% of parents brought up adoption or guardianship on a less than monthly basis (see Table 4.18). Similarly, 33% of children never brought up adoption or guardianship and 41% brought it up less than monthly.

Table 4.18. Conversations about Adoption and Guardianship: Child-Initiated vs. Caregiver-Initiated

		% CHILD (AGE 4+) BROUGHT UP ADOPTION OR GUARDIANSHIP IN CONVERSATION					% PARENT
		Never	< Monthly	Monthly	Weekly	Daily	
% PARENT BROUGHT UP ADOPTION OR GUARDIANSHIP WITH CHILD	Never	26%	8%	2%	1%	0%	37%
	< Monthly	6%	27%	5%	1%	0%	38%
	Monthly	1%	5%	8%	1%	0%	15%
	Weekly	1%	1%	3%	4%	0%	9%
	Daily	0%	0%	1%	0%	1%	1%
% CHILD		33%	41%	18%	6%	1%	100%

Birth Family Contact

This section focuses on the relationship between families formed through adoption and guardianship and birth families. We wanted to understand whether or not children had contact with their birth family, the type of contact, and how important contact was to caregivers. We found that 31% of caregivers indicated that contact was not possible between their child and their child's birth mother while 45% indicated contact was not possible between their child and their child's birth father.

We asked caregivers who felt contact was possible how important is it to them that their child has contact with his or her birth parents. The majority (42%) of caregivers reported that contact with their child's birth mother was not at all important while even more (54%) caregivers indicated that contact with their child's birth father was not at all important. (See table below). In the past six months, 48% of children had no contact with their birth mother and 66% had no contact with their birth father. The most common form of contact for both birth parents was through visitation or phone/Skype/FaceTime. A summary of birth parent contact is presented in Table 4.19 below.

Table 4.19. Birth Parents: Is Contact Important? Did It Happen?

SERVICE SECTOR	CONTACT NOT POSSIBLE			CONTACT NOT IMPORTANT			NO CONTACT IN PAST 6 MONTHS		
	N	n_1	%	N	n_2	%	N	n_3	%
BIRTH MOTHER	797	244	31%	553	230	42%	549	265	48%
BIRTH FATHER	794	358	45%	436	236	54%	436	287	66%

A total of 628 out of 809 caregivers (78%) indicated that their child had at least one birth sibling living outside of their home. Caregivers generally placed more importance on contact with birth siblings. Almost half (43%) indicated contact was either "very" or "extremely" important; however, 19% of caregivers still indicated birth sibling connections outside of the home were not at all important. Moreover, in the past six months, 45% of children had no form of contact with their birth siblings outside of their home. For those who did have contact, visitation was the most common type of contact reported. A summary of birth sibling contact is presented in Table 4.20 below.

Table 4.20. Birth Siblings: Is Contact Important? Did It Happen?

	BIRTH SIBLINGS OUTSIDE HOME			CONTACT NOT IMPORTANT			NO CONTACT IN PAST 6 MONTHS		
	N	n_1	%	N	n_2	%	N	n_3	%
BIRTH SIBLINGS	809	628	78%	618	119	19%	622	281	45%

Kinship Families

Lastly, we compared child and family wellbeing outcomes for caregivers who were biologically related to their child (kinship) and those who were not biologically related to their child (non-kin). There were 215 caregivers who indicated they were biologically related to their child (27%). Overall, kinship caregivers reported lower levels of caregiver strain and fewer child behavioral problems compared to non-kin caregivers. Kinship caregivers also had higher levels of nurturing and attachment and emotional security compared to non-kin; however, caregiver commitment was not significantly different between the two groups. (See Table 4.21 below.)

Table 4.21. Child & Family Wellbeing for Kinship and Non-Kin Caregivers

		KINSHIP	NON-KIN	KIN VS NON-KIN		
MEASURE	**Range**	**M**	**M**	***t***	***df***	***p***
ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN						
BEHAVIOR PROBLEM INDEX	0 - 56	15.68	19.22	-3.35	712	0.001
BPI EXTERNALIZING BEHAVIORS	0 - 38	13.86	11.34	-3.22	712	0.001
BPI INTERNALIZING BEHAVIORS	0 - 22	5.15	6.42	-3.28	712	0.001
CAREGIVER STRAIN (CGSQ-FA22)	1 - 5	1.84	2.02	-3.09	791	0.002
CGSQ-AG OBJECTIVE STRAIN	1 - 5	1.63	1.80	-2.55	790	0.011
CGSQ-AG SUBJECTIVE STRAIN	1 - 5	2.02	2.20	-3.19	791	0.001
MEASURE	**Range**	**M**	**M**	***t***	***df***	***p***
ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN						
PFS FAMILY FUNCTIONING	1 - 7	5.99	5.97	0.27	328.11	0.786
PFS NURTURING ATTACHMENT	1 - 7	6.22	5.89	5.00	498.69	<0.001
BEST-AG OVERALL	20 - 100	96.48	95.33	1.96	413.81	0.051
BEST-AG EMOTIONAL SECURITY	13 - 65	62.41	61.34	2.57	448.54	0.011
BEST-AG COMMITMENT	7 - 35	34.07	33.97	0.50	797	0.617

Outcome 1. Earlier Identification of Families Who May Be at Risk of Discontinuity

In order to understand the characteristics of families who are doing well and those who may be at risk for discontinuity, we compared caregivers who indicated that if they knew then what they know now, they "definitely would have" adopted or assumed guardianship of their child again vs. caregivers who responded they "probably would, might or might not, probably would not, or definitely would not." This question is part of the Illinois Post Permanency Commitment items that have been shown to be related to post permanency discontinuity (Liao & Testa, 2016; Liao & White, 2014; Testa, Snyder, Wu, Rolock, & Liao, 2015).

Table 4.22 examines differences in child, caregiver and family wellbeing measures for caregivers who would definitely adopt or assume guardianship again and those who were uncertain or would not. Overall, we found differences between those who definitely would adopt again and those who were less certain or would not on all wellbeing indicators with the exception of caregiver ACES.

Table 4.22. Differences in Wellbeing Indicators by Adopt Again Status

		ADOPT AGAIN?		BIVARIATE COMPARISON		
		UNCERTAIN WOULD NOT	DEFINITELY WOULD	(UNCERTAIN/WOULD NOT VS DEFINITELY WOULD)		
MEASURE	**Range**	**M**	**M**	***t***	***df***	***p***
ON THE FOLLOWING MEASURES, HIGHER SCORES = MORE CONCERN						
BEHAVIOR PROBLEM INDEX	0 - 56	26.45	14.95	11.51	760	<.001
BPI EXTERNALIZING BEHAVIORS	0 - 38	19.06	10.79	10.02	760	<.001
BPI INTERNALIZING BEHAVIORS	0 - 22	8.70	4.99	11.17	760	<.001
CAREGIVER STRAIN (CGSQ-FA22)	1 - 5	2.55	1.80	12.80*	258	<.001
CGSQ-AG OBJECTIVE STRAIN	1 - 5	2.35	1.58	10.28*	236	<.001
CGSQ-AG SUBJECTIVE STRAIN	1 - 5	2.72	1.99	12.77	792	<.001
CAREGIVER ACES	1 - 11	2.18	2.34	-0.83	769	0.406
MEASURE	**Range**	**M**	**M**	***t***	***df***	***p***
ON THE FOLLOWING MEASURES, HIGHER SCORES = LESS CONCERN						
PFS FAMILY FUNCTIONING	1 - 7	5.60	6.07	-7.21	788	<.001
PFS NURTURING ATTACHMENT	1 - 7	5.10	6.22	-12.92*	228	<.001
BEST-AG OVERALL	20 - 100	89.43	97.31	-9.80*	207	<.001
BEST-AG EMOTIONAL SECURITY	13 - 65	56.77	92.95	-10.61*	205	<.001
BEST-AG COMMITMENT	7 - 35	32.67	34.37	-6.74*	214	<.001

*Variance not assumed to be equal – Standard error of the difference of means was calculated using Satterthwaite's method rather than the pooled variance estimator method.

Caregivers who would definitely adopt their child again had higher levels of resilience, open communication, perseverance in time of crisis, and more positive parent-child interactions compared to caregivers who indicated they were uncertain or definitely would not adopt again. They had less strain attributed to parenting their child, more confidence to meet their child's needs, felt more prepared at the time of their finalization, and used fewer services in the past six months. Additionally, these caregivers were more likely to be related to their child or have a relationship with their child prior to their child's removal from his or her birth family's home. The number of ACEs a caregiver experienced growing up and the current age of the caregiver were not significantly different between the two groups.

The average age of the child for caregivers who would definitely adopt their child again was 10 years old, whereas the average age of the child for uncertain caregivers or caregivers who would definitely not adopt again was 13 years old. Based on what caregivers reported, children of caregivers who would definitely adopt again had fewer behavioral challenges, performed better in school, were more likely to stay calm when faced with a challenge, felt more optimistic about their future, found it easier to make friends, and had a teacher who understood their needs.

Outcome 2. Increased Identification of Post Permanency Service Needs by District and System of Care Provider Type

For STO 2, we report findings on what caregivers had to say about services and supports for families formed through adoption and guardianship in Vermont. We explore pre and post permanency service use across the Vermont system of care. We also summarize the services and supports caregivers felt were most important, those that were most needed but hard to get or not available, and the top barriers to getting supports and services.

Pre Permanency Service Use

Overall, 77% of caregivers felt prepared at the time of finalization and 61% of caregivers rated DCF as "good" or "very good" in preparing them to meet the needs of their child.

Caregivers were asked about their family's participation in eight pre permanency services. If a family had participated in service, the caregiver was then asked to rate the helpfulness of that service. Pre permanency service use ranged from zero to eight services. Table 4.23 provides a summary of pre permanency service use. Based on caregiver's responses, the most commonly used pre permanency services included Lund Finalization Case Managers and Fostering to Forever Training through Vermont DCF. The least commonly used services were the Adoption Learning Partnership Online Training, Vermont Kin as Parents, and the Transracial Cross-Cultural Training. About one-third of caregivers had not heard of the Adoption Learning Partnership or RPC+: Trauma-Informed Resource Parenting Curriculum. It is important to note that RPC+ is a newer curriculum that was being rolled out to districts during this project period.

The most highly rated pre permanency services included the Lund Project Family's Pre Permanency Counselor and the Lund Finalization Case Manager. The RPC+: Trauma-Informed Resource Parenting Curriculum and Transracial Cross-Cultural Training were the most highly rated trainings, but fewer caregivers attended these trainings.

Table 4.23. Pre Permanency Service Use

		NOT AWARE OF		NOT USED		USED		% FOUND VERY HELPFUL
	N	n_1	%	n_2	%	n_3	%	
FOSTERING TO FOREVER TRAINING THROUGH DCF	783	104	13%	143	18%	536	69%	45%
LUND FINALIZATION CASE MANAGER	766	98	13%	164	21%	504	66%	79%
LUND PROJECT FAMILY'S PERMANENCY COUNSELOR	768	173	22%	288	38%	307	40%	72%
VFAFA TRAININGS/CONFERENCES*	436	92	21%	147	34%	197	45%	54%
SHARED PARENTING MEETINGS	774	127	16%	373	49%	274	35%	18%
RPC+: TRAUMA-INFORMED RESOURCE PARENTING CURRICULUM	774	233	30%	392	51%	149	19%	63%
VERMONT KIN AS PARENTS	777	127	16%	552	71%	98	13%	61%
ADOPTION LEARNING PARTNERSHIP ONLINE TRAINING	774	244	32%	440	57%	90	11%	40%
TRANSRACIAL CROSS-CULTURAL TRAINING	768	127	17%	616	80%	25	3%	65%

*Not asked in cycle 2

Post Permanency Service Use over Past Six Months

Table 4.24 displays services and supports used over the past six months by at least 10% of families.

Table 4.24. Service Use in Past 6 Months by Cross System Sector

FAMILY SUPPORT SERVICES	N	FREQ	%
FAMILY COUNSELING	796	213	27
CASE MANAGEMENT SERVICE COORDINATION	798	99	12
DCF SOCIAL WORK SERVICES	796	85	11
Note: Less than 10% of participants reported using online support/blogs, agency support services, intensive family-based services, family safety planning, or LGBTQ support services over the past six months,			
SCHOOL/CHILD CARE SERVICES	**N**	**FREQ**	**%**
REGULAR CHILD CARE SERVICES	796	178	22
AFTERSCHOOL PROGRAM	796	159	20
SCHOOL-BASED CLINICIAN	796	152	19
BEHAVIOR SUPPORT SERVICES	796	139	18
Note: Less than 10% of participants reported their child using alternative school or mentoring over the past six months.			
MEDICAL SERVICES FOR CHILD	**N**	**FREQ**	**%**
ROUTINE MEDICAL CARE	796	626	78.6
MEDICATION MANAGEMENT	796	199	25
SPEECH OR OCCUPATIONAL THERAPY	796	124	15.5
Note: Less than 10% of participants reported their child using developmental disability case management services, physical disability services, services for children who are deaf or hard of hearing, services for children who are blind or visually impaired, or other developmental disabilities services (including personal care or family managed respite) over the past six months.			
MENTAL HEALTH SERVICES	**N**	**FREQ**	**%**
INDIVIDUAL COUNSELING FOR CHILD	796	336	42
INDIVIDUAL COUNSELING FOR CAREGIVER	796	177	22
PSYCHOLOGICAL ASSESSMENT FOR CHILD	796	129	16
PSYCHIATRIC MEDICATION FOR CHILD	796	126	16
CARE COORDINATION/CASE MANAGEMENT FOR CHILD	796	78	10
Note: Less than 10% of participants reported their child using a coordinated service pan/ACT 264, group counseling, or substance abuse treatment over the past six months. Less than 10% of caregivers reported using group counseling, psychiatric medication, or substance abuse treatment over the past six months.			
POST PERMANENCY SERVICES	**N**	**FREQ**	**%**
ADOPTION/GUARDIANSHIP SUBSIDY	796	354	44.5
POST PERMANENCY SERVICES	796	145	18.2
VERMONT ADOPTION REGISTRY	796	88	11.1
Note: Less than 10% of participants reported using a parent support group, post permanency trainings, the Vermont Adoption Consortium (VAC) resource library, post permanency newsletter, trauma assessments for their child in the past six months. Less than 10% of caregivers reported attending a conference for families formed through adoption and guardianship.			

We also asked caregivers, "In the past 6 months, how often have the following services in your community met the needs of your family?" Participants had the option to mark whether or not they used services from each service sector and, if so, how often they met their needs (See Table 4.25 below). Overall, medical services, school services, and child mental health services were the most commonly used services. A total of 83% of caregivers who used medical services felt they met the needs of their family, whereas only 17% of families that used substance abuse services felt like those services met their needs most or all of the time. A total of 63% of families who used school services felt that their needs were met most or all of the time.

Table 4.25. Frequency Services Met Needs in the Past Six Months

	USED SERVICES	% SERVICE MET NEEDS		
SERVICE SECTOR	N	% Not at all or some of the time	% About half of the time	% Most of the time or always
FAMILY SUPPORT SERVICES	316	42%	8%	50%
SCHOOL SERVICES	563	25%	13%	63%
CHILD CARE SERVICES	375	33%	8%	60%
MEDICAL SERVICES	647	12%	6%	83%
CHILD MENTAL HEALTH SERVICES	409	29%	12%	59%
CAREGIVER MENTAL HEALTH SERVICES	242	38%	10%	53%
POST PERMANENCY SERVICES	276	38%	11%	51%
SUBSTANCE ABUSE SERVICES	78	76%	8%	17%
DCF CHILD WELFARE SERVICES	157	40%	14%	46%

Qualitative Findings

Lastly, caregivers were asked to write in: (1) three services that they found to be the most important, (2) three services they found to be the most needed but hard to get or not available, and (3) three barriers to accessing services and supports.

We used an inductive approach to qualitative content analysis to code participant's responses to what services were most important, what services were most needed, and what barriers got in the way. Participant responses were organized into initial categories for each question based on themes that emerged from the data using an open coding approach in Cycle 2. As we encountered data that did not fit an existing code, we added new codes to represent that data. Upon reviewing the initial open-codes, we grouped similar codes into categories. Categories were reorganized into broader, higher order categories and a codebook was developed and applied in subsequent cycles (3 through 5). Data from Cycle 2 was then retroactively re-coded using the conceptual codebook. Categories were reviewed and refined to ensure each category was mutually exclusive. In some cases, we had to establish decision criteria for responses that fell under more than one category but represented one idea. For example, participants sometimes would name a provider as an important service, others named the specific service, and some participants named both: "Lund" vs. "Case Management" vs. "Lund Case Management." In cases where both were provided, the service identified took precedence over the service provider. Due to the similarity in responses to the questions regarding the most important services and the most needed services, the same codebook was applied to the data gathered from those two questions.

We identified 12 main categories with 27 subcategories that represented participant responses (see Table 4.26). For barriers, we identified eight main categories with 16 subcategories (see Table 4.27). For each question, responses were coded by at least two trained coders. Discrepancies in coding were resolved through discussion, referral to the codebook definitions, and by soliciting input from an additional coder.

Most Important Services

The top services mentioned by participants were post permanency services, mental health services, and financial support (primarily the adoption and guardianship subsidy). Within post permanency services, caregivers most often did not specify a service or they reported a specific provider rather than a service. Of the services mentioned, trainings, support groups, and respite came up most frequently. Counseling and therapy (specifically child, family and adoption/trauma-informed therapy) were the most common mental health services mentioned by caregivers.

Most Needed Services That Are Hard to Get or Not Available

The most needed services mentioned by participants were post permanency services, mental health services, and childcare services. Respite was the most commonly mentioned post permanency service followed by support groups and then trainings. Counseling and therapy, particularly adoption and trauma-informed therapy, were the most needed mental health services.

Table 4.26. Most Important & Most Needed Services: Category Descriptions

CATEGORY DESCRIPTIONS	
ADOPTION, PERMANENCY & FAMILY SUPPORT SERVICES	Support services offered to foster, adoptive, or kinship families at any point prior, during, or after adoption/permanency, including but not limited to, case management, trainings or classes, support groups, respite and/or the name of a specific provider.
MENTAL HEALTH & DISABILITY SERVICES	Mental health and disability services including adoption or trauma-informed mental health, counseling or therapy, wrap services or the name of a specific provider.
MEDICAL SERVICES	Medical services or doctor's appointments, including but not limited to, psychiatric care, medication management, OT, PT, SLP, or personal care assistance.
SCHOOL-BASED SERVICES	Supports provided by the school or within the school environment, including but not limited to, special education services, mentoring, liaison or advocacy services, competency of staff, and connection to an alternative school.
CHILDCARE SERVICES	Childcare or daycare, including but not limited to, before or after school services, summer camps, and general references to child/youth activities. Respite is not included in this category but is captured in the adoption, permanency and family support services.
FINANCIAL SUPPORTS & SERVICES	Financial supports, including but not limited to, medical insurance, employment support, job training, college assistance, or subsidy.
CRISIS SERVICES	Specific mention of supports provided during crises or emergencies, including emergency beds (or e-beds).
LEGAL SERVICES	Supports and services referencing the legal system, including but not limited to, support navigating the legal system or workers within the legal system (i.e. judges, lawyers, guardian ad litems).
STAFF COMPETENCY	Knowledge, competency, and training of general staff not specific to any one service sector. If competency of a provider within one sector (mental health, adoption/perm, school, etc.) is mentioned, the item was coded within that sector.
INCREASED AWARENESS	Responses that describe the importance of or need for increased knowledge or level of understanding of services.
INFORMAL SUPPORT NETWORKS	Informal networks of support (i.e. other families, church, etc.).
OTHER SUPPORTS	Other supports or services that cannot be coded into one of the more specific categories above.

Top Barriers to Services and Supports

The top barriers to services and supports mentioned by participants fell into the following categories: access barriers, provider barriers, financial barriers, and system barriers. In terms of access, participants mentioned issues related to the location of services (rural area, not local, too far to drive, etc.), services not existing, and transportation. The most common provider barrier mentioned was the quality of the providers. Caregivers reported that providers didn't have the expertise needed to meet their child's needs. About half of the caregivers who commented on quality mentioned that providers were not adoption competent nor trauma-informed. The number of times system barriers and financial barriers came up was similar. System barriers included things like staffing, service fragmentation, navigating the system, and policy or regulation barriers. Insurance was the largest financial barrier.

Table 4.27. Barriers to Services: Codebook Definitions

CATEGORY DESCRIPTIONS	
ACCESS/ AVAILABILITY	Responses that describe barriers related to limited or lack of accessibility/availability of services, resources, and providers, including but not limited to, issues related to location, transportation, waitlists, and inconvenient appointment times.
PROVIDER BARRIERS	Responses that relate to service providers, including but not limited to, mention of a specific service provider without additional detail, issues related to provider communication, quality, or lack of adoption and trauma competency.
FINANCIAL/ PAYER BARRIERS	Responses that reference general financial issues from the provider or the payer, including but not limited to insurance coverage.
SYSTEM BARRIERS	Responses that describe general issues with systematic barriers or the organizational structure of services, including but not limited to, staffing, service fragmentation, paperwork, navigation, and policy or regulation barriers.
CAREGIVER CHARACTERISTICS	Responses that attribute the lack of service acquisition to caregiver's personal lack of knowledge, perceptions of services, or lack of interest in seeking out services.
CHILD-LEVEL BARRIERS	Responses that attribute the lack of service acquisition to the child/youth, such as behavior has been a barrier to getting services.
STIGMA/LACK OF GENERAL KNOWLEDGE FROM COMMUNITY	Responses that express concern with the level of understanding or compassion from individuals or community at large.
OTHER BARRIERS	Responses that represent other barriers that cannot be coded into a more specific category.

Outcome 3 & 4. Improved Ability to Share Information & Deliver Data-Driven, Relevant and Timely Services

The Vermont Site team used the survey as one way to identify families who may need services in a timelier manner. Caregivers were asked at the end of the electronic survey if they would like someone to contact them about post permanency services. There were 77 out of 419 caregivers (19%) who took the electronic version of the survey and indicated they would like to talk to someone about post permanency services. Caregivers who received a paper copy of the survey were provided with contact information for post permanency services and could call or email for services if desired.

We analyzed data at the Agency of Human Services (AHS) district level[2] for the state of Vermont, in order to provide targeted findings regarding regional differences in service usage and service needs. Both the statewide data set and the more specific district-level findings, are being used by the state to drive future improvements to the systems of care for post permanency families. The Vermont Site team has presented the data to each district and across the system of care. They also held a summit at the end of the project to share findings with both families and providers.

Lastly, the Vermont Site team developed a post permanency guide, *The Continuing Journey of Children and Families: An Informal Guide for Those Parenting by Adoption or Guardianship*, to provide an additional opportunity to connect with families and highlight themes common to families formed through adoption or guardianship with a particular focus on the impact of trauma and developmental stages. While parenting always has its ups and downs, families who are formed through adoption and guardianship face unique experiences, both rewarding and challenging. Additionally, the guide highlights the unique dynamics of kinship families and families identifying as transracial/transcultural at the end of the study, we mailed a hard copy of this guide to all families formed through adoption and guardianship in Vermont (including private domestic or intercountry adoptive families known to the state).

[2] The state of Vermont has 12 AHS districts, which roughly correspond to the size of a county in the state.

Limitations

There are several limitations to this study. First, based on AFCARS data, we found no instances of post permanency discontinuity over the time-frame this survey was implemented. In order to identify predictors of discontinuity, survey responses would need to be linked to families who have and have not experienced discontinuity. If this survey data is linked to families at a future time point, it will likely be possible to use the survey to identify predictors.

In this study, we were only able to identify risk and protective factors using variables we know play a role in understanding post permanency discontinuity. When we look at these factors, it is difficult to determine how they are related. For example, we don't know whether a child having more behavior challenges leads to more negative parent-child interactions or if more negative parent-child interactions lead to a child having more behavior challenges. We only know there is a relationship between these factors.

Lastly, we found significant differences between caregivers who responded to the survey and those who did not in the number of times their child moved while in foster care and whether their child had a disability. There may be additional differences that we were not able to capture in our analysis. Therefore, care should be used in interpreting the results for those families who responded to the survey—for example, they may have more (or less) needs and/or challenges than other adoptive families.

Cost Evaluation

The Vermont QIC-AG project implemented a survey of adoptive parents to understand the needs of adoptive families and to understand the best ways to reach families. There were 1,470 surveys sent to families formed through adoption and 809 caregivers completed the survey.

Cost Evaluation Approach

Cost evaluations for each site were designed to understand the cost-effectiveness of the intervention selected by the site. The cost-effectiveness research (CER) analysis provides information for policymakers and administrators to help maximize desired outcomes based on the associated cost of achieving them (Meunnig, 2002). With Vermont, a cost-effectiveness analysis was conducted using the desired outcome as the number of caregivers who completed the survey.

Assumptions, Constraints, and Conditions

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

ASSUMPTIONS

Assumptions are those factors which will likely impact the program and thus, the accuracy of the cost analysis (Department of Health and Human Services, Administration for Children and Families & Health Care Finance Administration, 1993). The primary assumption with Vermont is that the state was able to access a complete list of families who had adopted from the public child welfare system. An additional assumption is that the resource allocation captured in costs paid to sites is accurate. It is likely that staff time may be over or under-budgeted depending on the time constraints.

CONSTRAINTS

Constraints are factors that have a direct impact on a project. Constraints may include legal regulations, technological issues, political issues, financial issues and/or operational issues. For Vermont, constraints included legal changes at the state agency that delayed data sharing.

CONDITIONS

Conditions are factors that may influence system processes but are not necessarily constraints. During the planning process in Vermont, the site decided on a process to roll out the survey in phases based on the state's districts. Within that process, families formed by private and/or intercountry adoption were also included in a phase of the survey.

Cost Estimation

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

KEY POINTS IN COST ESTIMATION

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

Costs should generally include all resources used and not simply the direct financial expenses spent on a program. The project was managed by Lund which is a well-established non-profit with existing office space. The sites also received substantial technical support from consultants and evaluators during implementation. Although the consultation was crucial to moving sites into implementation, the costs associated with the consultation will only be noted in the conclusion as additional costs for future programs to consider. Evaluation costs are also not included in this cost estimation, so other programs interested in this intervention would need to budget for evaluation in addition to the cost estimates.

Perspective refers to the person or group that incurred the costs. The perspective is essentially a filter that helps determine what costs are included. In this cost evaluation, the costs are determined from the perspective of the Vermont QICAG site. In other words, if funds were spent by the program, they are considered costs.

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

Both variable and fixed costs should be captured in a cost estimation. For Vermont, fixed costs include salaries, fringe and facility/office space. Variable costs were charged to the project as needed for items necessary to implement the survey such as gift cards and postage.

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

COST ESTIMATION STEPS

The steps involved in the cost estimation of this analysis are described below. All QIC-AG sites used a standardized budget form and cost reimbursement form. Costs for Vermont were taken from monthly budget forms and summarized into Table 4.28.

Table 4.28. Costs for Vermont

	IMPLEMENTATION			TOTAL
	FY 2019*	FY 2018	FY 2017**	
PERSONNEL EXPENSES				
SITE IMPLEMENTATION MGR SALARY	$33,300	$28,118	$36,927	$98,345
SITE IMPLEMENTATION MGR FRINGE	$9,600	$8,435	$11,078	$29,113
IN-KIND SALARIES	$14,905.58	$56,365	$39,077	$110,347
NON-PERSONNEL DIRECT EXPENSES				
CONTRACTED SERVICES: LUND	$22,325	$54,782	$49,449	$126,556
CONTRACTED SERVICES: UNIV OF VT	$499	$27,811	$1,504	$29,814
CONTRACTED SERVICES: PHONE SURVEY SUPPORT	$659	$0	$0	$659
CONTRACTED SERVICES: LEXISNEXIS	$0	$3,503	$3,415	$6,918
CONTRACTED SERVICES: ANTICIPATORY GUIDANCE-JAYNE SCHOOLER	$71	$0	$0	$71
CONTRACTED SERVICES: DANIEL ZIEGLER		$0	$5,000	$5,000
CONTRACTED SERVICES: BETSY SMALLEY		$360	$473	$833
CONTRACTED SERVICES; JON BABBAGE			$455	$455
PROGRAM SUPPLIES			$1,182	$1,182
GIFT CARD INCENTIVES		$1,405	$5,899	$7,304
POSTAGE		$10,851	$6,649	$17,501
PRINTING/DUPLICATION			$0	$0
INDIRECT COSTS		$298	$681	$979
TOTAL	**$81,359**	**$244,291**	**$164,646**	**$490,295**

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

Collect Data on Resource Costs

In order to collect accurate information, monthly expense forms were used to track actual costs. All QIC-AG sites developed an annual budget. The actual costs billed to QIC-AG were provided to the evaluation team via monthly expense reports. These expense reports contained a year to date summary of expenses. Expenses for each fiscal year were then compiled into Table 4.28.

Collect Data on Resource Allocation

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

Estimation of Direct Costs

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

Personnel

Personnel costs totaled $98,344 for the SIM's time allocated to the project during the implementation phase. The SIM was located at LUND. Given that the scope of this project was a survey, other staff time needed for the project was contracted out to other agencies.

In addition to these personnel costs, there were multiple individuals who provided time to the project as an in-kind donation. Four individuals were employed by the Department of Children & Families. These individuals contributed time throughout the project as implementation team members. Another individual provided administrative support to the SIM. A private agency provider participated in small group work to provide survey feedback. Finally, several non-profits assisted the project in sending out survey invitations to caregivers. In total, 714 hours were donated to the project. The site consultant kept track of hours and made calculations based on known salaries. In some cases, salaries include benefits. A conservative estimate of the cost of this in-kind donation of time in total is $110,347.

Fringe

Overall fringe for the SIM totaled $29,113. Fringe was calculated based on policies of LUND.

Contractual Expenses

Vermont contracted for services from the following entities.

- LUND was paid $126,555 over the course of the project. These funds were in addition to the salary and expenses related to the SIM who was housed at LUND. Funds were used to pay for time for an administrative assistant to support the project, particularly in monitoring participation and providing anticipatory guidance for participants.
- The University of Vermont was paid $29,813 for assistance in analyzing and presenting data from the survey.
- LexisNexis was paid $7,895 for address verification of participants.
- Jayne Schooler was paid $5,000 for assistance in developing the anticipatory guidance document.
- Daniel Ziegler was paid $833 for assistance with the graphic design and formatting of the anticipatory guidance document.
- Betsy Smalley was paid $455 for editing the anticipatory guidance booklet.
- Jon Babbage was paid $1,182 for assistance with developing REDCap for use in Vermont's child welfare system.

Gift Cards

Gift cards were provided to parents who participated in the project. A total of $17,500 was spent on gift card incentives. Parents who participated in focus groups were paid $100 honorarium and parents who completed the survey were provided a $20 gift card.

Materials and Supplies

Over the implementation period, $5,665 was spent on program supplies to administer the survey.

Travel

Over implementation, $14,275 was paid for travel. A large portion of these funds were used to pay for travel costs for the SIM to attend grantee and other required meetings for the QIC-AG.

Facilities/Office Space

No funds were expended for facilities and office space for the survey.

Other Direct Charges

Other direct charges include all non-personnel direct costs that do not fit into the categories listed above such as postage ($978) and printing ($40,944).

Estimation of Indirect Costs

In terms of general indirect costs, $13,524 were charged to the project by LUND. Indirect costs often include facility costs and infrastructure not captured in the above categories. Since this cost evaluation is designed to help other state child welfare policymakers understand the total costs associated with each site program, indirect costs are important to document. Because the state agency was the project lead, the Vermont site had a substantial infrastructure. Because the evaluation team assumed that other interested child welfare agencies would also have the infrastructure in place to run programs, we did not attempt to portion out the infrastructure costs that another agency would likely need. Likewise, we assumed that indirect costs will vary greatly by state due to the cost of living issues influencing real estate prices and wages and thus, more detailed indirect cost calculations would not be useful to other entities. In order to run a similar program in another area, programs would need building space with heating, air, electricity and water; and some administrative support for contracting and financial management.

Summary of Costs

Total implementation costs for Vermont were **$490,296** over the course of the three years.

Cost Calculations

Based on the total costs of $490,296 and 1,470 participants, the cost per survey was $334.

For this evaluation, an effective outcome is a completed survey. There were 809 caregivers that completed a survey. Thus, the cost per positive outcome or cost-efficiency ratio is

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

which results in a cost of $606 per completed survey.

Sensitivity Analysis

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

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

For this sensitivity analysis, costs that are most likely not needed by other agencies have been removed from the cost calculation. Inclusion or exclusion of costs in a sensitivity analysis such as this one is subjective. A decision was made based on the following question: Is this expense critical to the functioning of the intervention? Another agency would want to adjust costs specific to their program needs. Because this intervention was a survey, the gift card line was left in the sensitivity analysis. Although the monetary amount of gift cards may vary, they are fairly standard practice with surveys.

The following exclusions were made for this sensitivity analysis:

1. The salary and fringe for the Site Implementation Manager were removed. At this site, the Site Implementation Manager would not be necessary to implement a survey. This position served as a liaison with external entities and managed internal processes. Internal management could be provided by the agency staff.

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

3. All travel costs were excluded. Travel was primarily to off-site locations for annual and quarterly meetings. Travel is not necessary for a survey conducted online or by mail.

4. Contracted services by Lund were removed because these costs could be absorbed by the agency.

5. All contracting fees and printing related to anticipatory guidance were removed.

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

Based on these exclusions, Table 4.29 details the costs included in the sensitivity analysis. For this analysis, the total cost of the project was $172,862 which amounted to $117 per survey and $214 for each completed survey.

Table 4.29. Sensitivity Analysis: Adjusted Costs for Vermont

	IMPLEMENTATION			TOTAL
	FY 2019	FY 2018	FY 2017	
PERSONNEL EXPENSES				
IN-KIND SALARIES	$14,905.58	$56,365	$39,077	$110,347
NON-PERSONNEL DIRECT EXPENSES				
CONTRACTED SERVICES: UNIV OF VT	$499	$27,811	$1,504	$29,814
PROGRAM SUPPLIES			$1,182	$1,182
GIFT CARD INCENTIVES		$1,405	$5,899	$7,304
POSTAGE		$10,851	$6,649	$17,501
TOTAL	**$15,404**	**$100,233**	**$57,225**	**$172,862**

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

The Vermont QIC-AG site focused on families formed by public, private and intercountry adoption. The intention was to provide universal outreach to these families. Of the 1,470 families identified, 809 caregivers completed the survey resulting in a cost of $334 per survey. However, the cost per completed survey was $606. In order to achieve a 55% response rate, the site spent $606 per survey. However, cutting substantial costs could result in $118 per survey or $214 per completed survey.

Discussion

By surveying a high percentage of families, Vermont was able to understand the needs, risks, and strengths of families post permanency in order to provide timely and relevant services and supports. The system of care was able to identify regional gaps in service, identify the types of services and supports that are most important and most needed for families, and identify potential barriers to those services. The system of care, however, was not able to identify direct predictors of discontinuity. To predict discontinuity, survey responses would need to be linked to families who have and have not experienced discontinuity, and we had no cases of discontinuity. If this survey data is linked to families at a future time point, it will likely be possible to use the survey to identify predictors.

Findings of this study are consistent with previous post adoption literature which indicates that most children and families adjust well after adoption from foster care, while a small proportion of families (i.e., about 5-20%) report unmet needs, child behavior problems, placement instability, and other issues (Rolock, 2015; Rolock & White, 2016; Rolock & White, 2017; White, 2016). These families may benefit from additional outreach and timely, relevant services. The Vermont Permanency Survey itself served as a form of outreach and provided families the opportunity to request a follow-up from post permanency services. Almost 20% of families who completed the survey electronically requested to be contacted by a post permanency provider.

The most needed services and supports in Vermont included post permanency services, mental health services, and childcare services. Respite was the most commonly mentioned post permanency service followed by support groups and trainings. Counseling and therapy, particularly adoption and trauma-informed therapy, were the most needed mental health services. The top two barriers to services and supports were lack of access and provider quality. In terms of access, caregivers mentioned issues related to the location of services (rural area, not local, too far to drive, etc.), services not existing, and transportation. In terms of provider quality, caregivers reported that providers were not adoption competent or trauma-informed across the system of care.

Survey findings also indicated that parents and caregivers were not talking to their children about adoption and guardianship or working to keep their child connected to their birth family. Caregivers may need additional training and support around talking to children about adoption, guardianship and birth families with their child. Providers may want to help families understand why birth families matter and how to help their child maintain connections to their birth family.

Lastly, reliable and valid measures are needed in post permanency research. By looking at the relationship between variables we know are connected to post permanency discontinuity and other wellbeing measures, we were able to identify potential measures that begin to help us understand characteristics of families who may be at risk for discontinuity. The Behavior Problem Index, Belonging and Emotional Security Tool (particularly the Emotional Security subscale), the Caregiver Strain Questionnaire for Foster and Adoptive Families, and the Protective Factors Survey (Nurturing and Attachment and Family Functioning subscales) may be useful to include in future studies on post permanency.

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Appendix

VERMONT CYCLE 3A DATA REPORT: PRIVATE DOMESTIC AND INTERCOUNTRY/INTERNATIONAL ADOPTIONS

July 2018

Learning from Families Formed Through Adoption and Guardianship

Vermont Cycle 3A Data Report: Private Domestic and Intercountry/International Adoptions

Data Collected July-December 2017

National Quality Improvement Center QIC•AG Adoption & Guardianship Support and Preservation
VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES FAMILY SERVICES DIVISION
LUND HOPE•OPPORTUNITY•FAMILY
Spaulding for Children
The University of Texas at Austin Texas Institute for Child & Family Wellbeing Steve Hicks School of Social Work
The UNIVERSITY of VERMONT



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Vermont Private Domestic & International Adoptions Overview

The Vermont Department for Children and Families, Family Services Division has partnered with Lund, Spaulding for Children, the University of Texas at Austin, and the University of Vermont to learn from families formed through adoption and guardianship. For Cycle 3A, the survey was emailed electronically and/or mailed to 129 families throughout the state of Vermont who **opted into** the survey. This report summarizes findings from the 117 participating families (91%). The figure below illustrates the number of families who responded by district. Most of families who responded are from the Burlington district (34%).

Participation by FSD District

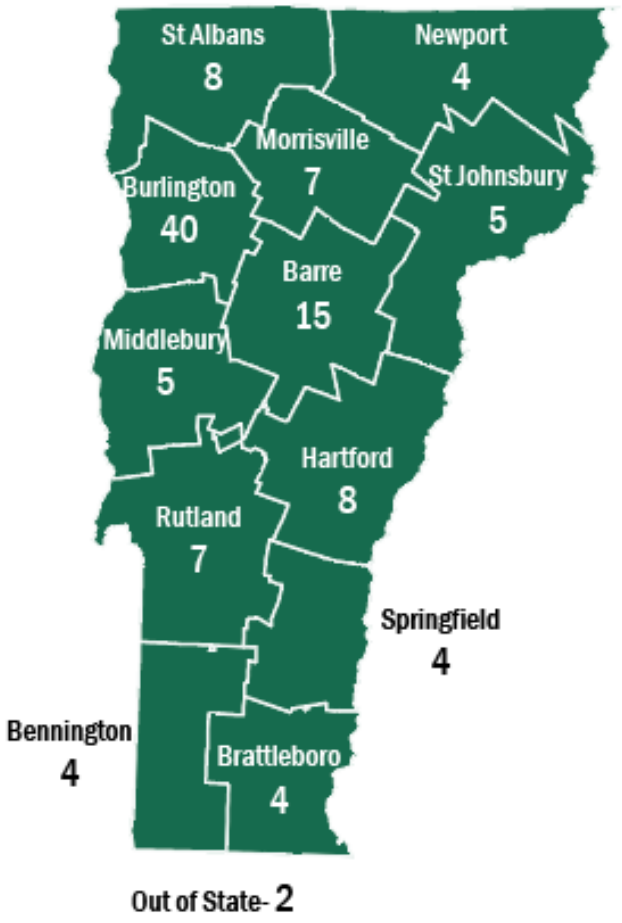


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Family Household Composition

The 117 caregivers who completed the survey represent 117 unique family households. Most households (80.3%) had two adult caregivers living at home. Additionally, 20 households were single parent homes (17.1%) and three households had more than two adult caregivers (2.6%).

Adult Caregivers

How many adult caregivers, including yourself, live in your household?

		Frequency	Percent	Valid %	Cumulative %
Valid	1	20	17.1	17.1	17.1
	2	94	80.3	80.3	97.4
	3+	3	2.6	2.6	100.0
	Total	117	100.0	100.0	

Children <21 Years Old

A total of 184 children under the age of 21 years old were represented by the 117 family households. Most of these children under 21 years old were living at home (170, 92.4%). Caregivers reported having between zero and five children under 21 who were currently living at home.

How many of your children under the age of 21 live in your household?

		Frequency	Percent	Valid %	Cumulative %
Valid	0	21	17.9	17.9	17.9
	1	43	36.8	36.8	54.7
	2	38	32.5	32.5	87.2
	3	10	8.5	8.5	95.7
	4	4	3.4	3.4	99.1
	5	1	0.9	0.9	100.0
	Total	117	100.0	100.0	

How many children under 21 years old do you have? How many of these children live in your household?

		How many of your children under 21 live in your household?							
		0	1	2	3	4	5	6	Total
How Many Children Under the Age of 21 Do You Currently Have?	0	17	0	0	0	0	0	0	17
	1	2	40	0	0	0	0	0	42
	2	2	2	35	1	0	0	0	40
	3	0	1	2	9	0	0	0	12
	4	0	0	1	0	4	0	0	5
	5	0	0	0	0	0	0	0	0
	6	0	0	0	0	0	0	1	1

Children <21 Years Old who were Adopted or are in Legal Guardianship

The following tables represent the number of children within each family that are adopted through a private domestic agency, a private agency that facilitated an intercountry/international adoption, and through a child welfare agency/foster care.

Number of children who were adopted through a private domestic agency

		Frequency	Percent	Valid %	Cumulative %
Valid	0	69	56.4	57.9	57.9
	1	35	29.9	30.7	88.6
	2	13	11.1	11.4	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Number of children who were adopted through a private agency that facilitated an intercountry/international adoption

		Frequency	Percent	Valid %	Cumulative %
Valid	0	73	62.4	63.5	63.5
	1	28	23.9	24.3	87.8
	2	13	11.1	11.3	99.1
	3	0	0.0	0.0	99.1
	4	1	0.9	0.9	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

Number of children who were adopted from a child welfare agency/foster care in Vermont

		Frequency	Percent	Valid %	Cumulative %
Valid	0	98	83.8	86.7	86.7
	1	10	8.5	8.8	95.6
	2	4	3.4	3.5	99.1
	3	1	0.9	0.9	100.0
	Total	113	96.6	100.0	
Missing	No Response	4	3.4		
Total		117	100.0		

Number of children who were adopted from another state's child welfare agency/foster care

		Frequency	Percent	Valid %	Cumulative %
Valid	0	106	90.6	93.0	93.0
	1	7	6.0	6.1	99.1
	2	0	0.0	0.0	99.1
	3	0	0.0	0.0	99.1
	4	1	0.9	0.9	100.0
	Total	113	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

The number of children whose caregivers assumed legal guardianship in each household ranged from zero to three. Most caregivers did not assume legal guardianship of a child (85%).

Number of children who are in legal guardianship

		Frequency	Percent	Valid %	Cumulative %
Valid	0	96	82.1	85.0	85.0
	1	9	7.7	8.0	92.9
	2	6	5.1	5.3	98.2
	3	2	1.7	1.8	100.0
	Total	113	96.6	100.0	
Missing	No Response	4	3.4		
Total		117	100.0		

Relationship to the Identified Child

For families that had adopted or were guardians to more than one child in their home, the caregivers were asked to select one child as the "Identified Child" for the purposes of the survey. Caregivers were asked to think about their "Identified Child" as they answered the survey. This section provides a summary of responses from questions that asked caregivers about their relationship to their child. Please note that in this cycle, several caregivers answered questions about their adult children (over the age of 21).

Are you biologically related to your child, or are you not biologically related to your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Biologically Related	5	4.3	4.3	4.3
	Not Biologically Related	112	95.7	95.7	100.0
	Total	117	100.0	100.0	

*While 5 caregivers reported being biologically related to their child, the biological relationship to another caregiver in the household was not asked. Therefore, there may be additional families who have a biological relationship to their child.

Biologically Related Caregivers

The following two questions were asked to the 48 caregivers who reported being biologically related to their child:

What is your biological relationship to your child?

Are you biologically related to your child through (his/her) birth mother or birth father?

The next two tables summarize caregiver's responses below.

What is your biological relationship to this child? (N=5)

		Frequency	Percent	Valid %	Cumulative %
Valid	Grandparent	1	20.0	25.0	25.0
	Aunt/Uncle	2	40.0	50.0	75.0
	Other Relative	1	20.0	25.0	100.0
	Total	4	80.0	100.0	
Missing	No Response	1	20.0		
Total		5	100.0		

Are you biologically related to your child through (his/her) birth mother or birth father? (N=5)

		Frequency	Percent	Valid %	Cumulative %
Valid	Through Birth Mother	1	20.0	25.0	25.0
	Through Birth Father	3	60.0	75.0	100.0
	Total	4	80.0	100.0	
Missing	No Response	1	20.0		
Total		5	100.0		

Child's Adoption and Guardianship History

Did you have a relationship with your child prior to when he/she was removed from his/her birth parents home?

		Frequency	Percent	Valid %	Cumulative %
Valid	Had Prior Relationship	3	2.6	2.6	2.6
	Did Not Have Prior Relationship	111	94.9	97.4	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Has your child previously been adopted or in legal guardianship?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	5	4.3	4.3	4.3
	No	109	93.2	94.8	99.1
	Don't know	1	0.9	0.9	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

Did you or do you have an agreement to maintain contact with the birth family of your adopted child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	51	43.6	44.0	44.0
	No	64	54.7	55.2	99.1
	Don't Know	1	0.9	0.9	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Child Wellbeing

This section provides an overview about the Identified Child selected within each household. Each caregiver was asked to respond to questions as they relate to this child.

About the Identified Child

What is your child's gender?

		Frequency	Percent	Valid %	Cumulative %
Valid	Male	56	47.9	47.9	47.9
	Female	61	52.1	52.1	100.0
	Total	117	100.0	100.0	

Is your child of Hispanic/Latino origin, or is this child not of Hispanic/Latino origin?

		Frequency	Percent	Valid %	Cumulative %
Valid	Hispanic/Latino Origin	16	13.7	13.8	13.8
	Not of Hispanic/Latino Origin	100	85.5	86.2	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

What is your child's race?

		Frequency	Percent	Valid %	Cumulative %
Valid	Asian	26	22.2	23.0	23.0
	Black/African American	31	26.5	27.4	50.4
	White/Caucasian	42	35.9	37.2	87.6
	Multi-Racial	14	12.0	12.4	100.0
	Total	113	96.6	100.0	
Missing	No Response	4	3.4		
Total		117	100.0		

Does your child consider him or herself to be?

		Frequency	Percent	Valid %	Cumulative %
Valid	Heterosexual or Straight	77	65.8	67.0	67.0
	Gay or Lesbian	2	1.7	1.7	68.7
	Bisexual	1	0.9	0.9	69.6
	I Am Unsure	35	29.9	30.4	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

What is your child's age?

	N	Minimum	Maximum	Mean	Std. Deviation
Age In Years	117	0	34	13.27	7.89

Child's age in years (grouped)

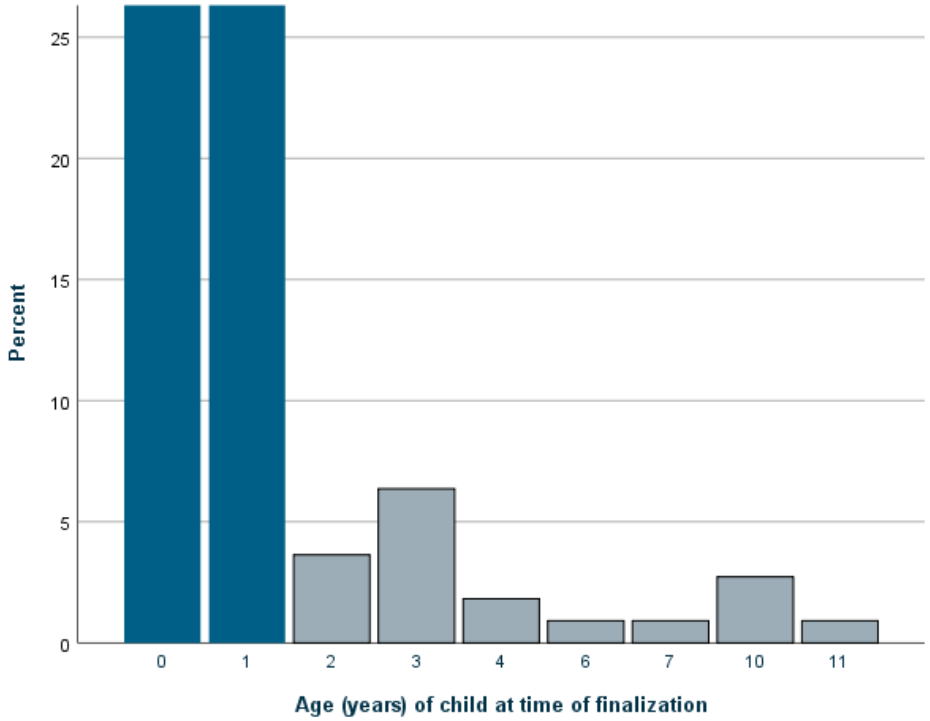
		Frequency	Percent	Valid %	Cumulative %
Valid	0 - 3 Years Old	10	8.5	8.5	8.5
	4 - 7 Years Old	15	12.8	12.8	21.4
	8 - 12 Years Old	29	24.8	24.8	46.2
	13 - 17 Years Old	26	22.2	22.2	68.4
	18 or Older	37	31.6	31.6	100.0
	Total	117	100.0	100.0	

Age at Finalization

How old was your child when you finalized the adoption or guardianship? (Years)

		Frequency	Percent	Valid %	Cumulative %
Valid	0	60	51.3	54.5	54.5
	1	31	26.5	28.2	82.7
	2	4	3.4	3.6	86.4
	3	7	6.0	6.4	92.7
	4	2	1.7	1.8	94.5
	5	0	0.0	0.0	94.5
	6	1	0.9	0.9	95.4
	7	1	0.9	0.9	96.4
	8	0	0.0	0.0	96.4
	9	0	0.0	0.0	96.4
	10	3	2.6	2.7	99.1
	11	1	0.9	0.9	100.0
	Total	100	94.0	100.0	
Missing	No Response	7	6.0		
Total		117	100.0		

Age in years at time of finalization



Child's age in years (grouped) by length of time since finalization

		<2 Years	2-4 Years	5-9 Years	10+ Years	Total
Valid	0 - 3 Years Old	2	7	0	0	9
	4 - 7 Years Old	0	7	7	0	14
	8 - 12 Years Old	0	0	15	12	27
	13 - 17 Years Old	0	1	2	21	24
	18 or Older	0	0	0	36	36
	Total	2	15	24	69	110*

*Seven caregivers did not provide information on the date of their adoption finalization.

Educational Wellbeing

What grade is your child currently in?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Not Started School	13	11.1	11.6	11.6
	Preschool to Pre-K	6	5.1	5.4	17.0
	Kindergarten	3	2.6	2.7	19.6
	Elementary School) (1-5)	28	23.9	25.0	44.6
	Middle School (6-8)	13	11.1	11.6	56.3
	High School (9-12)	22	18.8	19.6	75.9
	In School, No Assigned Grade	0	0.0	0.0	75.9
	Graduated	25	21.4	22.3	98.2
	Dropped Out	0	0.0	0.0	98.2
	Not In School for Other Reason	2	1.7	1.8	100.0
	Total	112	95.7	100.0	
Missing	No Response	5	4.3		
Total		117	100.0		

This section seeks to better understand the educational experiences of the child. A little over half of the children (66, 58.9%) are in school (kindergarten through 12th grade). The following tables summarize the educational wellbeing of these 66 children.

Does your child currently have a 504 plan, or does this child not have a 504 plan? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Has a 504 Plan	10	15.2	15.2	15.2
	Does Not Have a 504 Plan	56	84.8	84.8	100.0
	Total	66	100.0	100.0	

Does your child currently have an Individualized Education Program (IEP)? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Has an IEP	13	19.7	19.7	19.7
	Does Not Have an IEP	53	80.3	80.3	100.0
	Total	66	100.0	100.0	

Does your child have a least one teacher at school who really understands his or her needs? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	49	74.2	75.4	75.4
	No	4	6.1	6.2	81.5
	Don't Know	12	18.2	18.5	100.0
	Total	65	98.5	100.0	
Missing	No Response	1	1.5		
Total		66	100.0		

How would you describe your child's school performance in reading and language arts? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Excellent	29	43.9	43.9	43.9
	Good	20	30.3	30.3	74.2
	Fair	11	16.7	16.7	90.9
	Poor	5	7.6	7.6	98.5
	Very Poor	1	1.5	1.5	100.0
	Total	66	100.0	100.0	

How would you describe your child's school performance in math? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Excellent	20	30.3	30.3	30.3
	Good	29	43.9	43.9	74.2
	Fair	11	16.7	16.7	90.9
	Poor	4	6.1	6.1	97.0
	Very Poor	2	3.0	3.0	100.0
	Total	66	100.0	100.0	

Since starting kindergarten, has your child repeated any grades? (N=66)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes, Has Repeated Grade	2	3.0	3.1	3.1
	No, Has Not Repeated a Grade	63	95.5	96.9	100.0
	Total	65	98.5	100.0	
Missing	No Response/Has Not Started	1	1.5		
Total		66	100.0		

Child participated in the following activities after school or on weekends in the past 6 months

	N	Frequency	Valid %
Academic Tutoring/Support	64	18	28.1
Sports or Athletic Activities	65	55	84.6
Martial Arts	64	7	10.9
Art, Dance, or Music Class	66	44	66.7
Clubs or Organizations	66	36	54.5
Religious Youth Group	66	14	21.2
Religious Instruction/Sunday School	66	26	39.4
Volunteer Work	66	28	42.4
Part-Time Job	65	14	21.5
Unpaid Internship	63	2	3.2

During the past 6 months, the child has:

	N	Frequency	Valid %
Changed Schools for Reasons Other than Grade Promotion	65	6	9.2
Skipped School or Cut Classes Without Your Permission	65	2	3.1
Received an In-School Suspension	65	2	3.1
Received an Out-Of-School Suspension	65	1	1.5
Been Expelled From School	65	0	0.0
Received Any Awards, Certificates, or Made Honor Roll	65	29	44.6
Held a Leadership Position In Any Club or Organization	65	15	23.1

Social and Emotional Wellbeing

Caregivers were asked the following questions ask about their Identified Child's social and emotional wellbeing. Tables summarizing caregiver's responses are presented below.

In general, how easy or hard is it for your child to make friends?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	48	41.0	42.1	42.1
	Somewhat Easy	34	29.1	29.8	71.9
	Somewhat Hard	26	22.2	22.8	94.7
	Very Hard	6	5.1	5.3	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

How much is your child liked by other children?

		Frequency	Percent	Valid %	Cumulative %
Valid	A Great Deal	44	37.6	38.3	38.3
	A Lot	43	36.8	37.4	75.7
	A Moderate Amount	24	20.5	20.9	96.5
	A Little	3	2.6	2.6	99.1
	Not at All	1	0.9	0.9	100.0
	Total	115	98.3	100.0	
Missing	Don't Know/Does Not Apply	2	1.7		
Total		117	100.0		

How much does your child get along with other adults in his/her life?

		Frequency	Percent	Valid %	Cumulative %
Valid	A Great Deal	62	53.0	53.0	53.0
	A Lot	38	32.5	32.5	85.5
	A Moderate Amount	15	12.8	12.8	98.3
	A Little	1	0.9	0.9	99.1
	Not at All	1	0.9	0.9	100.0
	Total	117	100.0	100.0	

Does your child have others outside of your family that are positive influences in his/her life?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	114	97.4	98.3	98.3
	No	2	1.7	1.7	100.0
	Total	116	99.1	100.0	
Missing	Don't Know/No Response	1	0.9		
Total		117	100.0		

Has anyone consistently been in your child's life since birth?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	86	73.5	74.1	74.1
	No	30	25.6	25.9	100.0
	Total	116	99.1	100.0	
Missing	Don't Know/No Response	1	0.9		
Total		117	100.0		

How easy or hard is it for your child to bounce back quickly when things don't go his or her way?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	28	23.9	23.9	23.9
	Somewhat Easy	53	45.3	45.3	69.2
	Somewhat Hard	29	24.8	24.8	94.0
	Very Hard	7	6.0	6.0	100.0
	Total	117	100.0	100.0	

How easy or hard is it for your child to find things he/she likes about himself/herself?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	48	41.0	43.2	43.2
	Somewhat Easy	47	40.2	42.3	85.6
	Somewhat Hard	12	10.3	10.8	96.4
	Very Hard	4	3.4	3.6	100.0
	Total	111	94.9	100.0	
Missing	Don't Know/Does Not Apply	6	5.1		
Total		117	100.0		

How easy or hard is it for your child to stay calm when faced with a challenge?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	14	12.0	12.0	12.0
	Somewhat Easy	41	35.0	35.0	47.0
	Somewhat Hard	50	42.7	42.7	89.7
	Very Hard	12	10.3	10.3	100.0
	Total	117	100.0	100.0	

How easy or hard is it for your child to ask for help?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	38	32.5	32.8	32.8
	Somewhat Easy	43	36.8	37.1	69.8
	Somewhat Hard	25	21.4	21.6	91.4
	Very Hard	10	8.5	8.6	100.0
	Total	116	99.1	100.0	
Missing	Don't Know/Does Not Apply	1	0.9		
Total		117	100.0		

How optimistic is your child about his or her future?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely	24	20.5	25.0	25.0
	Very Optimistic	42	35.9	43.8	68.8
	Moderately Optimistic	20	17.1	20.8	89.6
	Slightly Optimistic	7	6.0	7.3	96.9
	Not at All Optimistic	3	2.6	3.1	100.0
	Total	96	82.1	100.0	
Missing	Don’t Know/No Response	21	17.9		
Total		117	100.0		

How often does your child help others?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	21	17.9	18.4	18.4
	Most of the Time	53	45.3	46.5	64.9
	About Half of the Time	25	21.4	21.9	86.8
	Some of the Time	11	9.4	9.6	96.5
	Never	4	3.4	3.5	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

During the past 6 months, how often did your child show interest and curiosity in learning new things?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	43	36.8	37.1	37.1
	Most of the Time	42	35.9	36.2	73.3
	About Half of the Time	20	17.1	17.2	90.5
	Some of the Time	10	8.5	8.6	99.1
	Never	1	0.9	0.9	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Child Behavior

The Behavior Problem Index (BPI) consists of 28 statements regarding specific behaviors children that ages four or older might exhibit. For each statement, caregivers were asked to rate whether the statement was "not true," "sometimes true," or "often true" for the Identified Child over the past 6 months. An additional item, "has taken things that do not belong to him or her" was included in Vermont. Scores for each item ranged from 0 "not true" to 2 "often true". The items with the means at or above a score of one ("sometimes true") include: "has had difficulty concentrating", "has been impulsive or has acted without thinking" and "has sudden changes in mood or feelings". The table below summarizes the number of participants who answered the question, the minimum and maximum scores reported, the mean score, and the standard deviation for each item (how spread out the score is from the mean). Overall scores are reported on the next page.

Response choices: 0=Not True | 1=Sometimes True | 2=Often True

Descriptive Statistics for Behavior Problem Index Items

In the past 6 months, your child…	N	Min	Max	Mean	Std. Dev
Has had difficulty concentrating	106	0	2	0.89	0.67
Has been impulsive or has acted without thinking	106	0	2	0.85	0.73
Has cheated or told lies	106	0	2	0.52	0.69
Has argued too much	106	0	2	0.77	0.71
Has demanded a lot of attention	106	0	2	0.82	0.75
Has sudden changes in mood or feelings	106	0	2	0.76	0.71
Has been restless or overly active and/or has not been able to sit still	106	0	2	0.55	0.71
Has been stubborn, sullen, or irritable	106	0	2	0.75	0.70
Has had a very strong temper and lost it easily	106	0	2	0.57	0.72
Has been rather high strung, tense, or nervous	106	0	2	0.42	0.69
Has not seemed to feel sorry after (he/she) has misbehaved	106	0	2	0.40	0.64
Has been disobedient at home	106	0	2	0.58	0.62
Has had difficulty getting mind off certain thoughts or had obsessions	106	0	2	0.54	0.69
Has been disobedient at school	106	0	2	0.24	0.49
Has been easily confused or seemed to be in a fog	106	0	2	0.17	0.45
Has been too fearful or anxious	106	0	2	0.40	0.63
Has had trouble getting along with other children	106	0	2	0.26	0.52
Has bullied or has been cruel or mean to others	106	0	2	0.13	0.39
Has been too dependent on others	106	0	2	0.31	0.54
Has had trouble getting along with teachers	106	0	2	0.11	0.35
Has felt worthless or inferior	106	0	2	0.38	0.59
Has been unhappy, sad, or depressed	106	0	2	0.50	0.64
Has been clinging to adults	106	0	2	0.17	0.45
Has broken things on purpose or deliberately destroyed things	106	0	2	0.23	0.46
Is not liked by other children	106	0	2	0.17	0.40
Has felt or complained that no one loves (him/her)	106	0	2	0.25	0.51
Has cried too much	106	0	2	0.12	0.38
Has been withdrawn or has not gotten involved with others	106	0	2	0.25	0.51
Has taken things that do not belong to him or her	106	0	2	0.15	0.41

*All items were scored for children ages four and older only

The total BPI Index score can be calculated by summing each item to produce an overall score. Higher scores indicate that a child may be exhibiting more behavior problems. For children ages four and older, the total score may range from 0 to 56. With the addition item added, scores may range from 0 to 58.

Additionally, the total BPI index score can be further broken down into two subscales: the BPI Internalizing Subscale (11 items, BPI: IS) and the BPI Externalizing Subscale (19 items, BPI: ES; note that three items are included in both subscales and one items is not included in either subscale). Descriptive statistics are reported below for the total BPI index score and two subscales for children ages four and older.

BPI Scores of Children Ages Four and Older

Total BPI score and subscale scores for children ages four and older

	N	Min	Max	Mean	Std. Dev
BPI Total Index Score	106	0	51	12.08	9.77
BPI Total Index Score + 1 Item	106	0	53	12.23	9.99
BPI Internalizing Behavior Subscale Score	106	0	22	4.25	4.01
BPI Externalizing Behavior Subscale Score	106	0	33	8.50	6.93

Another way to look at the data to gain a better understanding of the relationship between BPI total scores and subscales is to compare the mean scores rather than the total scores. The mean scores will all range from 0 ("not true") to 2 ("often true"). The table below reports the minimum mean score, maximum mean score, and average mean score for the BPI scales and subscales.

Mean BPI scores and subscale scores for children ages four and older

	N	Min	Max	Mean	Std. Dev
Mean BPI Index Score	106	0.00	1.82	0.43	0.35
Mean BPI Index Score + 1 Item	106	0.00	1.83	0.42	0.34
Mean BPI Internalizing Behavior Subscale Score	106	0.00	2.00	0.39	0.36
Mean BPI Externalizing Behavior Subscale Score	106	0.00	1.74	0.45	0.36

Additional Behavior Challenges

In the past 6 months, has your child been in trouble with the law or juvenile justice system?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	5	4.3	4.3	4.3
	No	112	95.7	95.7	100.0
	Total	117	100.0	100.0	

In the past 6 months, has your child been involved in a gang?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	2	1.7	1.7	1.7
	No	114	97.4	98.3	100.0
	Total	116	99.1	100.0	
Missing	Don't Know/No Response	1	0.9		
Total		117	100.0		

In the past 6 months, has your child run away for a period of more than seven days?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	2	1.7	1.8	1.8
	No	112	95.7	98.2	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Job Impact

Please think about this child's physical and mental health, behavioral issues, and child care. In the past 6 months, did you or did anyone in your family have to quit a job, refuse a job offer, or change jobs because of any of these issues with this child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes, Had Job Impact	4	3.4	3.4	3.4
	No, Did Not Have Job Impact	113	96.6	96.6	100.0
	Total	117	100.0	100.0	

General Wellbeing

Physical Health

Does this child have a physical health issue that impacts their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has a Physical Health Issue	13	11.1	11.2	11.2
	Has No Physical Health Issue	103	88.0	88.8	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	.9		
Total		117	100.0		

Mental Health

Does this child have a mental health issue that impacts their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has a Mental Health Issue	27	23.1	23.3	23.3
	Has No Mental Health Issue	89	76.1	76.7	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Sibling Conflicts

Does your child have sibling conflicts that impact their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Sibling Conflicts	12	10.3	15.8	15.8
	Has No Sibling Conflicts	64	54.7	84.2	100.0
	Total	76	65.0	100.0	
Missing	No Response	1	0.9		
	No Siblings	40	34.2		
Total		117	100.0		

Challenges with Food

Does your child have food or eating issues that impact their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Food or Eating Issues	16	13.7	13.8	13.8
	Has No Food or Eating Issues	100	85.5	86.2	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Physical Disability

Does your child have a physical disability that impacts their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Physical Disability Issues	5	4.3	4.3	4.3
	Has No Physical Disability Issues	112	95.7	95.7	100.0
	Total	117	100.0	100.0	

Language

Does your child have language issues that impact their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Language Issues	6	5.1	5.3	5.3
	Has No Language Issues	108	92.3	94.7	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Substance Use

Was your child exposed prenatally to alcohol or substance use?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	24	20.5	35.8	35.8
	No	43	36.8	64.2	100.0
	Total	67	57.3	100.0	
Missing	No Response/Don't Know	50	42.7		
Total		117	100.0		

Does your child have alcohol or substance use problems that impact their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Alcohol/Substance Use Issues	3	2.6	2.6	2.6
	No Alcohol/Substance Use Issues	113	96.6	97.4	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Intellectual Disability

Does your child have an intellectual disability that impacts their daily functioning?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has an Intellectual Disability	14	12.0	12.0	12.0
	Has No Intellectual Disability	103	88.0	88.0	100.0
	Total	117	100.0	100.0	

Living Arrangements of the Identified Child

Out of Home Care

Since the adoption or guardianship was finalized, has your child ever lived outside of your home for two weeks or longer because he or she was…?

	N	Frequency	Valid %
Living With a Relative or Family Friend?	116	5	4.3
Receiving Treatment In a Residential Treatment Setting?	116	2	1.7
Receiving Treatment In a Psychiatric Hospital Setting?	115	1	0.9
At Summer Camp or On Extended Vacation?	116	20	17.2
In a Juvenile Justice Setting?	116	1	0.9
At a Boarding School or In College?	117	17	14.5
Homeless or Ran Away From Home?	114	3	2.6
In an Emergency Assessment Bed?	116	2	1.7

Current Living Arrangement

Where is your child currently living?

		Frequency	Percent	Valid %	Cumulative %
Valid	With Me	93	79.5	79.5	79.5
	Boarding School or College	8	6.8	6.8	86.3
	Homeless or Ran Away From Home	1	0.9	0.9	87.2
	Other	15	12.8	12.8	100.0
	Total	117	100.0	100.0	

Caregiver Wellbeing

Caregiver Demographics

The tables below provide an overview of the demographics information of the participating caregivers. Most caregivers were female (92.2%), White (98.2%), and had some college education or higher (98.3%) and married 79.8%). The average age of participating caregivers was 53.1 years old.

What is your gender?

		Frequency	Percent	Valid %	Cumulative %
Valid	Male	8	6.8	7.0	7.0
	Female	106	90.6	92.2	99.1
	Other	1	0.9	0.9	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

Are you of Hispanic/Latino origin, or are you not of Hispanic/Latino origin?

		Frequency	Percent	Valid %	Cumulative %
Valid	Hispanic/Latino Origin	1	0.9	0.9	0.9
	Not of Hispanic/Latino Origin	114	97.4	99.1	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

What is your race?

		Frequency	Percent	Valid %	Cumulative %
Valid	American Indian/Alaska Native	0	0.0	0.0	0.0
	Asian	0	0.0	0.0	0.0
	Black/African American	0	0.0	0.0	0.0
	Native Hawaiian/Pacific Islander	0	0.0	0.0	0.0
	White/Caucasian	112	95.7	98.2	98.2
	Multi-Racial	2	1.7	1.8	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Caregiver's age in years

	N	Minimum	Maximum	Mean	Std. Deviation
Age In Years	114	27	73	53.05	9.85

Caregiver's age in years (grouped)

		Frequency	Percent	Valid %	Cumulative %
Valid	25-34	4	3.4	3.6	3.6
	35-44	17	14.5	15.3	18.9
	45-54	39	33.3	35.1	54.1
	55-64	33	28.2	29.7	83.8
	65+	18	15.4	16.2	100.0
	Total	111	94.9	100.0	
Missing	No Response	6	5.1		
Total		117	100.0		

Caregiver's age (grouped) by child's age

		0-3 Yrs.	4-7 Yrs.	8-12 Yrs.	13-17 Yrs.	18+ Yrs.	Total
*Valid	25 - 34 Years Old	2	1	1	0	0	4
	35 - 44 Years Old	7	5	5	0	0	17
	45 - 54 Years Old	0	8	17	9	5	39
	55 - 64 Years Old	0	0	4	12	17	33
	65+ Years Old	0	0	1	4	13	18
	Total	9	14	28	25	35	111*

*Six cases did not include sufficient information to be included in this analysis.

What is the highest level of education you have completed?

		Frequency	Percent	Valid %	Cumulative %
Valid	Some High School	0	0.0	0.0	0.0
	High School Diploma	2	1.7	1.7	1.7
	GED	0	0.0	0.0	1.7
	Some College	12	10.3	10.4	12.2
	2 or 4-Year College Degree	48	41.0	41.7	53.9
	Master's Degree	40	34.2	34.8	88.7
	Advanced Graduate Work or Ph.D.	13	11.1	11.3	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

What is your current relationship status?

		Frequency	Percent	Valid %	Cumulative %
Valid	Single, Never Married	8	6.8	7.0	7.0
	Living With a Partner	4	3.4	3.5	10.5
	Married	91	77.8	79.8	90.4
	Separated	1	0.9	0.9	91.2
	Divorced	6	5.1	5.3	96.5
	Widowed	4	3.4	3.5	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Do you consider yourself to be?

		Frequency	Percent	Valid %	Cumulative %
Valid	Heterosexual or Straight	104	88.9	92.9	92.9
	Gay or Lesbian	6	5.1	5.4	98.2
	Bisexual	2	1.7	1.8	100.0
	Total	112	95.7	100.0	
Missing	No Response	5	4.3		
Total		117	100.0		

What is your best estimate of your household income for this past year?

		Frequency	Percent	Valid %	Cumulative %
Valid	Under $15,000	5	3.0	3.2	3.2
	$15,001 to $30,000	3	2.6	2.7	2.7
	$30,001 to $45,000	6	5.1	5.4	8.0
	$45,001 to $60,000	24	20.5	21.4	29.5
	$60,001 to $75,000	8	6.8	7.1	36.6
	$75,001 to $90,000	9	7.7	8.0	44.6
	$90,001 to $105,00	16	13.7	14.3	58.9
	$105,001 to $120,00	23	19.7	20.5	79.5
	Over $120,000	23	19.7	20.5	100.0
	Total	112	95.7	100.0	
Missing	No Response	5	4.3		
Total		117	100.0		

Caregiver Resilience

The Brief Resilience Scale (BRS) consists of 6 items, measured on a scale of 1 through 5, where 1 = strongly disagree and 5 = strongly agree. The scale is designed to measure how easily caregivers cope and respond to stressful events in their lives. The first table displays the min score, max score, average score, and standard deviation for each item. The second table display the mean scale score for this measure. To get the mean scale score, items two, four and six were reverse scored and summed with scores from items one, three and five. The sum score was then divided by six. For the mean scale score, higher responses indicate higher levels of resilience.

Descriptive Statistics for the Brief Resilience Scale items

	N	Min	Max	Mean	Std Dev
I tend to bounce back quickly after hard times.	116	1	5	4.01	0.92
I have a hard time making it through stressful events.*	116	1	5	2.26	0.97
It does not take me long to recover from a stressful event.	116	1	5	3.66	0.94
It is hard for me to snap back when something bad happens.*	115	1	5	2.15	0.96
I usually come through difficult times with little trouble.	116	2	5	3.69	0.91
I tend to take a long time to get over setbacks in my life.*	115	1	5	2.10	0.94

*These items are reverse scored when calculating the mean scale score

Brief Resilience Questionnaire Mean Score

	N	Minimum	Maximum	Mean	Std. Dev
Brief Resilience Questionnaire Mean Score	116	1.67	5.00	3.81	0.69

Caregiver Strain

The Caregiver Strain Questionnaire- Foster Care/Adoption Adaptation (CGSQ-FA) consists of 22 items designed to measure how much objective and subjective strain caregivers are experiencing as a result of parenting a child in foster care, who has been adopted, or is in legal guardianship. Caregivers rated each statement on a scale of 1 through 5, with 1 = not at all and 5 = a great deal. The first ten items measure objective strain and ask, "During the past 6 months, as a result of parenting your child who was adopted or in legal guardianship, how much was each of the following a problem for you (caregiver)?" The remaining items measure a caregiver's subjective strain and asked caregivers to think how they have felt over the past 6 months as a result of parenting their child. Three items highlighted in gray are reverse coded prior to calculating the overall scale scores.

Descriptive statistics for the CGSQ-FA Objective Strain items

	N	Min	Max	Mean	Std Dev
Interruption of personal time?	116	1	5	2.23	1.15
Missing obligations related to your job or similar responsibilities?	116	1	4	1.53	0.73
Disruption of family routines?	116	1	4	1.54	0.76
Financial strain for your family?	116	1	5	1.62	0.94
Less attention paid to other family members?	115	1	5	1.74	0.93
Disruption or upset relationships within in the family?	115	1	5	1.56	0.86
Disruption of your family's social activities?	116	1	5	1.43	0.77
Disruption of friendships or significant relationships within the community?	116	1	4	1.34	0.70
Poor self-care?	116	1	5	1.43	0.87
Increase in your alcohol consumption or substance use?	116	1	4	1.16	0.55

Descriptive statistics for the CGSQ-FA Subjective Strain items

	N	Min	Max	Mean	Std Dev
How isolated have you felt?	116	1	5	1.58	0.92
How sad or unhappy have you felt?	116	1	5	1.61	0.89
How angry or frustrated have you felt?	115	1	5	1.78	0.89
How worried have you felt about your child's future?	116	1	5	2.39	1.18
How worried have you felt about your family's future?	116	1	5	1.61	0.91
How resentful have you felt?	115	1	5	1.29	0.72
How overwhelmed have you felt?	116	1	5	1.85	0.95
How hopeful have you felt?*	116	1	5	3.82	1.07
How proud have you felt?*	116	1	5	4.19	1.06
How supported have you felt?*	116	1	5	3.57	1.16
How misunderstood have you felt?	116	1	5	1.69	0.94
How judged or criticized have you felt?	116	1	5	1.74	0.96

*These items are reverse scored when calculating the mean scale score

CGSQ-FA mean scale and subscale scores

	N	Min	Max	Mean	Std Dev
Mean Caregiver Strain Score	116	1	3.77	1.94	0.45
Mean Objective Caregiver Strain Score	116	1	3.70	1.56	0.58
Mean Subjective Caregiver Strain Score	116	1	4.17	2.26	0.43

Caregiver Adverse Childhood Experiences

The Adverse Childhood Experiences instrument used in Vermont contains 11 statements, where each item represents an adverse childhood experience that the caregiver may or may not have endured. for a caregiver's total ACE score, each item was dichotomized to a "yes/no" response, and each caregiver's "yes" responses were added together to get their individual ACE score. The average was then calculated for the sample. The items, total ACE scores and grouped scores are shown below.

ACE Items

Before the age of 18...	N	Frequency	Valid %
Did you live with anyone who was depressed, mentally ill, or suicidal?	114	28	24.6
Did you live with anyone who was a problem drinker or alcoholic, used illegal street drugs or who abused prescription medications?	112	31	27.7
Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	116	1	0.9
Were your parents separated or divorced?	116	17	14.7
Did you live with a parent or guardian who died?	116	5	4.3
Did anyone at least 5 years older than you or an adult ever touch you sexually or try to make you touch them sexually?	114	22	19.3
Did anyone at least 5 years older than you force you to have sex?	115	3	2.6
How often did your parents, guardians or adults in your home ever slap, hit, kick, punch, or beat each other up? (more than once)	114	13	11.4
How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? (more than once)	113	35	31.0
How often did a parent or adult in your home ever swear at you, insult you, or put you down? (more than once)	115	39	33.9
How often were your basic needs unmet (food, shelter, clothing)? (more than once)	115	7	6.1

Total ACE score

	N	Minimum	Maximum	Mean	Std. Dev
Total ACE Score	115	0	7	1.75	1.84

Total ACE score grouped

		Frequency	Percent	Valid %	Cumulative %
Valid	0	38	32.5	33.0	33.0
	1	25	21.4	21.7	54.8
	2	20	17.1	17.4	72.2
	3	12	10.3	10.4	82.6
	4+	20	17.1	17.4	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

Caregiver Support

In the past 6 months, how often have you felt you could turn to a friend or family member for support?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	61	52.1	53.0	53.0
	Most of the Time	35	29.9	30.4	83.5
	About Half the Time	3	2.6	2.6	86.1
	Sometimes	12	10.3	10.4	96.5
	Never	4	3.4	3.5	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

In the past 6 months, has the support you received from others increased, stayed about the same, or decreased?

		Frequency	Percent	Valid %	Cumulative %
Valid	Support Increased	10	8.5	8.6	8.6
	Support Stayed the Same	100	85.5	86.2	94.8
	Support Decreased	6	5.1	5.2	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

In the past 6 months, how easy or hard has it been to get child care when needed?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	28	23.9	39.4	39.4
	Somewhat Easy	23	19.7	32.4	71.8
	Somewhat Hard	16	13.7	22.5	94.4
	Very Hard	4	3.4	5.6	100.0
	Total	71	60.7	100.0	
Missing	Have Not Needed	44	37.6		
	No Response	2	1.7		
Total		117	100.0		

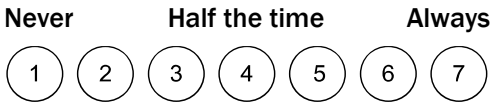
In the past 6 months, how easy or hard has it been to get respite when needed?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Easy	12	10.3	23.5	23.5
	Somewhat Easy	17	14.5	33.3	56.9
	Somewhat Hard	16	13.7	31.4	88.2
	Very Hard	6	5.1	11.8	100.0
	Total	51	43.6	100.0	
Missing	Have Not Needed	64	54.7		
	No Response	2	1.7		
Total		117	100.0		

Family Wellbeing

Protective Factors Survey

This Protective Factor Survey (PFS) is traditionally used with caregivers receiving child abuse prevention and family support services such as parent education and home visiting. It can be used once to obtain a snap-shot of how families are doing but is often used as a pre-post survey to measure changes in protective factors that may occur because of a family participating in an intervention. There are five protective factors: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. The Family Functioning/Resiliency Subscale and the Nurturing and Attachment Subscale were included along with individual items used to measure knowledge on parenting and child development. For the two subscales, caregivers were asked to indicate on a scale of 1 to 7 how often a statement was true for their family (1=never to 7 = always). Higher scores on the Family Functioning/Resilience Subscale indicate more open communication within the family and a greater ability to persevere or manage problems in times of crisis. On the Nurturing and Attachment Subscale, higher scores indicate a higher level of emotional bonding and positive interaction between the parent and child. The mean scale scores of these two subscales are reported below.



Protective Factors Survey Results: Family Functioning + Nurturing and Attachment Subscales

	Valid N	Min	Max	Std. Dev	Mean Score
Mean Family Functioning Score	116	4.0	7.0	0.80	5.88★
Mean Nurturing Attachment Score	117	2.0	7.0	0.88	5.93★

There are five items in the PFS that ask about the caregiver's knowledge of parenting and child development. Three of these items ask caregivers to indicate how much they agree with each statement on a scale from 1 to 7 (1=strongly disagree to 7=strongly agree). The means of these items are listed in the table below.

PFS: Knowledge of Parenting and Child Development Items (1=Strongly Disagree to 7=Strongly Agree)

	Valid N	Min	Max	Mean	Std. Dev
There are many times when I don't know what to do as a parent.	117	1	7	3.15	1.65
This child misbehaves just to upset me.	116	1	7	2.46	1.65
I know how to help this child learn.	117	1	7	6.05	1.01

PFS: Knowledge of Parenting and Child Development Items (1=Never true to 7=Always true)

	Valid N	Min	Max	Mean	Std. Dev
I praise this child when he/she behaves well.	116	4	7	6.17	0.75
When I discipline this child, I lose control.	117	1	5	2.10	0.87

Belonging and Emotional Support Tool (BEST)

The BEST was originally designed for youth who are unable to reunify with their family of origin and do not yet have a legal family relationship; however, in this study it is used to measure a sense of emotional security within the family and the level of belonging, or commitment of the caregiver post permanency. Examples of statements include: *My child belongs to our family. (1=Strongly Disagree…to 5=Strongly Agree). The* BEST has 20 items. In Vermont, an additional item was added.

Descriptive Statistics for BEST items

	Valid N	Min	Max	Mean	Std. Dev
My child belongs to our family.	117	2	5	4.92	0.42
When something important happens to my child, I want to talk with him/her about it.	117	4	5	4.94	0.24
I care deeply about what happens to my child.	117	4	5	4.97	0.16
It makes me feel happy when we spend time together.	117	2	5	4.79	0.48
I let my child know he/she is wanted.	117	3	5	4.88	0.35
I expect to exchange holiday cards or gifts with my child just like	117	3	5	4.95	0.29
I feel close to my child.	117	2	5	4.83	0.48
I love my child.	117	4	5	4.99	0.09
I trust my child.	117	1	5	4.56	0.86
I would give my child money if he/she ever needed it.	117	3	5	4.68	0.60
I include my child in family photos and portraits.	117	1	5	4.96	0.38
I pay attention to my child when she/he asks for help.	117	4	5	4.94	0.24
My child cares deeply about what happens to me.	117	1	5	4.74	0.70
I include my child in family vacations.	117	1	5	4.89	0.55
My child loves me.	117	1	5	4.85	0.55
I let my child know he/she will be in our family for life.	117	3	5	4.97	0.23
I let my child know he/she will always be able to count on my help.	117	1	5	4.91	0.49
I will do everything to keep my relationship going when my child is no longer living at home.	117	2	5	4.91	0.41
I find a way to stand behind my child even when he/she is wrong.	117	1	5	4.54	0.76
I have done everything I can to make my child feel he/she belongs to our family.	117	3	5	4.92	0.30
I am committed to my child for life, no matter what*	117	2	5	4.93	0.39

*Item was added to original scale

Additional Commitment Item:

I am committed to my child for life, no matter what.

		Frequency	Percent	Valid %	Cumulative %
Valid	Strongly Disagree	0	0.0	0.0	0.0
	Disagree	1	0.9	0.9	0.9
	Neutral	2	1.7	1.7	2.6
	Agree	1	0.9	0.9	3.4
	Strongly Agree	113	96.6	96.6	100.0
	Total	117	100.0	100.0	

The BEST includes two subscales, the Emotional Security Subscale (13 items) and the Commitment Subscale (7 items). Emotional security, or the shared sense of family belonging plays an important role in legal permanence. This cumulative scoring of this subscale ranges from 13 to 65. The commitment subscale looks at the degree to which the caregiver is claiming the child either emotionally or legally. This cumulative scoring on this subscale ranges from 7 to 35. Cumulative scoring for the BEST ranges from a low of 20 to a high of 100 (21 to 105 with additional item). A higher cumulative score is protective and indicates a higher level of commitment and emotional security. Total scores for the overall instrument and two subscales are displayed in the table below.

BEST scale and subscale scores

	Valid N	Min	Max	Mean	Std. Dev
Total BEST Score	117	63	100	97.01	5.90
Total BEST Score + 1 Item	117	67	105	101.94	6.15
Total BEST Emotional Security Subscale	117	38	65	62.72	4.47
Total BEST Commitment Subscale Score	117	25	35	34.29	1.66

Additional Parent Child Relationship Items

Three additional items were asked to better understand relationship between the Caregiver and the Identified Child. A summary of responses from each item are reported below.

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

		Frequency	Percent	Valid %	Cumulative %
Valid	Everyday	1	0.9	0.9	0.9
	A Few Times a Week	11	9.4	9.6	10.4
	Once a Week	20	17.1	17.4	27.8
	Less than Once a Week	53	45.3	46.1	73.9
	Never	30	25.6	26.1	100.0
	Total	115	98.3	100.0	
Missing	No Response	2	1.7		
Total		117	100.0		

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

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Confident	50	42.7	42.7	42.7
	Very Confident	42	35.9	35.9	78.6
	Somewhat Confident	21	17.9	17.9	96.6
	Slightly Confident	2	1.7	1.7	98.3
	Not at All Confident	2	1.7	1.7	100.0
	Total	117	100.0	100.0	

How would you describe your relationship to this child over the past 6 months?

		Frequency	Percent	Valid %	Cumulative %
Valid	Has Gotten Better	58	49.6	49.6	49.6
	About the Same	59	50.4	50.4	100.0
	Has Gotten Worse	0	0.0	0.0	100.0
	Total	117	100.0	100.0	

Adoption and Guardianship

Impact

Caregivers were also asked to consider the impact of parenting the Identified Child on their family. A summary of responses from each item are reported below.

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

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Positive	91	77.8	78.4	78.4
	Moderately Positive	17	14.5	14.7	93.1
	Slightly Positive	5	4.3	4.3	97.4
	Neither Positive nor Negative	1	0.9	0.9	98.3
	Slightly Negative	1	0.9	0.9	99.1
	Moderately Negative	1	0.9	0.9	100.0
	Extremely Negative	0	0.0	0.0	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Overall, how do you think your spouse, partner, or other adult caring for your child would rate the impact of your child's adoption/guardianship on your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Positive	77	65.8	72.0	72.0
	Moderately Positive	18	15.4	16.8	88.8
	Slightly Positive	5	4.3	4.7	93.5
	Neither Positive nor Negative	2	1.7	1.9	95.3
	Slightly Negative	2	1.7	1.9	97.2
	Moderately Negative	3	2.6	2.8	100.0
	Extremely Negative	0	0.0	0.0	100.0
	Total	107	91.5	100.0	
Missing	No Response	1	0.9		
	Not Applicable	9	7.7		
Total		117	100.0		

Overall, would you say the impact of your child's adoption/guardianship on your relationship with your partner, spouse, or other adult caring for this child has been…?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Positive	58	49.6	55.8	55.8
	Moderately Positive	19	16.2	18.3	74.0
	Slightly Positive	3	2.6	2.9	76.9
	Neither Positive nor Negative	14	12.0	13.5	90.4
	Slightly Negative	7	6.0	6.7	97.1
	Moderately Negative	2	1.7	1.9	99.0
	Extremely Negative	1	0.9	1.0	100.0
	Total	104	88.9	100.0	
Missing	No Response	2	1.7		
	Not Applicable	11	9.4		
Total		117	100.0		

Overall, would you say the impact of your child's adoption/guardianship on your other children has been…?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Positive	37	31.6	48.7	48.7
	Moderately Positive	21	17.9	27.6	76.3
	Slightly Positive	9	7.7	11.8	88.2
	Neither Positive nor Negative	2	1.7	2.6	90.8
	Slightly Negative	4	3.4	5.3	96.1
	Moderately Negative	3	2.6	3.9	100.0
	Extremely Negative	0	0.0	0.0	100.0
	Total	76	65.0	100.0	100.0
Missing	No Response	1	0.9		
	Not Applicable	40	34.2		
Total		117	100.0		

Conversations about Adoption and Guardianship

In the past 6 months, how often did you bring up adoption or guardianship with your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	3	2.6	2.6	2.6
	Weekly	13	11.1	11.2	13.8
	Monthly	36	30.8	31.0	44.8
	Less than Monthly	50	42.7	43.1	87.9
	Never	11	9.4	9.5	97.4
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

In the past 6 months, how often did your child bring up adoption or guardianship in conversation?

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	0	0.0	0.0	0.0
	Weekly	14	12.0	13.5	13.5
	Monthly	15	12.8	14.4	27.9
	Less than Monthly	52	44.4	50.0	77.9
	Never	23	19.7	22.1	100.0
	Total	104	88.9	100.0	
Missing	No Response/Not Applicable	13	10.1		
Total		117	100.0		

Relationship between Caregiver and Child's Frequency of Discussion of Adoption or Guardianship

		Caregiver's Frequency of Discussion of Adoption or Guardianship					
		Daily	Weekly	Monthly	< Monthly	Never	Total
Child's Frequency of Discussion of Adoption or Guardianship	Daily	0	0	0	0	0	0
	Weekly	1	7	4	1	0	13
	Monthly	0	1	12	2	0	15
	Less than Monthly	0	0	9	40	3	52
	Never	0	3	7	5	8	23
	Total	1	11	32	48	11	103*

*Fourteen cases did not include sufficient information to be included in this analysis.

Level of comfort answering child's questions about his/her birth parents' history?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Comfortable	83	70.9	74.1	74.1
	Somewhat Comfortable	24	20.5	21.4	95.5
	Somewhat Uncomfortable	4	3.4	3.6	99.1
	Very Uncomfortable	1	0.9	0.9	100.0
	Total	112	95.7	100.0	
Missing	No Response/Not Applicable	5	4.3		
Total		117	100.0		

Birth Family Contact

Several items were asked to better understand the relationship a child may or may not have with his or birth parents and birth siblings.

Contact with Birth Mother

Is contact with your child's birth mother possible?

		Frequency	Percent	Valid %	Cumulative %
Valid	Contact Is Possible	72	61.5	62.0	62.0
	Contact Is Not Possible	44	37.6	37.9	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.00		

In general, how important is it to you that your child has contact with his or her birth mother? (N=72)

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Important	12	10.3	16.7	16.7
	Very Important	18	15.4	25.0	41.7
	Moderately Important	6	5.1	8.3	50.0
	Slightly Important	17	14.5	23.6	73.6
	Not at All Important	19	16.2	26.4	100.0
	Total	72	61.5	100.0	

In the past 6 months, how often has your child had contact with his or her birth mother? (N=72)

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	2	2.8	3.0	3.0
	Weekly	2	2.8	3.0	6.0
	Monthly	3	4.2	4.5	10.5
	Less than Monthly	13	18.1	19.7	30.2
	Never	46	63.9	69.8	100.0
	Total	66	91.7	100.0	
Missing	No Response	6	8.3		
Total		72	100.0		

In the past 6 months, what type of contact has your Identified Child had with his/her birth mother?

	Valid N	Frequency	Percent
In Person/Visitation	20	9	45.0
Phone/Skype/FaceTime	20	5	25.0
Mail/Email	20	8	40.0
Social Media	20	6	30.0
Other Contact	20	1	5.0

In the past 6 months, how has your child's contact with his/her birth mother impacted your family (N=20)

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Positive Impact	8	40.0	42.1	42.1
	Slightly Positive Impact	3	15.0	15.8	57.9
	Neither Positive nor Negative	6	30.0	31.6	89.5
	Slightly Negative Impact	0	0.0	0.0	89.5
	Very Negative Impact	2	10.0	10.5	100.0
	Total	19	95.0	100.0	
Missing	No Response	1	5.0		
Total		20	100.0		

Contact with Birth Father

Is contact with your child's birth father possible?

		Frequency	Percent	Valid %	Cumulative %
Valid	Contact Is Possible	51	43.5	43.9	43.9
	Contact Is Not Possible	65	55.6	56.0	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.00		

In general, how important is it to you that your child has contact with his or her birth father? (N=51)

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Important	5	9.8	9.8	9.8
	Very Important	11	21.6	21.6	31.4
	Moderately Important	6	11.8	11.8	43.1
	Slightly Important	8	15.7	15.7	58.8
	Not at All Important	21	41.2	41.2	100.0
	Total	51	100.0	100.0	

In the past 6 months, how often has your child had contact with his or her birth father? (N=51)

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	0	0.0	0.0	0.0
	Weekly	2	3.9	4.7	4.7
	Monthly	3	5.9	7.0	11.6
	Less than Monthly	4	7.8	9.3	20.9
	Never	34	66.7	79.1	100.0
	Total	43	84.3	100.0	
Missing	No Response/Not Applicable	8	15.7		
Total		51	100.0		

In the past 6 months, what type of contact has your child had with his/her birth father? (N=9)

	Valid N	Frequency	Percent
In Person/Visitation	9	6	66.7
Phone/Skype/FaceTime	9	4	44.4
Mail/Email	9	5	55.6
Social Media	9	0	0.0
Other Contact	9	1	11.1

In the past 6 months, how has your child's contact with his/her birth father impacted your family (N=9)

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Positive Impact	4	44.4	44.4	44.4
	Slightly Positive Impact	3	33.3	33.3	77.8
	Neither Positive nor Negative	1	11.1	11.1	88.9
	Slightly Negative Impact	1	11.1	11.1	100.0
	Very Negative Impact	0	0.0	0.0	100.0
	Total	9	100.0	100.0	

Contact with Birth Siblings

Caregivers indicated that their child had anywhere from 0 to 10 birth siblings. On average, a child had two birth siblings (Mean= 1.95; SD=2.10).

Does your child have any birth siblings? (N=117)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	61	52.1	52.1	52.1
	No	27	23.1	23.1	75.2
	Unknown	29	24.8	24.8	100.0
	Total	117	100.0	100.0	

*A total of 137 out of 166 caregivers (83.0%) indicated that their child had at least one birth sibling living outside of their home.

Do any of your child's birth siblings live outside of your home? (N=61)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	57	93.4	96.6	96.6
	No	2	3.3	3.4	100.0
	Total	59	96.7	100.0	
Missing	No Response	2	3.3		
Total		61	100.0		

In general, how important is it to you that your child has contact with his or her birth siblings living outside of your home? (N=57)

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Important	13	22.8	26.0	26.0
	Very Important	13	22.8	26.0	52.0
	Moderately Important	7	12.3	14.0	66.0
	Slightly Important	13	22.8	26.0	92.0
	Not at All Important	4	7.0	8.0	100.0
	Total	50	87.7	100.0	
Missing	No Response	7	12.3		
Total		57	100.0		

In the past 6 months, how often has your child had contact with his or her birth sibling living outside of your home? Please refer to the birth sibling living outside of your home with has the most contact with the identified child. (N=57)

		Frequency	Percent	Valid %	Cumulative %
Valid	Daily	1	1.8	2.1	2.1
	Weekly	7	12.3	14.9	17.0
	Monthly	6	10.5	12.8	29.8
	Less than Monthly	6	10.5	12.8	42.6
	Never	27	47.4	57.4	100.0
	Total	47	82.5	100.0	
Missing	No Response	10	17.5		
Total		57	100.0		

In the past 6 months, what type of contact has your child had with his/her birth siblings? Please refer to the birth sibling living outside of your home with has the most contact with your child. (N=20)

	Valid N	Frequency	Percent
In Person/Visitation	20	11	55.5
Phone/Skype/FaceTime	20	7	35.0
Mail/Email	20	4	20.0
Social Media	20	8	40.0
Other Contact	20	1	5.0

In the past 6 months, how has your child's contact with his/her birth siblings impacted your family (N=20)

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Positive Impact	10	50.0	50.0	50.0
	Slightly Positive Impact	3	15.0	15.0	65.0
	Neither Positive nor Negative	5	25.0	25.0	90.0
	Slightly Negative Impact	1	5.0	5.0	95.0
	Very Negative Impact	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

Adoption and Guardianship Experiences

How often do you think of ending the adoption or guardianship? Would you say…?

		Frequency	Percent	Valid %	Cumulative %
Valid	Never	111	94.9	95.7	95.7
	Rarely	5	4.3	4.3	100.0
	Sometimes	0	0.0	0.0	100.0
	Usually	0	0.0	0.0	100.0
	Always	0	0.0	0.0	100.0
	Total	116	98.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Have you or your spouse/partner ever taken any of the following actions to end this adoption or guardianship?

	Valid N	Frequency 'Yes'	Percent
Spoke With a Caseworker, Adoption Agency Worker or Social Service Agency Worker About It	5	0	0.0
Spoke With an Attorney About It	5	0	0.0
Spoke With a Close Friend or Family Member About It	5	1	20.0
Spoke With Clergy or Religious Leader About It	5	0	0.0
Reached Out Online or Via Social Media	5	0	0.0
Spoke With Others	5	0	0.0

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

		Frequency	Percent	Valid %	Cumulative %
Valid	Definitely Would Have	108	92.3	93.1	93.1
	Probably Would Have	0	0.0	0.0	93.1
	Might or Might Not Have	5	4.3	4.3	97.4
	Probably Would Not Have	2	1.7	1.7	99.1
	Definitely Would Not Have	1	0.9	0.9	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Overall, how would you describe your adoption or guardianship experience?

		Frequency	Percent	Valid %	Cumulative %
Valid	Easier than I Anticipated	35	29.9	30.7	30.7
	What I Anticipated	42	35.9	36.8	67.5
	Harder than I Anticipated	37	31.6	32.5	100.0
	Total	114	97.4	100.0	
Missing	No Response	3	2.6		
Total		117	100.0		

Given your experience of adoption or guardianship with this child, how likely would you be to recommend adoption or guardianship to others?

		Frequency	Percent	Valid %	Cumulative %
Valid	Definitely Would Have	93	79.5	80.2	80.2
	Probably Would Have	11	9.4	9.5	89.7
	Might or Might Not Have	8	6.8	6.9	96.6
	Probably Would Not Have	2	1.7	1.7	98.3
	Definitely Would Not Have	2	1.7	1.7	100.0
	Total	116	99.1	100.0	
Missing	No Response	1	0.9		
Total		117	100.0		

Service Use

Pre-Permanency Services

Caregivers were asked about their family's participation in eight different pre-permanency services. If a family had participated in service, the caregiver was asked to rate how helpful each service was from 1=Not helpful to 3=Very helpful.

Did your family use the following pre-permanency services?

	Don't know about		No		Yes	
	N	Valid %	N	Valid %	N	Valid %
Pre-Placement Social Work Services	19	16.4	28	24.1	69	59.5
Post-Placement Supervision Services	16	32.5	38	33.3	60	52.6
Pre-Placement Training	22	19.6	42	37.5	48	42.9
Vermont Adoption Consortium Training/Conference	30	26.1	46	40.0	39	33.9
Adoption Learning Partnership Online Training	41	36.0	61	53.5	12	10.5
VFAFA Training/Conferences	33	28.9	57	50.0	24	21.1
Vermont Kin As Parents	35	30.7	77	67.5	2	1.8
Transracial Cross-Cultural Training	24	20.7	53	45.7	39	33.6

How helpful is this service?

	Not helpful		Somewhat		Very helpful	
	N	Valid	N	Valid %	N	Valid %
Pre-Placement Social Work Services	3	4.3	25	36.2	41	59.4
Post-Placement Supervision Services	7	11.7	22	36.7	31	51.7
Pre-Placement Training	2	4.2	25	52.1	21	43.8
Vermont Adoption Consortium Training/Conference	0	0.0	13	33.3	26	66.7
Adoption Learning Partnership Online Training	1	8.3	7	58.3	4	33.3
VFAFA Training/Conferences	3	12.5	9	37.5	12	50.0
Vermont Kin As Parents	0	0.0	0	0.0	2	100.0
Transracial Cross-Cultural Training	4	10.3	14	35.9	21	53.8

Overall, how prepared did you feel to meet the needs of your child at the time of finalization?

		Frequency	Percent	Valid %	Cumulative %
Valid	Extremely Prepared	61	36.7	38.1	38.1
	Very Prepared	52	31.3	32.5	70.6
	Somewhat Prepared	36	21.7	22.5	93.1
	A Little Prepared	6	3.6	3.8	96.9
	Not at All Prepared	5	3.0	3.1	100.0
	Total	160	96.3	100.0	
Missing	No Response	6	3.6		
Total		166	100.0		

Overall, how would you rate the Vermont Department for Children and Families (DCF) in preparing you to meet the needs of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Very Good	52	31.3	31.3	31.3
	Good	48	28.9	28.9	60.2
	Fair	42	25.3	25.3	85.5
	Poor	15	9.0	9.0	94.6
	Very Poor	9	5.4	5.4	100.0
	Total	166	100.0	100.0	

Post Permanency Services

Service use is reported for families over the past six months in the tables below. Services highlighted in gray represent services where at least 20% of families indicated they had used on the past 6 months.

Family support services used in past 6 months

	N	Frequency	Valid %
Family Counseling through Community Mental Health	117	4	3.4
Intensive Family Based Services	117	1	0.9
Case Management Service Coordination	117	7	6.0
DCF Social Work Services	117	1	0.9
Family Safety Planning	117	2	1.7
Agency Support Services	117	5	4.3
LGBTQ Support Services	117	1	0.9
Online Support/Blogs	117	11	9.4
Family Counseling through a Private Provider	117	12	10.3

School/Child care services for child used in past 6 months

	N	Frequency	Valid %
Regular Child Care Services	117	10	8.5
Afterschool Program	117	19	16.2
Mentoring	117	2	1.7
Behavior Support Services	117	7	6.0
School-Based Clinician	117	13	11.1
Alternative School	117	5	4.3

Medical services for child used in past 6 months

	Valid N	Frequency	Percent
Routing Medical Care	117	94	80.3
Medication Management	117	14	12.0
Services for Children Who Are Blind or Visually Impaired	117	0	0.0
Services for Children Who Are Deaf or Hard of Hearing	117	1	0.9
Speech or Occupational Therapy	117	8	6.8
Developmental Disability Case Management Services	117	7	6.0
Physical Disability Services	117	1	0.9
Other Developmental Disabilities Services (Including Personal Care	117	4	3.4

Mental health services for child used in past 6 months

	N	Frequency	Valid %
Psychological Assessment	117	7	6.0
Individual Counseling or Therapy through Community Mental Health	117	23	19.7
Group Counseling	117	1	0.9
Psychiatric Medication	117	9	7.7
Coordinated Service Plan/ACT 264	117	1	0.9
Care Coordination/Case Management	117	5	4.3
Individual Counseling through a Private Provider	117	12	10.3
Substance Abuse Treatment	117	0	0.0

Mental health services for caregiver used in past 6 months

	N	Frequency	Valid %
Individual Counseling or Therapy through Community Mental Health	117	7	6.0
Group Counseling	117	0	0.0
Psychiatric Medication	117	1	0.9
Substance Abuse Treatment	117	0	0.0
Individual Counseling or Therapy through Private Provider	117	10	8.5

Post permanency services used in past 6 months

	N	Frequency	Valid %
Post Permanency Services	117	7	6.0
Vermont Adoption Consortium (VAC) Resource Library	117	1	0.9
Vermont Adoption Registry	117	3	2.6
Post Permanency Newsletter	117	3	2.6
Parent Support Group	117	5	4.3
Post Permanency Trainings for Adoptive Parents & Guardians	117	3	2.6
Trauma Assessment	117	0	0.0
Conference for Families Formed through Adoption & Guardianship	117	2	1.7
LGBTQ Services / Trainings	117	0	0.0
Adoption/Guardianship Assistance Agreement (Subsidy)	117	4	3.4

How often do services meet the needs of your family?

In the past 6 months how often have family support services (family counseling/family-based services) in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	3	2.6	13.0	13.0
	Most of the Time	6	5.1	26.1	39.1
	About Half of the Time	1	0.9	4.3	43.5
	Some of the Time	5	4.3	21.7	65.2
	Never	8	6.8	34.8	100.0
	Total	23	19.7	100.0	
Missing	No Response	7	6.0		
	Have Not Used	87	74.4		
Total		117	100.0		

In the past 6 months how often have school services in your community met the needs of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	21	17.9	31.8	31.8
	Most of the Time	24	20.5	36.4	68.2
	About Half of the Time	2	1.7	3.0	71.2
	Some of the Time	13	11.1	19.7	90.9
	Never	6	5.1	9.1	100.0
	Total	66	56.4	100.0	
Missing	No Response	4	3.4		
	Have Not Used	47	40.2		
Total		117	100.0		

In the past 6 months how often have child care services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	13	11.1	32.5	32.5
	Most of the Time	15	12.8	37.5	70.0
	About Half of the Time	2	1.7	5.0	75.0
	Some of the Time	2	1.7	5.0	80.0
	Never	8	6.8	20.0	100.0
	Total	40	34.2	100.0	
Missing	No Response	7	6.0		
	Have Not Used	70	59.8		
Total		117	100.0		

In the past 6 months how often have medical services in your community met the needs of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	48	41.0	60.8	60.8
	Most of the Time	21	17.9	26.6	87.3
	About Half of the Time	3	2.6	3.8	91.1
	Some of the Time	4	3.4	5.1	96.2
	Never	3	2.6	3.8	100.0
	Total	79	67.5	100.0	
Missing	No Response	7	6.0		
	Have Not Used	31	26.5		
Total		117	100.0		

In the past 6 months how often have mental health services in your community met the needs of your child?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	7	6.0	23.3	23.3
	Most of the Time	11	9.4	36.7	60.0
	About Half of the Time	1	0.9	3.3	63.3
	Some of the Time	4	3.4	13.3	76.7
	Never	7	6.0	23.3	100.0
	Total	30	25.6	100.0	
Missing	No Response	7	6.0		
	Have Not Used	80	68.4		
Total		117	100.0		

In the past 6 months how often have mental health services in your community met your needs as a caregiver?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	7	6.0	30.4	30.4
	Most of the Time	5	4.3	21.7	52.2
	About Half of the Time	3	2.6	13.0	65.2
	Some of the Time	1	0.9	4.3	69.6
	Never	7	6.0	30.4	100.0
	Total	23	19.7	100.0	
Missing	No Response	7	6.0		
	Have Not Used	87	74.4		
Total		117	100.0		

In the past 6 months how often have post permanency services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	7	6.0	35.0	35.0
	Most of the Time	2	1.7	10.0	45.0
	About Half of the Time	1	0.9	5.0	50.0
	Some of the Time	2	1.7	10.0	60.0
	Never	8	6.8	40.0	100.0
	Total	20	17.1	100.0	
Missing	No Response	6	5.1		
	Have Not Used	91	77.8		
Total		117	100.0		

In the past 6 months how often have substance abuse services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	0	0.0	0.0	0.0
	Most of the Time	1	0.9	10.0	10.0
	About Half of the Time	0	0.0	0.0	10.0
	Some of the Time	0	0.0	0.0	10.0
	Never	9	7.7	90.0	100.0
	Total	10	8.5	100.0	
Missing	No Response	8	6.8		
	Have Not Used	99	84.6		
Total		117	100.0		

In the past 6 months how often have DCF child welfare services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	0	0.0	0.0	0.0
	Most of the Time	0	0.0	0.0	0.0
	About Half of the Time	1	0.9	11.1	11.1
	Some of the Time	0	0.0	0.0	11.1
	Never	8	6.8	88.9	100.0
	Total	9	7.7	100.0	
Missing	No Response	7	6.0		
	Have Not Used	101	86.3		
Total		117	100.0		

In the past 6 months how often have physical disability services in your community met the needs of your family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Always	1	0.9	12.5	12.5
	Most of the Time	0	0.0	0.0	12.5
	About Half of the Time	0	0.0	0.0	12.5
	Some of the Time	0	0.0	0.0	12.5
	Never	7	6.0	87.5	100.0
	Total	8	6.8	100.0	
Missing	No Response	8	6.8		
	Have Not Used	101	86.3		
Total		117	100.0		

Psychiatric Medication Service by Age of Child

Due to concerns about the overmedication of children that have been involved in the child welfare system, psychiatric medication usage was examined in more detail. Specifically, in conjunction with the age groups of the children who are receiving these medications. A total of 34 children out of 166 (20.5%) in the cycle were currently prescribed prescription medication, according to their caregiver's self-report.

Psychiatric Medication Use by Child's Age (grouped)

		Yes	No	Total
Child's age in years	0 - 3 years old	0	0	0
	4 - 7 years old	3	23	26
	8 - 12 years old	11	44	55
	13+ years old	20	65	85
	Total	34	132	166

Transracial/Transcultural Adoption Experiences

Does your family see itself as a transracial family?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	77	65.8	71.3	71.3
	No	31	26.5	28.7	100.0
	Total	108	92.3	100.0	
Missing	No Response	9	7.7		
Total		117	100.0		

Has your family talked about being a transracial family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	70	90.9	92.1	92.1
	No	6	7.8	7.9	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Has your family chosen childcare providers, teachers, or other role models similar to your child's race and ethnicity? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	38	49.4	51.4	51.4
	No	36	46.8	48.6	100.0
	Total	74	96.1	100.0	
Missing	No Response	3	3.9		
Total		77	100.0		

Does your family have friends that share the same racial or ethnic background of your child? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	62	80.5	81.6	81.6
	No	14	18.2	18.4	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Has your family prepared foods associated with your child's racial or ethnic background? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	53	68.8	69.7	69.7
	No	23	29.9	30.3	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Has your family lived in or moved to a racially or culturally diverse neighborhood? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	11	14.3	14.5	14.5
	No	65	84.4	85.5	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Do you feel confident that your family can meet your child's needs based on his or her transracial ethnic identity? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	55	71.4	73.3	73.3
	No	20	26.0	26.7	100.0
	Total	75	97.4	100.0	
Missing	No Response	2	2.6		
Total		77	100.0		

Is your child comfortable being in a transracial family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	72	93.5	96.0	96.0
	No	3	3.9	4.0	100.0
	Total	75	97.4	100.0	
Missing	No Response	2	2.6		
Total		77	100.0		

Has your family discussed your child's international or private adoption? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	73	94.8	96.1	96.1
	No	3	3.9	3.9	100.0
	Total	76	98.7	100.0	
Missing	No Response	1	1.3		
Total		77	100.0		

Did you have a travel support group when you adopted internationally? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	15	19.5	24.2	24.2
	No	47	61.0	75.8	100.0
	Total	62	80.5	100.0	
Missing	No Response	15	19.5		
Total		77	100.0		

Do you keep in touch with that travel support group? (N=15)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	10	66.7	66.7	66.7
	No	5	33.3	33.3	100.0
	Total	15	100.0	100.0	

Has there been any impact of your child's transracial adoption on your immediate family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	30	39.0	40.5	40.5
	No	44	57.1	59.5	100.0
	Total	74	96.1	100.0	
Missing	No Response	3	3.9		
Total		77	100.0		

Has there been any impact of your child's transracial adoption on your extended family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	25	32.5	34.2	34.2
	No	48	62.3	65.8	100.0
	Total	73	94.8	100.0	
Missing	No Response	4	5.2		
Total		77	100.0		

Has your family been involved in religious, social, or recreational groups or activities that reflect your child's race, ethnicity, or culture? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	45	58.4	60.8	60.8
	No	29	37.7	39.2	100.0
	Total	74	96.1	100.0	
Missing	No Response	3	3.9		
Total		77	100.0		

Does your child have problems being in a transracial/transcultural family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	7	9.1	9.6	9.6
	No	66	85.7	90.4	100.0
	Total	73	94.8	100.0	
Missing	No Response	4	5.2		
Total		77	100.0		

Does your child have sources of support in your transracial/transcultural family? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	47	61.0	62.7	62.7
	No	28	36.4	37.3	100.0
	Total	75	97.4	100.0	
Missing	No Response	2	2.6		
Total		77	100.0		

Does your child have problems with racial discrimination? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	28	36.4	37.8	37.8
	No	46	59.7	62.2	100.0
	Total	74	96.1	100.0	
Missing	No Response	3	3.9		
Total		77	100.0		

Do you feel you know how to help your child when he or she is being teased, bullied, or discriminated against because of race? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	51	66.2	72.9	72.9
	No	19	24.7	27.1	100.0
	Total	70	90.9	100.0	
Missing	No Response	7	9.1		
Total		77	100.0		

Has your child's wellbeing been impacted by the transracial/transcultural adoption? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	25	32.5	34.2	34.2
	No	48	62.3	65.8	100.0
	Total	73	94.8	100.0	
Missing	No Response	4	5.2		
Total		77	100.0		

Has the transracial adoption had an impact on your marriage or significant other relationship? (N=77)

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	13	16.9	17.3	17.3
	No	62	80.5	82.7	100.0
	Total	75	97.4	100.0	
Missing	No Response	2	2.6		
Total		77	100.0		

Chapter 10

CROSS-SITE EVALUATION

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Overview

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

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

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

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

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

Cross-Site Results

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

Engagement with Adoptive and Guardianships Families

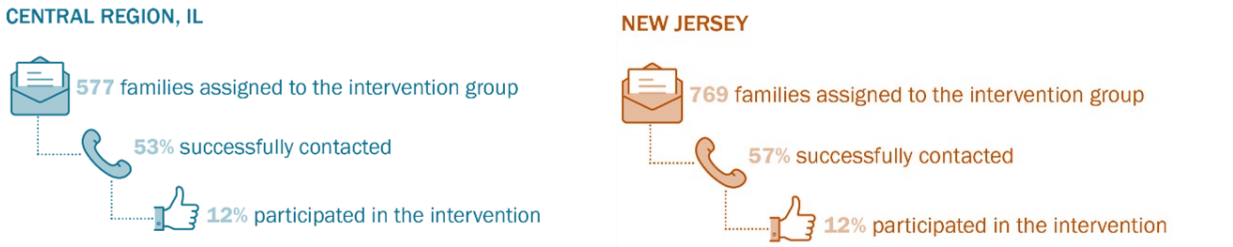
Not all child welfare jurisdictions consider outreach to families after legal finalization of adoption and guardianship as the responsibility of a child welfare system. Yet, families who have adopted or assumed guardianship of children, particularly children who have experienced trauma and maltreatment,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

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

SERVICE ENGAGEMENT FOR SELECTIVE PREVENTION SITES

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

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



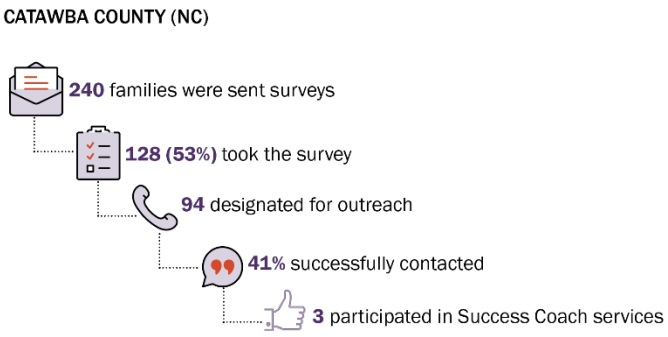
In both sites, a variety of outreach methods were used to make contact with families and increase uptake. For example, at the suggestion of the stakeholders in Illinois, the project staff made additional follow-up calls to families who initially said they wanted to participate in the project but later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

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

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

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

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



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

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

Survey Response Rates

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

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

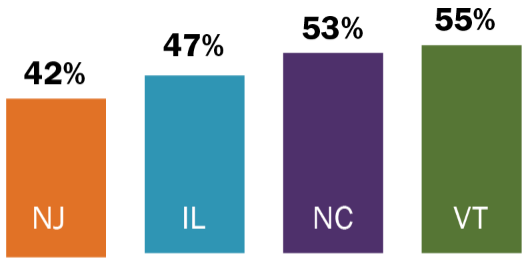
[1] The survey responses from Illinois and New Jersey discussed in this section are from the primary outcome surveys only.

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

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

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

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



Overall Response Rates

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

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

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

SERVICE ENGAGEMENT SUMMARY

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

Service Needs and Use

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

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

SURVEYS IN VERMONT AND CATAWBA COUNTY (NC)

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

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

Table 10.2. Vermont Service Use in Past 6 Months

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

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

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

SUMMARY OF SERVICE NEEDS FROM WISCONSIN, ILLINOIS AND NEW JERSEY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SERVICE NEEDS AND USE SUMMARY

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

Outcomes

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

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

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

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

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

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

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

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

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

Limitations

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

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

Examining Post Permanency Discontinuity

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

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

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

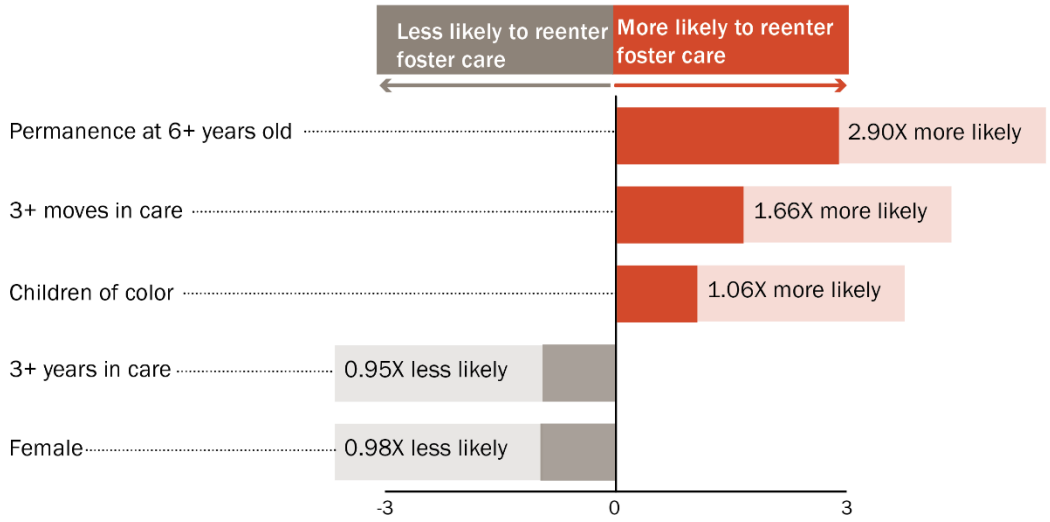
In sites that used BPI and caregiver commitment measures, families were compared across the continuum to see if there were differences in the families targeted for outreach. Specifically, it was hypothesized that families targeted for outreach at the Universal level would, on average, have low-risk scores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

Post Permanency Discontinuity

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

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

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



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

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

Analysis Along the Prevention Continuum

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

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

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

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

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

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

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

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

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

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

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

Behavioral Problem Index (BPI)

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

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

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

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

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

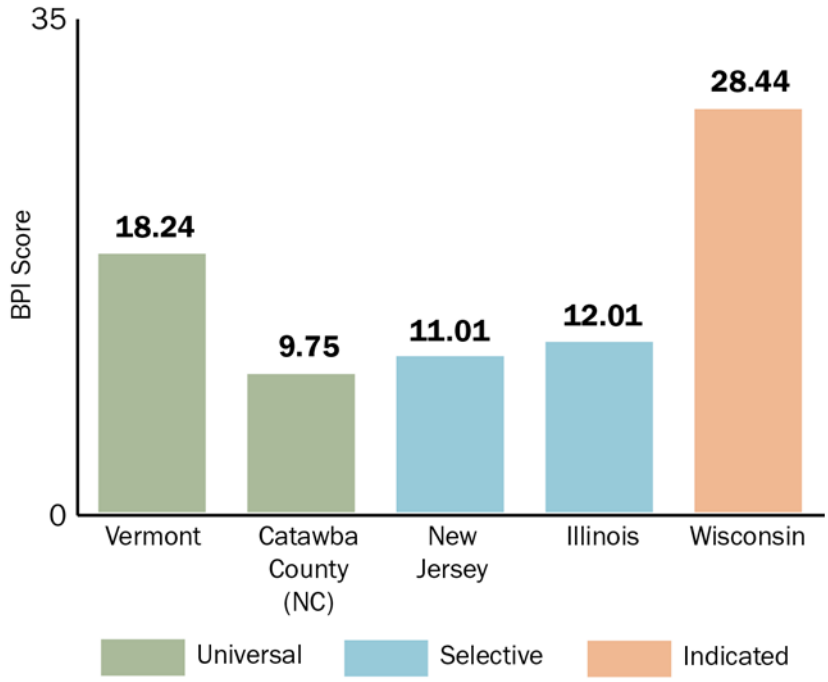


Figure 10.2 note: It should be noted that we expect to see higher levels of behavior problems in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin are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

Caregiver Strain

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

Figure 10.3. Mean Caregiver Strain Scores by Site

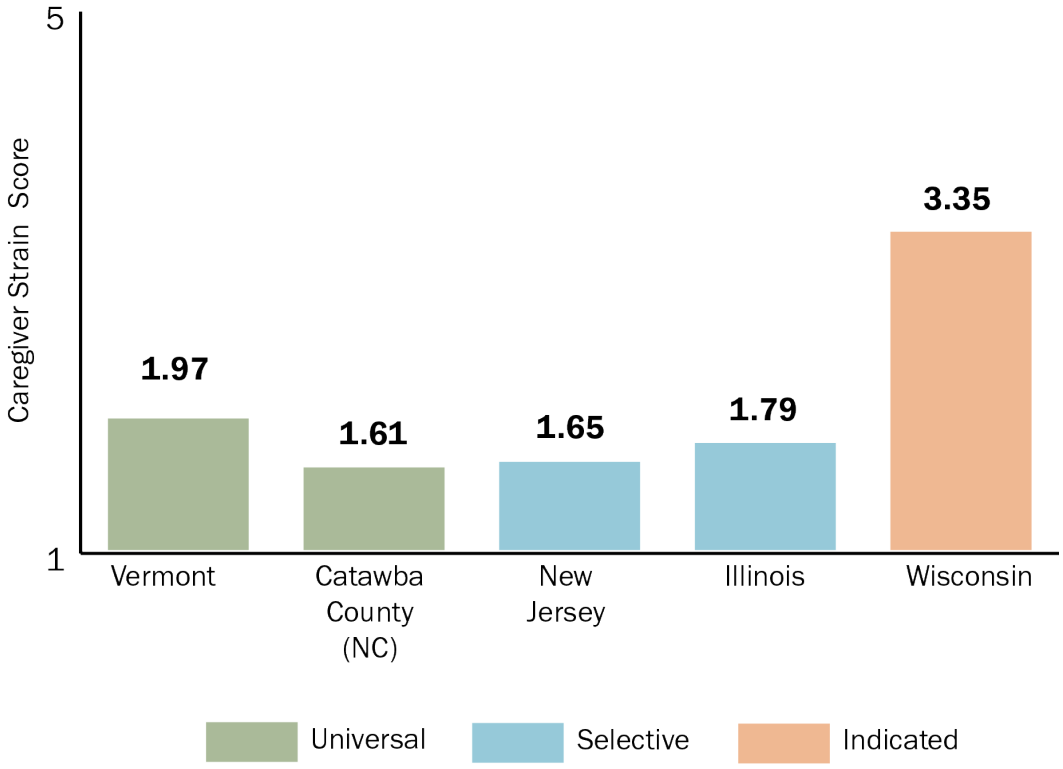


Figure 10.3 note: It should be noted that we expect to see higher levels of caregvier strain in the site that is serving families who reach out to request assistance (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families in Wisconsin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

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

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

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

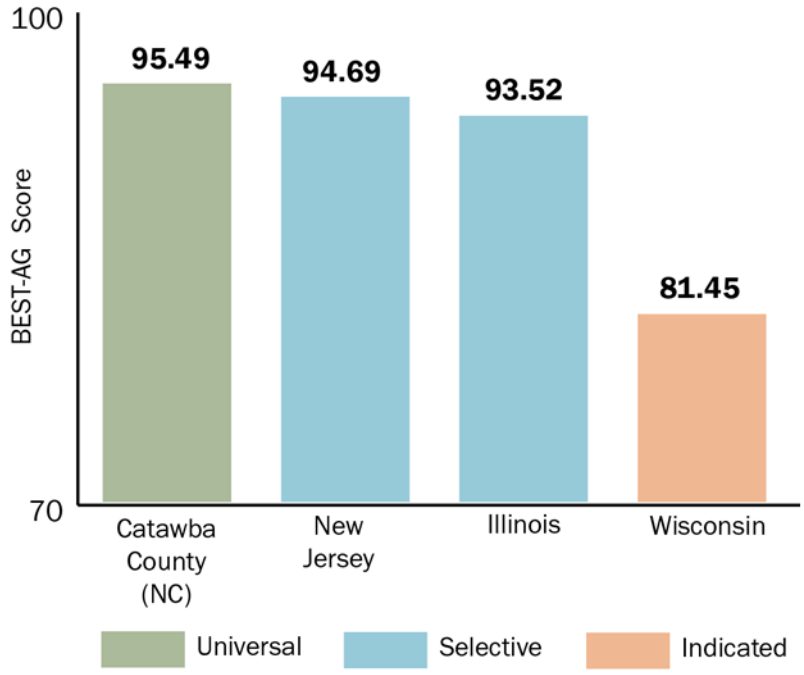


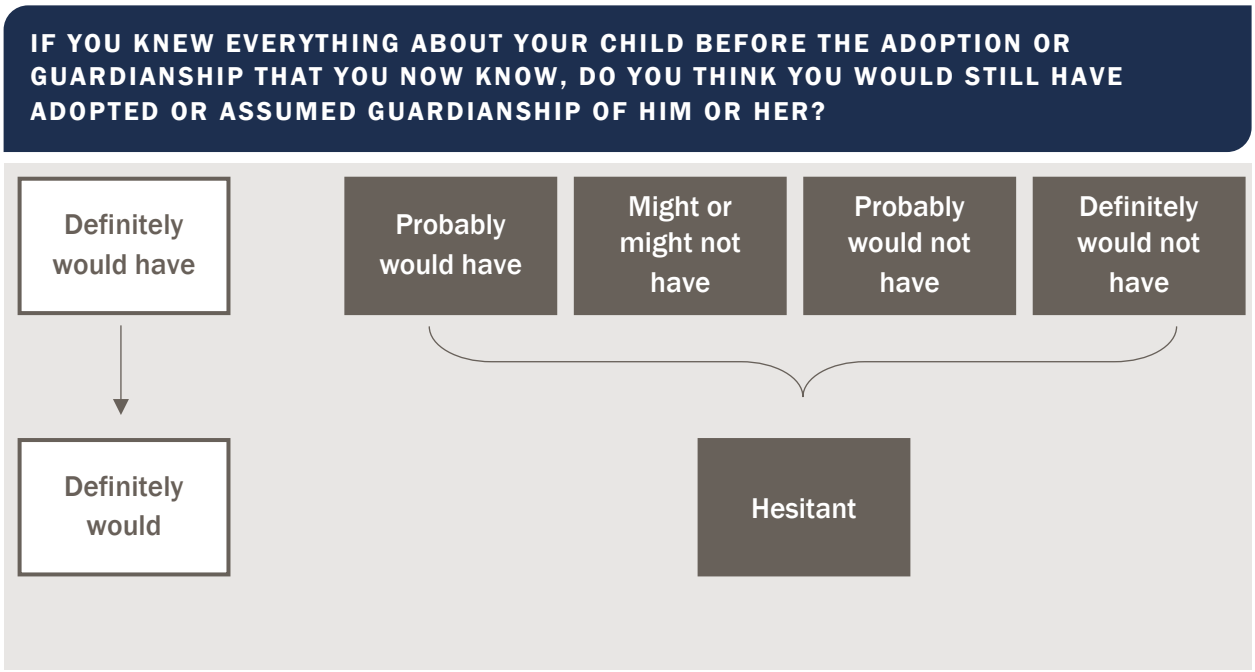
Figure 10.4 note: It should be noted that we expect to see lower levels of belonging and emotional security in the site that is serving families who reach out to request services (Wisconsin) than in sites where the project reached out to families (Vermont, Catawba, New Jersey and Illinois.) Families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

Impact of Caregiver Commitment on Key Measures

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

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

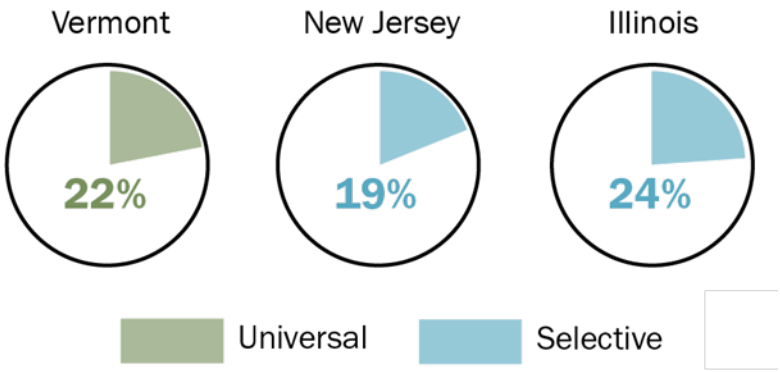
Keeping in mind the significant role caregiver commitment has played in understanding post permanency discontinuity and other challenges in prior studies (Liao & Testa, 2016; Testa et al., 2015; White et al., 2018), a series of commitment questions were asked of parents and guardians involved with this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



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

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

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



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

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

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

GUIDE TO FIGURES 10.6 – 10.8

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

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

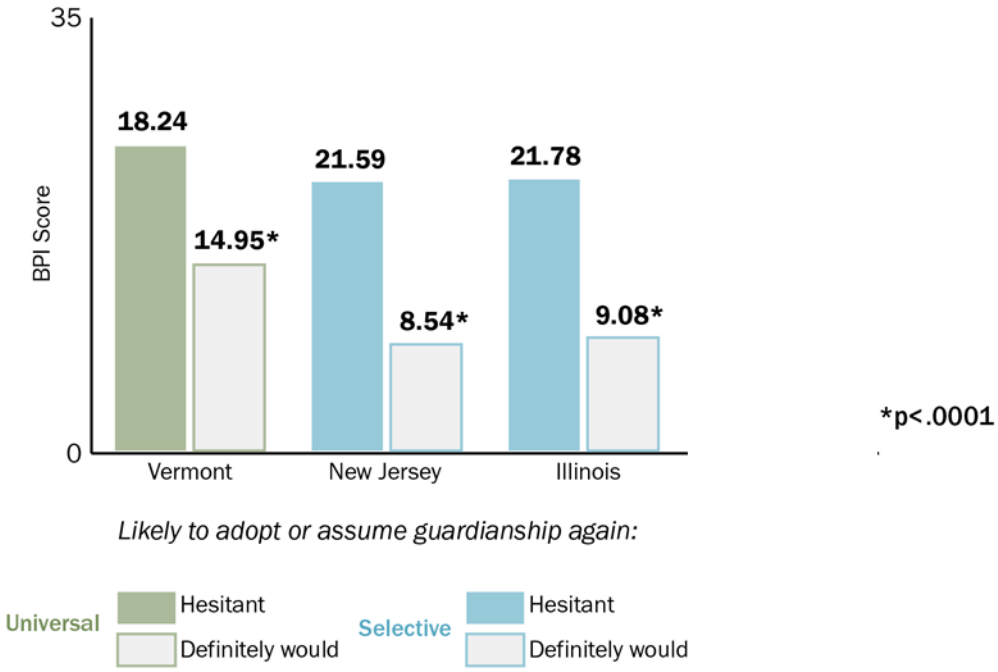
- Families who were hesitant to adopt or assume guardianship again.
- Families who expressed no hesitancy (definitely would adopt or assume guardianship again).

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

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

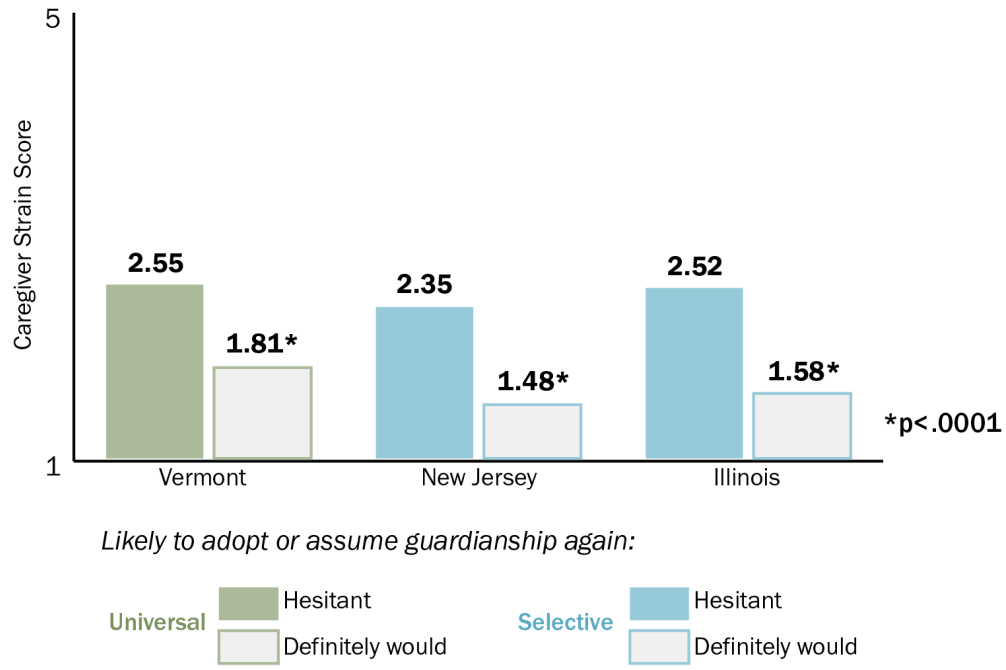
This analysis revealed some interesting trends that are examined along the continuum and across three key measures: The Behavioral Problem Index (BPI), Caregiver Strain (CS), and the Belonging and Emotional Security Tool for Adoption and Guardianship (BEST-AG).

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



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

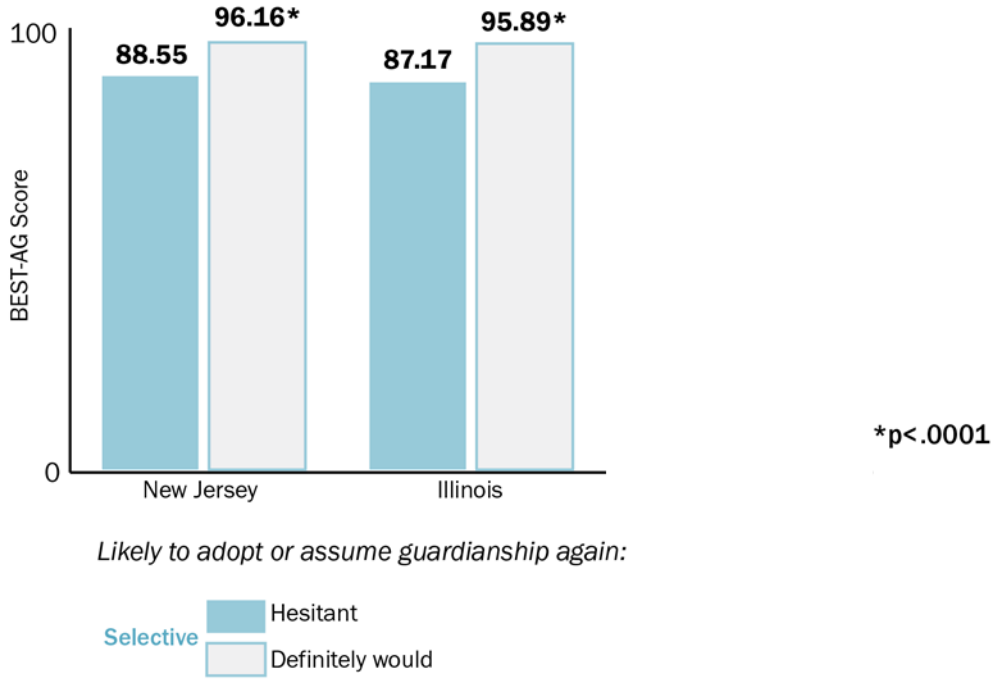
Figure 10.7. Caregiver Strain by Inclination to Adopt or Assume Guardianship Again



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

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

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



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

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

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

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

Discussion

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

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

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

SERVICE UPTAKE DID NOT OVERWHELM POST PERMANENCY SERVICE PROVIDERS

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

ONGOING SERVICE NEEDS

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

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

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

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

In sum, some suggestions moving forward:

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

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

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

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

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

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

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

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

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

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

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

IDENTIFYING FAMILIES AT RISK FOR POST PERMANENCY DISCONTINUITY

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

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

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

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

MULTI-PRONG APPROACH TO OFFERING SUPPORT AND SERVICES

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

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

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

ADOPTIVE PARENTS AND GUARDIANS REPORT ON THEIR POST PERMANENCY EXPERIENCES

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

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

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

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

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

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

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

> **"Our biggest challenge is the close proximity of the birth family, specifically birth dad. He does not respect the boundaries of adoption and is a constant threat and worry.**
>
> **"We spent many years trying to find appropriate providers who understood our son. We were often given misinformation & guidance about our son's needs. For years, professionals looked only at behaviors rather than brain functioning & disabilities. Both he & us as parents were blamed."**
>
> **"Attachment disorder has severely impacted my daughter…She has struggled with attachment and reciprocity. I, too, have struggled with attachment to her, given her lack of reciprocity. Having worked with a therapist years ago who purportedly understood attachment disorder, my daughter and I received very little helpful guidance…The fact that she is still alive is testament to my husband's and my determination to support her and find resources for her--mostly out of state."**

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

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

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

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

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Appendices

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

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

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

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

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

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

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

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

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

Appendix B. Data Tables

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

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

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

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

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

Note: HR stands for Hazard Ratio.