Arizona Waiver Demonstration Project Final Evaluation Report

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Prepared for:
Arizona Department of Child Safety

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Executive Summary

From FFY 2011 to FFY 2014, Arizona experienced a 47% increase in the number of children living in out-of-home care, from 11,535 to 16,990 respectively (ADCS, 2016). During this period there was also an increase in the number of children placed in congregate care settings. As such, the average monthly expenditure for congregate care in Arizona doubled, from $3,429,605 in FFY 2009 to $6,856,877 in FFY 2014 (ADCS, 2016). Apart from the high cost of congregate care, for most children family-like living arrangements are preferable (Annie E. Casey Foundation, 2015).

The Arizona experience was similar to the national trend of children placed in congregate care (Annie E. Casey Foundation, 2015). The Arizona Department of Child Safety (DCS) identified reduction in congregate care as the focus of its demonstration project due to the number of children placed in these settings who were able to live in a family-like setting, as well as the high cost of congregate care (ADCS, 2016).

Waiver Demonstration Project Intervention

The Arizona waiver demonstration project, Fostering Sustainable Connections (FSC), sought to reduce the time children spend in congregate care settings by a) enhancing family/fictive kin search and engagement activities (Family Finding), b) introducing new meeting types, and c) supporting the action plans created in partnership with family/fictive kin with needed services.

Family Engagement Specialists (FESs) were considered a key component of achieving the desired outcomes of FSC as they contribute to the four stages of the intervention:

Discovery and Engagement: locate and engage kin or fictive kin through components of the Family Finding model to build a lifelong and support network for the youth.

Planning: facilitate discussions and meetings such as the new Blended Perspective Meeting (BPM) that is intended to bring the family and other key participants together to connect or reconnect the youth and family and to learn about the greatest strengths and needs of the youth.

Decision Making/Action Plan: a new Life Long Connections Team Decision Making (LLC TDM) meeting targets youth placed in congregate care settings, which identifies family-like placement, transition planning, and the identification of services and supports for children and their families to ensure successful placement.

Follow-up: ensure formal and natural supports are in place, accessible, timely and meeting the needs of the youth and family.

FSC was implemented on July 1, 2016 in two Maricopa County offices. From April 2017 through June 2018, it was expanded to 13 additional locations in Maricopa, Pima, and Pinal counties and later to additional locations in Coconino, Yavapai, Mohave, and Navajo counties. The demonstration project officially ended on September 30, 2019. It is important to note that only select units within each intervention office implemented FSC. Throughout the demonstration project, a total of 576 children/youth and their family/fictive kin were served. The children ranged in age from 3 to 17 years at entry to FSC, with an average age of 13 (*SD* = 3). The greatest percentage of children served, 69%, were in the 13 through 17-year-old age range.

Target Population

The demonstration project initially targeted children and youth birth to 18 years of age who were placed in congregate care. Individuals who required behavioral health, juvenile justice, or medical placements were grouped together under the behavioral health congregate care placement type category. This category, that represented only three percent of the overall out-of-home care population upon first placement and two percent upon second placement, was excluded from the target population as it was clear that these placements were to meet children's behavioral health and safety needs.

Arizona's largest urban counties – Maricopa, Pima, and Pinal – encompassed 95% of children in congregate care as of July 1, 2015, with the remaining five percent spread across the state's 12 rural counties. Thus, the target population for the demonstration project evaluation was restricted to the three urban counties. Over time, the upper age limit of eligibility was reduced from 18 to 17.5 years, as it was determined difficult to engage youth who were about to reach the age of majority. FSC could work with a youth only until his or her 18th birthday.

Evaluation Design

A theory of change was developed for the waiver demonstration that links the intervention with key expected outcomes (see Figure 1) (AZDCS, 2016). Based on the FSC theory of change, an overarching logic model was developed (see Figure 2). The program hypothesis was that through the demonstration project intervention, the outputs and short and longer-term outcomes listed on the logic model would be achieved. The

logic model identifies the outcomes in terms of the three overarching child welfare goals: permanency, safety, and well-being. The outputs and outcomes in the logic model guided the development of the process, outcome, and cost evaluation studies described in the final evaluation report. The *process study* assessed whether or not the demonstration project was implemented as intended, and examined the preparation for successful implementation. The *outcome study evaluated* the extent to which the demonstration project achieved its intended results in the short, intermediate and long-term. The *cost study* examined the financial impact of the demonstration project at the individual level, which involved a simple cost analysis. The *sub-study* was focused on the social emotional well-being of the children and youth and used a longitudinal design that examined parent/caregiver and child/youth perspectives of well-being over time.

Intervention: Improve engagement with children in the congregate care setting and their families through:

1. DCS Family Engagement Specialists, in collaboration with the DCS Specialists, performing family/fictive kin search and engagement activities;
2. TDM Facilitators conducting TDM meetings to identify needs/strengths and develop action plans in partnership with the family/fictive kin; and
3. Providing in-home reunification, placement stabilization or other identified services when needed:

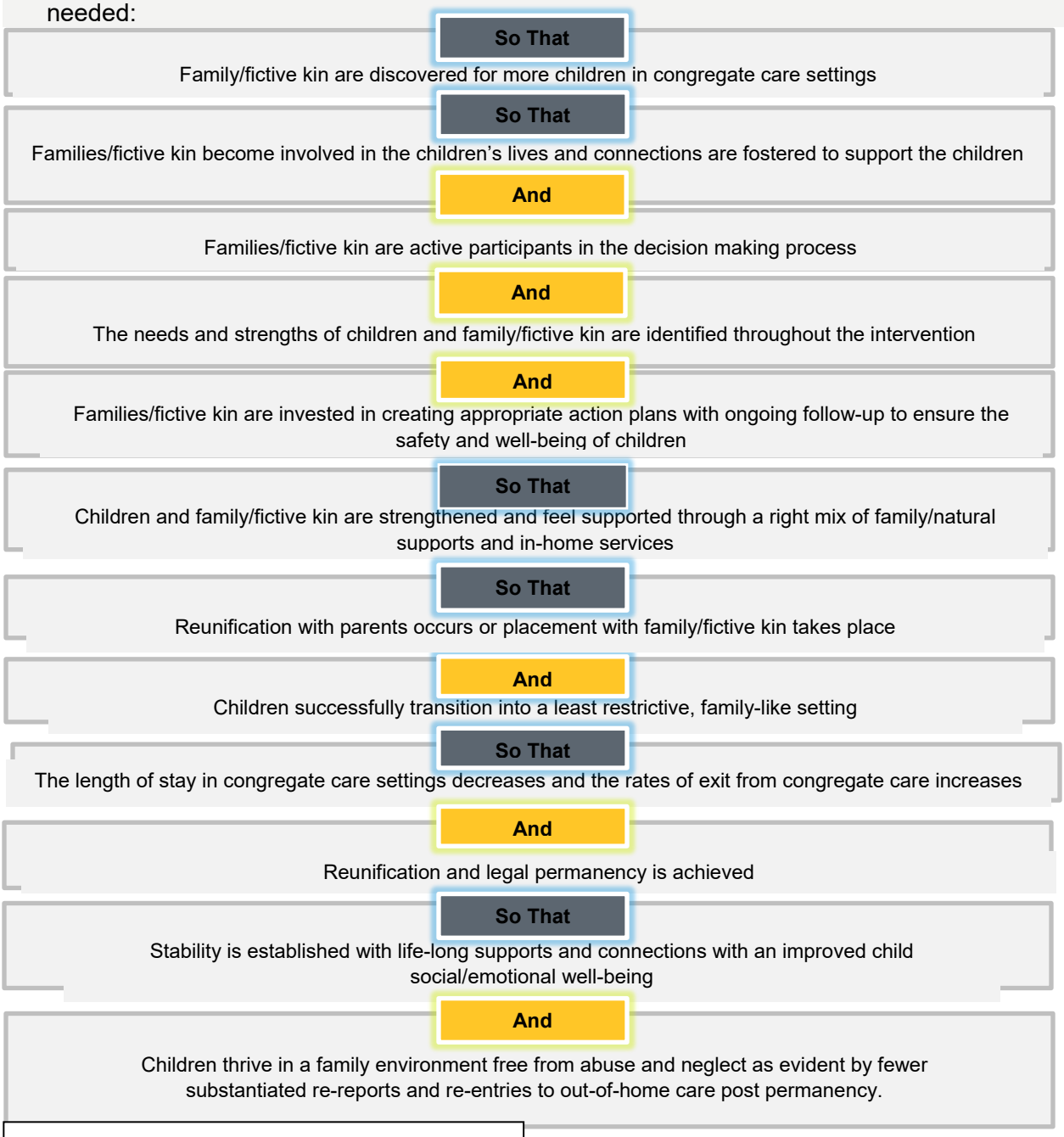


Figure 1. FSC Theory of Change

INPUTS	OUTPUTS	SHORT TERM OUTCOMES	INTERMEDIATE OUTCOMES	LONGER TERM OUTCOMES
Children birth to 17 years currently placed in or entering congregate care in Arizona Parents/Caregivers/Kin/Fictive Kin DCS Staff and Leadership including CQI, Placement Coordinators & Family Engagement Specialists DCS Policy and Procedure Guides Out-of-Home Care Providers Service Providers (Behavioral Health, DCS, Community) Foster Care Providers DCS Training and Data Units Federal Agency funding and technical assistance (e.g., Children's Bureau/Center for States, JBA) Other stakeholders (e.g., state legislators, courts)	Number and type of TDM meetings, Blended Perspective meetings, action plans Family search (Seneca and Family Locate) Identification of service needs and matching of needs to service referrals Family satisfaction <u>System-level</u> Waiver communication Readiness Collaboration Fidelity of intervention Contracts	Increase in parent/caregiver and child > 12 years participation in case plan development (TDM) Increased number of family/fictive kin available (Family Finding) Increased involvement of family/fictive kin (Family Finding) Increase in timely service receipt to meet identified need of family and child (Service Array) Increase utilization of in-home, community, and behavioral health services to support reunification and aftercare (Service Array)	Increase in reunification and other types of permanency (P) Decreased length of stay in congregate care (P) Increased rates of exit from congregate care (P) Lower restrictiveness of living environment for children in congregate care (WB)	Reduction in congregate care (WB) Improved child social/emotional well-being (WB) Fewer substantiated re-reports and re-entries to out of home care post permanency (S) Cost savings from less time in congregate care Changes in expenditure among categories as DCS In-Home Service Program expanded **P = Permanency** **WB = Well-being** **S = Safety**

Figure 2. FSC Logic Model

Findings

Process Study

The process study sought to answer two questions: 1. Was the intervention implemented as designed? and 2. Did the child welfare system support implementation of the intervention in a manner that optimized short, intermediate, and long-term outcomes? Program impacts are compromised when the intervention is not delivered as intended. The process study found the following with regard to fidelity of FSC:

- Stage 1. Discovery and Engagement: The Family Engagement Specialists (FESs) completed planned discovery and engagement activities including mining of the case file, interviewing the child's DCS Specialist, and interviewing the child/youth with increasing rates of completion within 30 days over the life of the project. For example, the FESs mined the case record within 30 days of being assigned the case in 48% of cases in Year 1, 78% in Year 2, 85% in Year 3, and 100% in Year 4. FESs used a variety of discovery tools to identify family and fictive kin including Mobility and Connectedness Maps, genograms, safety circles, ecomaps, the Three Houses activity, Tree of Life, All About Me Book, 3-5-7 Model activities, interviews and social media. Database searches were conducted through a variety of tools including the DCS Family Locate Unit, Lexis Nexis, Seneca, White Pages, Zaba Search and social media.
- Stages 2 & 3. In the planning and decision making/action plan phases of FSC two new meetings were introduced. Once family/fictive kin were identified, the Blended Perspective Meeting (BPM) sought to engage them in a meeting to support the child, identify the child's strengths, and identify the child's greatest unmet needs. The Lifelong Connections Team Decision Making meeting (LLC TDM) aimed to involve family/fictive kin in planning for the child's future by working with the child to develop an emotional and relational support plan, placement plan, and legal permanency plan. For the first three cohorts combined, a BPM was held for 34% of the 90 children sampled and a LLC TDM meeting for 30%. Just under 20% of the children sampled experienced both a BPM and LLC TDM meeting. There were a variety of reasons that these meetings did not occur including scheduling conflicts, connections unwilling to participate with other connections involved, and moving quickly to an LLC TDM instead of holding a BPM.
- Observations of these meetings found them to follow a consistent format and address the stated objectives.

- The Statewide Coordinator role was important to increasing fidelity as they encouraged implementation sites to hold regular monthly meetings that were structured and focused. They helped to address issues as they arose such as the FES workload, appropriateness of referrals, and the reduction in FES caseload. The Coordinators encouraged greater use of the BPM and LLC TDM meetings, and improved the collection of data and reporting of metrics for the demonstration project.

In all cohorts, the children and caregivers sampled reported high levels of engagement and satisfaction with their FESs. This finding was consistent across the domains measured including interpersonal relationships, commitment to the helping process, receptivity, trust, expectancy that things would change for the better, understanding, and advocacy.

At the system-level, the Department supported implementation of the intervention through an implementation science approach that involved assessing organizational readiness at the site level prior to implementation, assessing system collaboration, and monitoring implementation drivers with action planning and follow-up. Strengths identified through the assessment of organizational readiness that were supportive of the implementation of FSC included effective management, training, clarity in goals and roles, and capable supervision. Challenges to implementation in the initial years included staff turnover, high workload, and the resulting stress and strain. Representatives of the broader system through the assessment of collaboration continued to voice that the timing was right for the demonstration project and that the group had a shared vision/goals, commitment, and clear channels of communication. The assessment of collaboration was consistent with the assessment of readiness in identifying the availability of sufficient human and financial resources as an ongoing challenge that was perceived to improve over time, but remained the lowest rated subscale on the Wilder Collaboration Factors Inventory. Given the resource demands on DCS staff and the attrition in FSC in the early years, DCS moved to outsource FES/FES Supervisor services from a community agency, which aided in the planned rollout.

Finally, the examination of outputs in the process study did recognize that FSC had a broader impact on the overall system outside of the implementation units. The process study found a common theme in the site visit interviews, that DCS Specialists were beginning to perform similar activities with children on their caseloads who were not part of FSC. The units also recognized FSC as a best practice that would benefit children at initial entry to out- of-home care. FSC helped to identify and address concerns in the

broader system, such as restrictions around when and with what frequency children/youth were allowed or encouraged to have contact with family and fictive kin. Overall, FSC was viewed as increasing collaboration and communication among system partners including the child and family, the courts, and out-of-home caregivers.

The examination of context was an important part of the process study as it had the potential to identify nonwaiver activities that might pose a threat to the internal validity of the evaluation. Indeed, the Department was highly focused on the reduction of congregate care both through FSC and numerous other efforts. Targeted permanency activities were included each year in the annual DCS strategic plan and in the DCS Program Improvement Plan (PIP) in response to the 2015 Child and Family Service Review (CFSR). Efforts to reduce the use of congregate care focused on the front end of child welfare service delivery through consistent and transparent safety assessment, improved Hotline procedures, and Department and community efforts to support foster and kinship caregivers as well as families in areas of high need (e.g., the Glendale Family Strong Network). Efforts were also focused to reduce the amount of time children spent in care overall, and specifically in congregate care. These involved, for instance, enhanced supervision and training for DCS Specialists and community members; diligent recruitment and retention of foster parents as well as improved training for foster parents. Special initiatives within DCS and by contracted community providers helped to move children from congregate care to less restrictive family-like living arrangements and permanency. These included, for instance, efforts by the Placement Administration to work with the foster licensing agencies to match foster parents to children, and Child Specific Recruitment.

In summary, the process study noted that the conditions for implementing the waiver demonstration were mostly supportive and remained so, and improved over the life of the project. A structure was in place to monitor and improve fidelity to the intervention over time, that structure functioned as planned, and adaptations were made in response to recognized challenges. These included, for instance, adjusting FES workload and contracting community-based FESs. The evaluation was more of a utilization focused approach; providing assessments of readiness, collaboration, and implementation over time; than a controlled study environment. There were many threats to internal validity as noted in the sharing of best practices from FSC outside of the FES caseloads and numerous DCS and community initiatives to safely reduce the use of congregate care and overall time to permanency.

Outcome Study

The outcome study examined the achievement of short, intermediate and long-term outcomes. With regard to short term outcomes the evaluation found the following:

- An increase in the number of family/fictive kin identified during FSC. Depending on the data source, an average of 25 to 27 individuals per child were identified through FSC with a range from two to 116.
- The number of family/fictive kin involved in the children's lives increased significantly after enrollment to FSC, and was significantly greater in number than those involved with a comparison sample of children receiving services as usual.
- Combining all cohorts, a statistically significant difference was found in the number of Child Functioning needs identified in the FSC group compared to children receiving services as usual. The direction was consistent with that hypothesized, that participation in FSC would lead to greater identification of service needs.
- The FSC group was significantly more likely than the comparison group to receive referrals for identified needs in the areas of Maltreatment and Child Functioning.
- Both FSC and comparison groups had high rates of congruent referral/service access in Child Functioning, 87% and 91% respectively, indicating that in general, a majority of children accessed services after a referral was made. The intervention group, however, had a statistically higher rate of congruent service access than did the comparison group for Adult Functioning needs, indicating that the intervention group was more likely to access services after a referral was submitted.
- After a referral was submitted, services were accessed more quickly in the intervention group than in the comparison group for needs relating to Adult Functioning and Child Functioning. These differences were not statistically significant, however, the difference in Adult Functioning did approach significance. For Adult Functioning needs, it took 16 days on average for individuals in the intervention group to access services after a referral had been submitted, compared to 45 days in the comparison group.

With regard to intermediate outcomes, the outcome study found the following:

- The proportions of each group, FSC and comparison, achieving legal permanency did not differ significantly.

- Within the FSC group, those children who had a BPM or LLC TDM meeting had a higher percentage of permanency than those who did not, however the difference, 34% compared to 21% respectively, was not great enough to be statistically significant.
- There were no significant group differences in days in care for new entries post waiver demonstration or for legacy children (those who were already living in out-of-home care when the waiver demonstration started).
- There was no significant group difference in change of care setting restrictiveness score. The majority of children in both groups, approximately 67% experienced a decrease in restrictiveness of living environment.
- A decrease in restrictiveness of living environment while in out-of-home care was significantly associated with the achievement of legal permanency. Of those children in either group who achieved legal permanency, 83% had a prior decrease in restrictiveness, whereas only 17% had no change or an increase in restrictiveness of living environment prior to exiting care.

With regard to longer-term outcomes, the outcome study found the following:

- A majority of children/youth at entry to FSC rated themselves as Average or Above Average on the five social emotional subscales measured by the Behavioral Emotional Rating Scale (BERS-2), indicating they considered their strengths to be on par with children/youth in general. The children/youth also consistently reported higher social emotional well-being than their caregivers' ratings of them. Children and youth in FSC did not report greater improvement in social emotional well-being compared to those in the comparison group. In fact, children in the intervention group reported small, albeit not significant, decreases in overall well-being. This finding is consistent with a review of 13 recent evaluations of Family Finding where only one examined impact on well-being and found that treatment group youth were more likely to exhibit internalizing behavior problems than control group youth (Vandivere & Malm, 2015). Differences between the groups as a result of FSC may emerge at a later time. One goal of FSC is to identify family and fictive kin who may serve as lifelong supports for children as they exit out-of-home care. Further evaluation of the Family Finding model should examine the social emotional well-being of children in the intervention group after they have had more time to establish a new normal with new or renewed family relations and places of living outside of the child welfare system.
- Overall, about 16% of children who achieved legal permanency re-entered out-of-home care. There was no statistically significant group difference found between FSC and the comparison group on re-entry.

Cost Study

The cost study examined changes in placement cost associated with changes in the restrictiveness of care environments. The cost study found the following:

- A decrease in restrictiveness of living environment was associated with a decrease in cost ranging from $80 to $200 per day, with a move from shelter placement to kinship care being associated with the largest decrease.
- Increases in placement costs associated with increased restrictiveness of living environments ranged from $88 to $326 per day, with the move from kinship care to a specialized group home setting being associated with the greatest increase.
- In years two and three of the waiver demonstration, children in the comparison group had higher average placement costs than children in FSC with the between group difference being just under $15,000 in year three, a statistically significant group difference.

Sub Study

The purpose of the sub study was to identify factors important to the conceptualization of well-being from the perspective of youth residing in congregate care and their adult family connections. The findings crossed multiple domains of social-emotional well-being, and may hold part of the solution in identifying effective modifications for youth residing in congregate care as they transition to adulthood. In particular, youth residing in group homes have restricted access to their family members and communities of origin, and by default, lack stable parental figures in their lives. The findings indicate the powerful influence of caregivers on promoting social-emotional well-being. Specifically, the youth in the sub study clearly rely on their care providers to provide information pertaining to their well-being, as well as supportive direction pertaining to ways in which they can improve their current circumstances. Despite recognition that placement in congregate care settings are often interim placement stops, the youth expressed an overwhelming desire to strengthen and deepen their relationships with their care providers.

The two standardized measures of social emotional well-being (the BERS-2 and Youth Quality of Life-Short Form (YQoL-SF), although not nuanced to the congregate care setting and child welfare involvement, presented skill building opportunities for caregivers employed in congregate care settings on how to better connect with youth on an emotional level. This relates to the implementation of Public Law 113-183 in terms of

promoting normalcy and implementation of the reasonable and prudent parent standard as it relates to congregate care.

A further implication of this sub study involved the necessity for youth to adapt existing coping strategies to meet the new expectations, challenges, and restrictions of living in congregate care settings. Specifically, the youth in the study discussed recognizing the importance of self-regulation, however many did not feel as if they had the skills to accomplish this on their own without constant redirection from their caregivers. Still others described having restrictions on items that provided familiarity at home, further deepening their desire for normalcy, resulting in on-going patterns of dysregulation.

A final important implication of this sub study involves incorporating conversations with youth placed in out-of-home care settings about future goal planning and instilling hope for the future. The majority of the youth interviewed discussed the importance of future goal planning as a means of persevering through adversity. The youth had strong ideas about what they wanted their futures to look like after their involvement with the child welfare system ended, however many expressed uncertainties about their ability to achieve these goals because of contextual environmental instability.

Sustainability

The waiver demonstration project intervention is now available statewide. A sustainability plan for FSC was created prior to the demonstration project ending and DCS Executive Leadership supported its continuation. The program was implemented statewide in October 2019. Any unit from any office may refer children/youth to FSC. A request for proposal (RFP) was created and a contract awarded to Arizona's Children Association in February 2020. The Statewide Coordinator has made presentations on FSC to DCS offices that were not part of the demonstration project intervention and a communication on FSC was sent out via e-mail to all DCS staff. The FSC workbook is still used to track metrics and the Statewide Coordinator position continues to monitor fidelity and work on process improvement.

FSC approach over the four cohorts. The examination of fidelity presented in this section included analysis of data from the case-based FSC fidelity tool, which was adapted from the Family Finding Program fidelity tool, as well as an examination of data from the FSC workbook, and a survey of children and caregivers on engagement and satisfaction with FSC. Selection of children for the fidelity review was not completely random as initially planned due to FSC beginning with fewer FESs than anticipated. This limited the number of children available for the evaluation. Another unanticipated factor limiting the number of children available was the presence of several large sibling groups; only one child from each family could be selected in order to maintain independence of observations. Although it appeared that capacity would increase with additional FESs from contracted providers, random selection was not possible until Year 4 due to worker turnover and many sibling groups. Selection of children for review, therefore, occurred as new cases served by the FESs became available. Fidelity tools stored in the DCS case files were reviewed for 112 children (31 from Year 1, 27 from Year 2, 26 from Year 3 and 28 from Year 4). The target was 30 case files per year; however, a small number of case files were missing the fidelity tools.

The examination of fidelity examined the first three phases of the Family Finding Model. The first phase, Discovery and Engagement, was intended to identify family members and informal supports for the children. According to the FSC Process Standard Work (effective 6/6/2016 and revised 3/29/2018), within seven days of receiving the case, the FES should review the child's case file, staff the case with the assigned DCS Specialist, and reach out to the child's caregiver. In addition, within 14 days the FES should contact the child/youth in person and have an introduction/rapport building meeting. As shown in Figure 3, in over 75% of the 112 cases reviewed over the entire waiver demonstration, files were mined and DCS Specialists were contacted to identify potential relational connections within 30 days of the case being assigned to the FES. Additionally, in almost 70% of cases, youth were interviewed within 30 days of the case being assigned to the FES. The period of 30 days was chosen as the fidelity tool was to be updated monthly by the FES Supervisor in supervision with the FES. The fidelity tool charts progress on discovery and engagement activities within 30 days. Searching for and contacting kin, database searches and location efforts, and communicating with the DCS Specialists are ongoing activities.

Figure 3

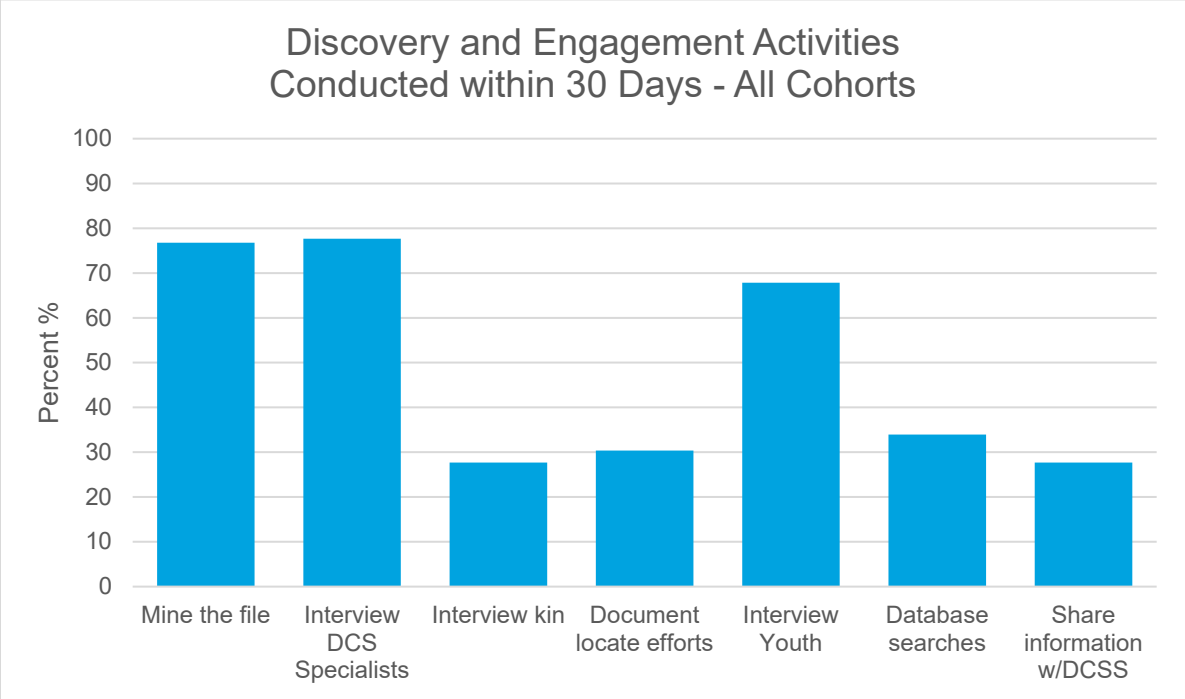
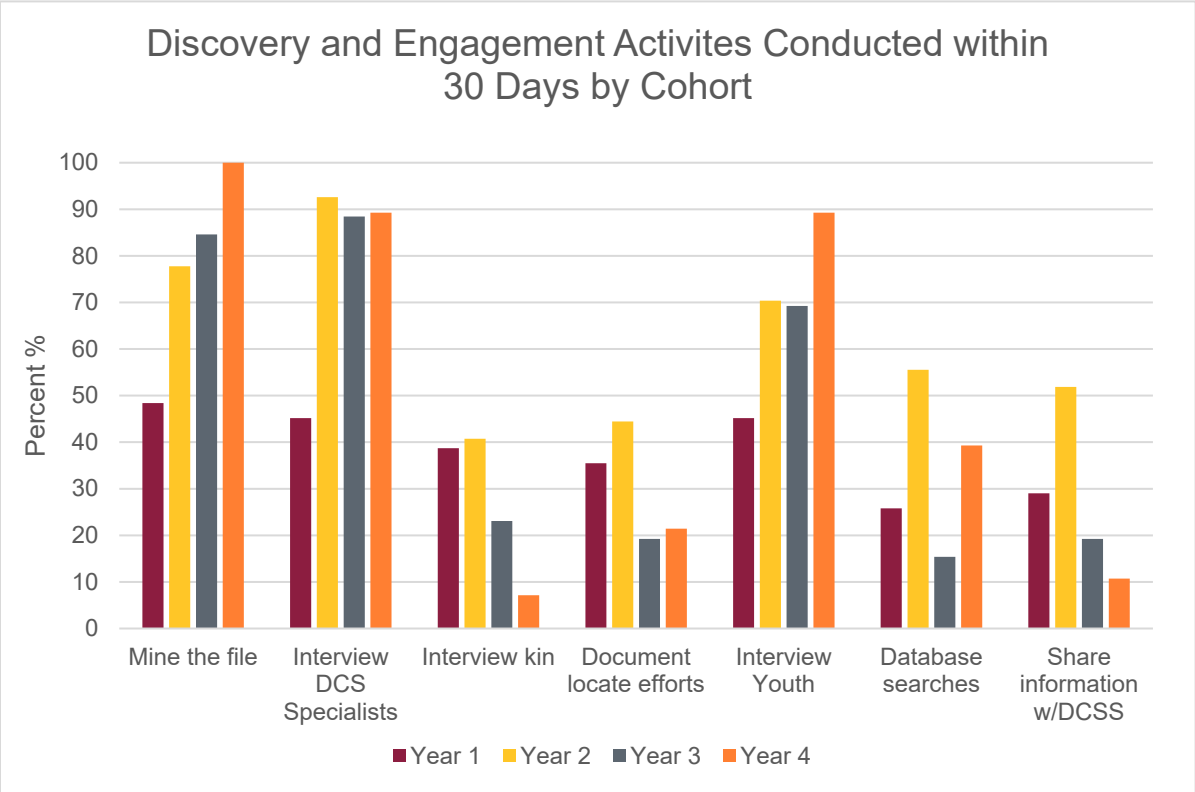


Figure 4 shows the percent of discovery and engagement activities that were completed by FESs for each cohort of the study as per the fidelity tool. Completion of the initial discovery and engagement activities appear to have increased over the four years. For example, FESs mined the file within 30 days of being assigned the case in 48% of cases in Year 1, 78% of cases in Year 2, 85% of cases in Year 3, and 100% of cases in Year 4. FESs completed interviews with DCS Specialists within 30 days of being assigned a case at higher rates over time, with between 89% and 93% completion in years 2 through 4. Interviews with youth within the first 30 days also increased as the project matured. The four activities that had lower rates in Figure 4 are intended to be ongoing throughout the discovery and engagement phase, and may not be ready to occur in the first 30 days. DCS again revised the FSC Process Standard of Work in 2019 to reflect lessons learned and best practice.

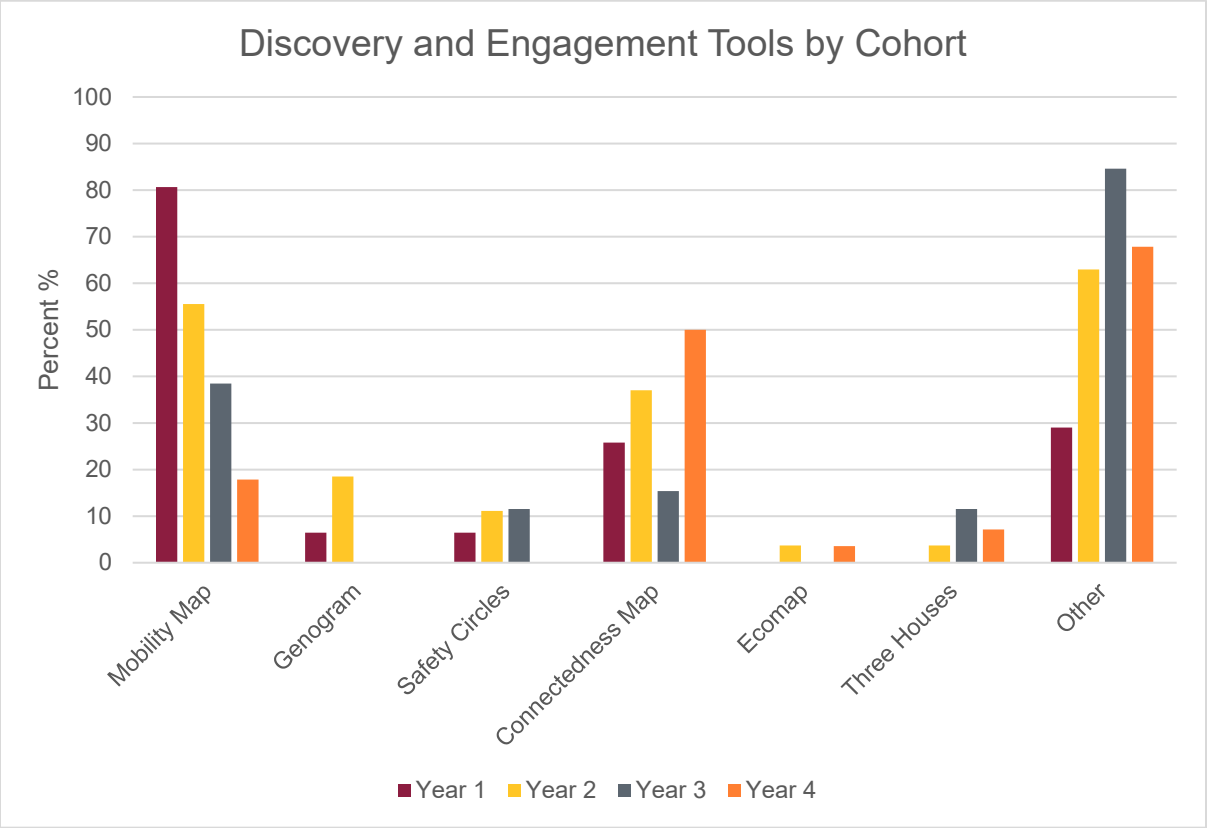
Figure 4



As shown in Figure 5, FES's reported using Mobility Maps and Connectedness Maps most frequently. Over time, FES's increasingly utilized a variety of engagement activities while decreasing their use of Mobility Maps. Engagement activities included genograms, safety circles, ecomaps, Three Houses, Tree of Life, All About Me Book, and 3-5-7 model activities. FES's were trained in the 3-5-7 Model in the third year and began utilizing these activities in years three and four. The Department found the 3-5-7 Model to be compatible with the Family Finding Model and enhanced rapport building with children. FES's worked to adapt activities to meet the needs of the child based on age, capacity of the child, child interest and the ability to focus during the time spent with the FES. For example, a FES may engage a child while playing basketball, going for a walk or taking a drive. There was no requirement for how many or which activities the FES's use therefore the "other" category in Figure 5 accounts for the Tree of Life, All About Me Book, 3-5-7 Model activities or other engagement activity adaptations.

Activities such as interviewing kin, initiating database searches, and sharing information with current DCS Specialists were at times initiated in the first month. Database searches were conducted through the DCS Family Locate Unit, Lexis Nexis, Seneca, White Pages, Zaba Search, and social media.

Figure 5

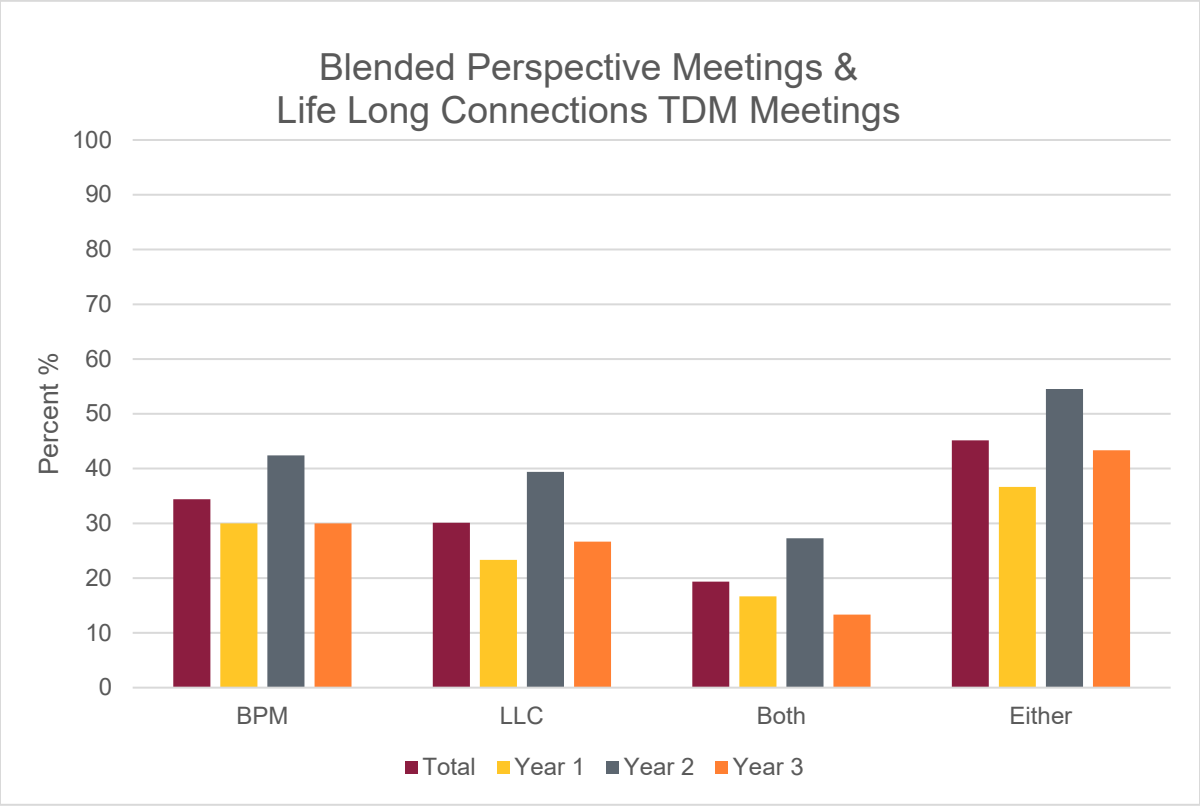


The Action Planning and Follow-up phases of Family Finding aim to gain family member's support and input for the child's permanency plan. During these phases, Blended Perspective Meetings (BPM) and Life Long Connections Team Decision Making (LLC TDM) meetings are held. BPMs seek to identify family and fictive kin who care about and can support the child, identify the child's strengths, and identify the child's greatest unmet needs. LLC TDM meetings aim to plan for the child's future by developing an emotional and relational support plan, placement plan, and legal permanency plan.

Although the fidelity tool included information about BPMs and LLC TDM meetings, that information was difficult to analyze as the tool is completed at different times throughout the case. The FSC workbook provides useful data regarding BPM and LLC TDM meeting completion. BPM and LLC TDM meeting data for Year 4 was not included as over half the cases from that year had been open less than 3 months when the information was pulled from the FSC workbook (note that Year 4 was only 3 months in duration). Figure 6 shows that overall, a BPM was held for 34% of cases and a LLC TDM meeting conducted for 30% of cases. Just under 20% of cases had both BPM and LLC TDM meetings. There was an increase in BPMs and LLC TDM meetings

conducted from Year 1 to Year 2, but a decrease from Year 2 to Year 3. According to the description of standard work, a BPM should be considered when: “family connections are unestablished or family members may not know the child; multiple family members have expressed interest in being a placement option, or when family members have been located; however, no placement options have been identified.” With Family Finding almost all children/youth should have a BPM once family connections are engaged. At times there were barriers to scheduling the BPM and at other times the case moved quickly to the LLC TDM meeting without a BPM. The Statewide Coordinators made extra efforts in Year 3 to increase the fidelity with regard to utilizing BPMs and efforts continued through Year 4 and with the new contract to ensure all children are offered the BPM.

Figure 6



The ASU evaluation team conducted observations of BPM and LLC TDM meetings in Years 1 through 3 of the demonstration project. It was observed that these meetings followed a consistent format. For the BPM, the FES provided an agenda, welcomed attendees, presented the ground rules for the meeting and facilitated introductions of all participants. All individuals in attendance at the BPM were asked to introduce

themselves with name and affiliation, and sign a confidentiality form. The FES then offered a summary of the child's background including culture, date placed in care, number of living arrangements, number of schools, and number of family connections. On occasion, when the child was not available in person, attempts were made to connect the child to the meeting by telephone. Other family members also had the option of joining by telephone. The DCS Specialist was responsible for arranging transportation for the child to attend the BPM. The structure of the BPM included reviewing the child's strengths/family strengths, needs apart from services or behaviors, and developing a statement of need that represented the child's perspective. Finally, next steps were delineated according to "who," would do "what," and "when." The LLC TDM meeting followed a similar structure with a TDM Facilitator opening the meeting, conducting introductions and reviewing the statement of confidentiality and LLC TDM meeting guidelines. It was observed that written guidelines were available to TDM Facilitators who were new to the role or who needed assistance. The LLC TDM meeting revolved around discussing the child's living arrangement, permanency goal, concerns, and what was currently working, and ended with discussion of a plan. After the LLC TDM meeting, it was the FES's role to follow-up with the child and family to ensure services were in place as needed prior to closing out the FSC service.

Engagement and Satisfaction

Engaging children and families in the services offered is a fundamental step in promoting change. Involving children and caregivers in the helping process and making them feel "empowered, supported, respected, and understood" is associated with a number of positive outcomes (Alpert & Britner, 2009, p. 137). For example, caregivers who are more actively engaged are more likely to comply with services and case plans. Increased compliance, in turn, is associated with decreased likelihood of out-of-home placement and maltreatment re-reports and increased likelihood of reunification (Fuller & Zhang, 2017; Littell, 2001). Similarly, child engagement can increase participation in services. Children who feel heard and understood by their child welfare workers report having a better working relationship with their child welfare workers (Bessell, 2001). This positive relationship helps facilitate their participation in services.

To understand children and caregiver perspectives on engagement and satisfaction with FSC, interviews were conducted and they were asked to report on their experiences with their FESs. Children completed a 7-item engagement survey and caregivers a 22-item survey. The surveys (see Appendix A) included questions adapted from the Client Engagement in Child Protection Services survey (Yatchmenoff, 2005), and included questions that related specifically to the responsibilities of the FES. Children and

caregivers rated each item on a scale from 1 (strongly disagree) to 5 (strongly agree). In total, 28 children in Years 1 through 3, and 17 caregivers in Years 2 and 3, completed the survey. The following seven domains were assessed:

- Working relationship: the interpersonal relationship between the FES and the child and caregivers
- Buy-in: children's and caregiver's commitment to the helping process
- Receptivity: children's and caregiver's openness to receiving help
- Trust: the belief that the FES can be trusted
- Expectancy: the perception that FES involvement will change things for the better
- Understanding: the belief that FES understands the child and caregiver and their circumstances
- Advocacy: the feeling that the FES has advocated for the child and caregiver

Overall, children and caregivers reported high levels of engagement with their FES. Children rated their FES highest in terms of understanding, reporting that they felt respected (M = 4.75, SD = 0.52) and understood (M = 4.64, SD = 0.56) by their FES, and also that their FES took the time to get to know them (M = 4.61, SD = 0.63). Caregivers reported high levels of expectancy, buy-in, and advocacy, noting that they felt like things would get better for their child because of their involvement with the FES (M = 5.00, SD = 0.00), that working with their FES had given them more hope (M = 4.94, SD = 0.24), and that their FES advocated for them (M = 4.94, SD = 0.24). Additionally, both children and caregivers reported feeling like they could trust their FES (M = 4.61, SD = 0.69 and M = 5.00, SD = 0.00, respectively). The near perfect scores across items and small amount of variance within, reflects positively on child and caregiver engagement and satisfaction with FSC.

Despite overall high ratings on all items as seen in Figure 7 (child/youth ratings) and Figure 8 (caregiver ratings), both children and caregivers rated their FES lowest on the same item relating to their working relationship. Children and caregivers reported not feeling like they could just call their FES if they felt the need to talk (M = 3.82, SD = 1.19 and M = 4.31, SD = 0.61, respectively).

Figure 7. Child/Youth Ratings on Engagement and Satisfaction

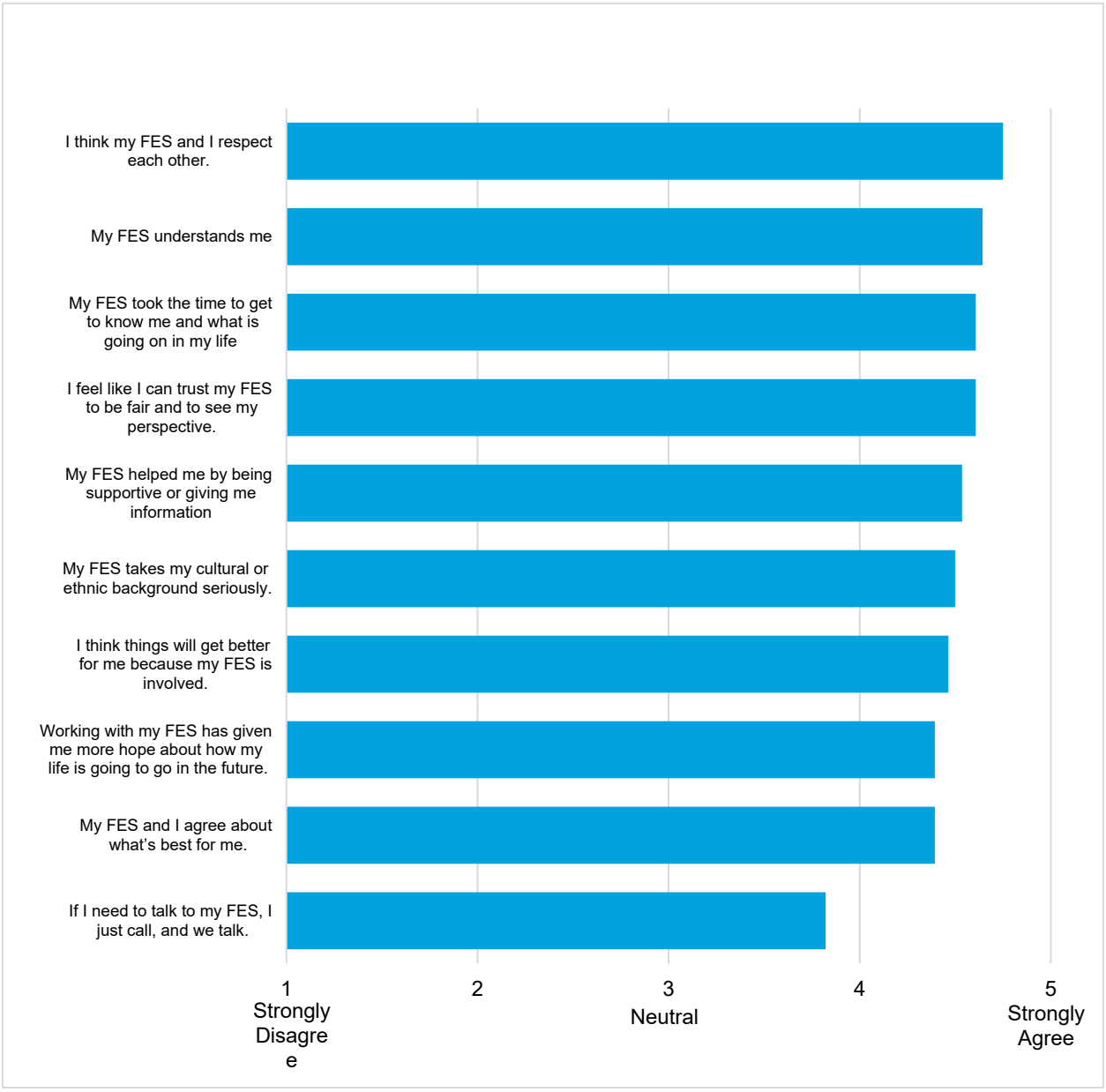
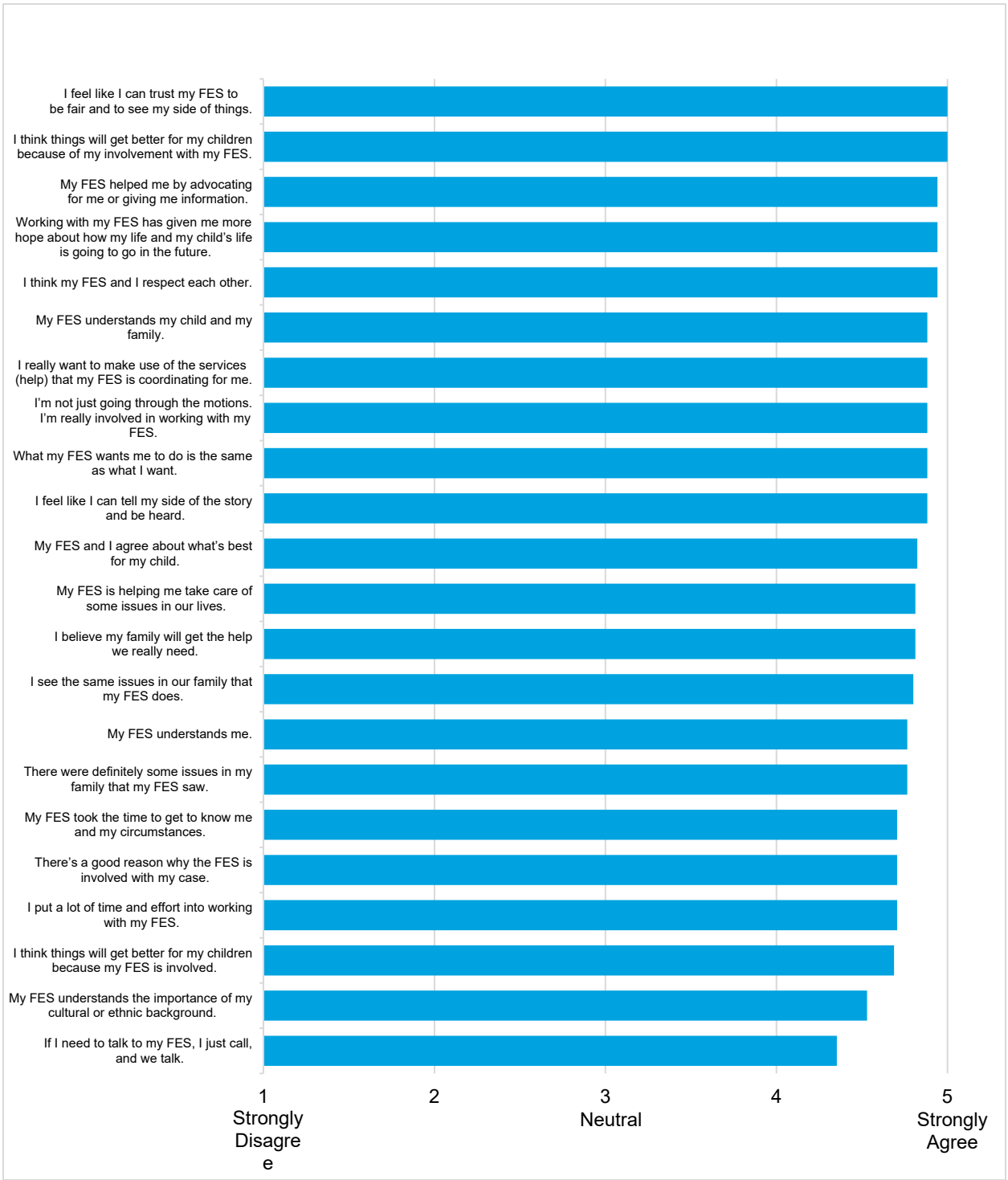


Figure 8. Caregiver Ratings on Engagement and Satisfaction



Implementation Science Approach

The FSC Evaluation Oversight Committee initiated a number of practices consistent with implementation science in their planning for FSC. Implementation science is understood as methods and strategies that facilitate implementation of evidence-based practice and research into regular use. Three of these practices were an assessment of organizational readiness prior to the rollout of FSC in each office, periodic assessment of collaboration among stakeholders as it relates to FSC, and once implementation was underway, the use of an implementation assessment (National Implementation Research Network (NIRN) Drivers Best Practices Assessment).

Assessing Organizational Readiness

Organizational readiness is a critical factor for successful implementation because it involves processes occurring at both the individual and organizational levels (Lehman, Greener, & Simpson, 2002). At the individual level, successful change involves personal motivation, trust, and confidence in the mission of the agency and its goals, and the perception that sufficient resources to accomplish tasks are available. The organizational level involves dynamics such as leadership adaptability, support for innovation, and organizational infrastructure that promote or impede movement from one stage to another (Lehman, et al., 2002). The Organizational Readiness for Change survey (ORC) (Lehman, et al., 2002) includes 115 Likert-type items scored on a 5-point agree-disagree response scale. The items are organized into six major areas: staff guidance, training needs, current pressure, strengths and challenges, perception on personal professional development and current work environment.

ASU worked with the FSC Evaluation Oversight Committee to adapt the ORC to meet the needs of FSC. ASU administered the adapted survey utilizing the Qualtrics online survey program following an orientation on the demonstration project evaluation to each site-based team (SBT). For each site, a link to the Qualtrics survey was emailed to individuals identified as being key stakeholders in the implementation of FSC. The first survey was administered in July 2016 to “champions of FSC” within the Tempe and Avondale DCS offices. Subsequently, the survey was administered to 11 SBTs as the intervention was rolled out in each office/unit with the final administration occurring in July 2018. Two implementation units located at the South Mountain Office did not receive the survey at rollout as ASU was not aware of their orientation meetings.

Data from the completed surveys were analyzed utilizing SPSS software (Statistical Package for the Social Sciences). Analysis of frequencies was completed for all 115 Likert-type items in the survey, and a report was shared with the FSC Evaluation Oversight Committee and the SBTs. Table 1 shows the domains addressed and items with more than 50% agreement across all offices/units surveyed.

Table 1. Aggregate Findings across Six Domains of Organizational Readiness

ORC Domain	Items with > 50% agreement
Staff need guidance (15 items)	1. Assessing client needs 2. Using client assessments to guide case planning 3. Reviewing client assessments to document client improvements 4. Matching client's needs with services 5. Referring clients/families to appropriate programs 6. Improving rapport with clients 7. Engaging parents in placement and permanency decision pertaining to their children 8. Setting specific goals for improving services 9. Evaluating staff performance 10. Improving relations among staff 11. Improving communication among staff 12. Improving record-keeping and information systems
Areas in which respondents need training (7 items)	1. New laws or regulations 2. New methods/developments in their area 3. New equipment or procedures being used or planned
Sources of current pressure (6 items)	1. The people being served 2. Program supervisors or manager 3. Local public policy makers or legislative overseers 4. Community groups
Strengths and challenges (30 items)	**Strengths**: 1. Effective management at their agency 2. Staff training and continuing education are priorities in their agency 3. Facilities are adequate for conducting meetings with families 4. Supervisors are capable and experienced 5. Learned new skills or techniques at a professional training in the last year

ORC Domain	Items with > 50% agreement
	6. Much time and attention are given to staff supervision when needed 7. Convenient access to computer, internet, and e-mail 8. Agency has adequate space to allow for privacy when needed to individual and family meetings 9. Agency holds regular in-service training 10. Staff are well-trained 11. Meet frequently with supervisors about client needs and progress 12. Program and management decisions for their agency are well planned **Challenges**: 1. Frequent staff turnover is a problem 2. Larger support staff is needed to help meet needs of their agency 3. Budget at their agency does not allow for attendance at professional trainings 4. Program does not have enough staff to meet current client needs 5. Staff are not able to spend the time needed with clients 6. Support staff in their agency do not have the skills needed to do their jobs
Perception on their personal professional development (26 items)	1. Have the skills needed to facilitate and engage in effective team and family meetings 2. Staff seek their advice 3. Satisfied with their job 4. Are considered an experienced source of advice about child welfare practices and procedures 5. Feel appreciated for the job they do at work 6. Are effective and confident in doing their job 7. Are able to adapt quickly when they have to make changes 8. Continuous career development is a priority 9. Give high value to the work they do 10. Regularly influence the decision of other staff they work with 11. Accomplish whatever they put their mind to 12. Do a good job of updating and improving skills

ORC Domain	Items with > 50% agreement
	13. Staff seek their opinions about practice 14. Willing to try new ideas even if others are reluctant 15. Have the skills needed to conduct effective individual interviews 16. Frequently share their knowledge of new practices with other 17. Proud to tell others where they work 18. Like the people they work with 19. Viewed as a leader by their staff 20. Consistently plan ahead and carry out their plans
Current work environment (31 items)	**Strengths**: 1. Frequently hear good ideas from other staff for improving practices 2. Case planning decision for clients often get revised by supervisor 3. General attitude of agency is to accept new and changing technology 4. Staff members work together as a team 5. Duties are clearly related to the goals for their agency 6. Staff are given broad authority in making decisions about how to best support families 7. Staff are given broad authority in making decision about how to protect children 8. Mutual trust and cooperation among staff in your agency are strong 9. Agency operates with clear goals and objectives 10. Staff can try out different techniques to improve their effectiveness 11. Staff at their agency get along well 12. Staff are quick to help one another when needed 13. The formal and informal communication channels in your agency work very well 14. Staff members always feel free to ask questions and express concerns 15. Management for your agency has a clear plan for its future 16. They feel encouraged to try new and different techniques

ORC Domain	Items with > 50% agreement
	Challenges: 1. Some staff members seem confused about the main goals for the agency 2. The heavy staff workload reduces the effectiveness of the agency 3. More open discussions about program issues are needed where they work 4. Staff members at their agency often show signs of high stress and strain 5. Staff members are given too many rules in their agency

Collaboration

The general purpose of the Wilder Collaboration Inventory is to help identify the strengths and potential weaknesses shown to be important in collaborative projects across 20 key areas (Mattessich, Murray-Close, & Monsey, 2001). There are 40 statements included in the Wilder Collaboration Factors Inventory. Respondents were asked to indicate their agreement with each statement on a six-point Likert-type scale with responses of: 0 = Strongly Disagree, 1 = Disagree, 2 = Neutral, 3 = Slightly Agree, 4 = Agree, and 5 = Strongly Agree. Each statement is included in one of 20 subscales representing an area of collaboration. The Wilder Collaboration Inventory was first administered to the Statewide Implementation Team members in September 2016 (*N* = 40), then again in 2017 (*N* = 14), and 2018 (*N* = 25). Findings from all three years of survey administration are provided for purposes of comparison (see Table 2). In 2018, DCS's FCS Project Management Team experienced changes to their organizational structure that may have impacted respondent feedback: i.e., management reorganization in February; FSC Statewide Coordinator voluntary turnover (relocation and promotion) and hiring during the summer; and FES high attrition rates internally and externally.

In 2018 there were seven areas that continued to have relatively high average scores (4.0 or higher on a 5.0 scale). Members continued to feel the timing of the collaborative project was right and that the group held a shared vision. Members also continued to indicate their commitment to the project and reported there were clear channels of communication as well as clearly defined goals. Members continued to report feeling that their organizations would benefit from their participation in the project and that the

right cross-section of stakeholders were involved in the project. Lastly, respect for other group members remained high (*M* = 4.3).

The lowest rated subscale across the three years was sufficient human and financial resources. This is understandable given that the rollout did not match the initial plan, and there was attrition and turnover within the project over time. With the exception of history of collaboration, all subscale scores increased from Year 1 to 3.

Implementation Drivers Best Practice Assessment

At implementation, the Evaluation Oversight Committee made the decision to implement the Implementation Drivers Assessment Process from the National Implementation Research Network (NIRN) (Fixsen et al., 2009). The assessment was first completed January 26, 2017. Based on the assessment, an action plan listing the individual responsible for each item, target dates of completion, and priority was finalized April 19, 2017. A decision was made to update the action plan at each monthly meeting beginning in October 2017. In April 2018, the Evaluation Oversight Committee took over responsibility for updating the action plan and leading the monthly discussion of the items from ASU. This change was purposeful to contribute to the sustainability of the practice beyond the evaluation.

Table 2. Findings from the Wilder Collaboration Factors Inventory FSC Stakeholder Survey

Factors	Years								
	2016			2017			2018		
	n	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*
History of Collaboration	40	3.6	1.3	16	3.8	1.0	25	3.4	1.1
How Members Feel the Group is Viewed by the Community	40	3.2	1.5	16	3.5	.61	25	3.5	.71
Favorable Political and Social Climate	40	4.0	1.0	16	4.1	.70	25	4.0	.78
Mutual Respect and Trust	36	3.4	1.4	14	3.9	.80	24	3.6	.76
Members Share a Stake in Both Process and Outcomes	38	3.8	.67	14	3.9	.75	24	4.1	.73
Proper Time Given to Confer w/Colleagues and Members Able to Speak for Their Entire Organization	36	3.6	2.0	12	4.0	.51	23	3.6	.79
Flexible and Open to Different Approaches	37	3.7	1.6	12	4.0	.85	23	3.8	.77
Clear Roles and Responsibilities among Group Members	37	3.4	1.3	12	3.4	1.3	23	3.5	.74
Adaptability of the Group	36	3.6	1.3	12	3.8	.70	23	3.7	.73
Working at an Appropriate Pace	36	3.6	1.5	12	3.7	.80	22	3.7	.92
Strength of Communication	36	3.6	.90	12	3.6	.90	22	3.8	.51
Level of Informal Relationships and Communications	36	3.9	1.4	12	4.1	.62	22	4.1	.75
Goals are Clear, Understood, and Reasonable	35	4.0	.65	12	4.2	.65	22	4.3	.70
Shared Vision	35	4.0	1.3	12	4.1	.56	22	4.3	.67
Group has a Unique Purpose	35	3.8	1.3	12	3.8	.57	22	3.9	.88
Sufficient Human and Financial Resources are Available	35	2.9	1.7	12	3.0	1.7	22	3.1	.95
Appropriate Cross-Section of Members	35	3.3	1.4	14	3.6	.79	24	3.6	.88
Self Interest	38	4.4	.72	14	4.5	.52	24	4.5	.58
Ability to Compromise	38	3.4	.79	14	3.6	.84	24	3.5	.80
Skilled Leadership	38	4.4	.95	12	3.6	.99	22	4.4	.90

Structure

The structure of FSC had multiple layers of accountability and support from the state to site levels. Key committees included the Statewide Implementation Team, the Communications Committee, and the Evaluation Oversight Committee. Key to fidelity was the Statewide Coordinator role, a position responsible for overseeing quality assurance. The Statewide Coordinators encouraged the sites to hold regular monthly meetings that were structured and focused. Over time the Statewide Coordinators improved and standardized the manner in which the FES's presented children's progress at the SBT meetings. The discussions in the SBT meetings led to improvements in the appropriateness of referrals for FSC. For example, initially youth who were about to age out of the child welfare system were being referred, which did not allow sufficient time for the FES to work with them. The Statewide Coordinators also monitored the use of BPMs and LLC TDM meetings, and encouraged their use. Thorough documentation and improving the FES workbooks and rollup of the workbooks was also an initiative of the Statewide Coordinators. A FSC Process Standard Work was developed and updated to define the frequency of required activities expected of FESs, and of all those involved in the project.

The monthly SBT meetings at each site were organized by identified staff within DCS to include the FSC Statewide Coordinator, DCS Specialists, Supervisors, Program Managers, and the FES to discuss children involved in FSC and potential referrals. The focus of SBT meetings was to provide updates on the children engaged with the FES, and to collaborate and identify needs, services, placement options for children and families, and ways to locate and increase family engagement. To gain an understanding of the fidelity of the FSC SBTs, observations and interviews were conducted annually in each implementation office. SBT members generally present at the SBT meetings included the DCS Program Manager, Supervisor, a Program Development representative, a FES (DCS or Arizona Children's Association (AzCA) and if applicable an AzCA Supervisor. Six questions created by ASU were used as a guide during the observations/group interviews (see Appendix B). The common themes discussed involved FSC strengths and challenges, and the influences of FSC on daily work and relationships with other staff within the office. The themes are described below.

Strengths. During the observations/interviews, the following themes were commonly stated regarding the strengths of FSC:

- Collaborative discussions occur between DCS and FESs to identify needs and services for children and families and ways to increase family involvement.
- Focus is on connections for the child, not just living arrangements.

- The FSC process provides the opportunity for children to discuss themselves and they enjoy the engagement activities.
- DCS Specialists are beginning to do activities with children on their caseloads who are not part of FSC.
- The SBT meetings provide opportunities to discuss the children in detail and make referrals to FSC.
- SBT members discuss the importance of DCS Specialists attending SBT meetings during the discussion of children on their caseloads.
- FES provides creative updates as to the children they work with (i.e. PowerPoint presentations, flip charts/poster boards, write-ups).

Challenges. The following themes were identified over time as challenges the SBT members encountered with FSC:

- Communication between FES and DCS Specialists are at times not occurring as quickly as intended when the FES is assigned a child.
- FES initiated referral forms are sometimes incomplete.
- New programs/initiatives occur at once, resulting in high and unrealistic expectations.
- Not all of the DCS Specialists attend the SBT meetings when discussing a child on their caseload, thus resulting in an inability to discuss the child's needs and family efforts.
- Not all the children referred to FSC are appropriate (i.e. close to aging out, current living arrangement does not meet the criteria)
- Not all SBT members are "bought in" to FSC.
- SBT meetings are not organized/implemented as designed (i.e. not occurring monthly and no agendas and/or scribe)
- External challenge: A group home has limitations as to when a youth can have phone calls, visits, and how many individuals can visit.
- Limitations as cases with large sibling groups take up the 'slots' that are allotted to the FES and then there is an inability to refer more cases.
-

Work Influences. The following items represent themes in response to the question of how FSC affects workload:

- Minimizes the DCS Specialist's workload, and in turn, benefits the family. However, one office reported the workload is the same, yet manageable as families are located and there is quality time to spend with the child/family.
- Provides the ability to look outside of the box regarding who "kin" is.
- Allows the use of social media to assist in looking for family.
- Increases communication with parties involved with the case.

Relationship Influences. Below are responses of how FSC, in general, influences relationships:

- Provides the ability to share and discuss FSC with the courts.
- Out-of-home caregivers are excited about FSC.
- Appears the parents/families have good relationships with non-DCS FESs and aids in disclosure of information that could help the children.
- Increases collaboration among DCS and other community partners.
- Increases interactions with family, connections, and the child.
- Everyone is working together for the child.

Overall, the SBT meetings observed and members interviewed reflected positively on FSC because children were believed to be benefiting by finding connections. SBT members regularly stated that they would like to see FESs assigned to children at initial removal, rather than after the child had been in care for years, i.e., they recognized it as a best practice. Since implementation, SBT members noted that DCS Specialists were engaging in FSC activities to locate family such as Mobility Mapping with children on their caseloads who were not part of the FSC program. In addition, FESs provided coaching to DCS Specialists who wanted to refer children but could not because they were not part of the intervention. This included consulting on cases where children were in care for a long period of time. The findings from the observations and group interviews were presented to the Statewide Coordinators on an ongoing basis and they in turn considered and acted upon them to achieve better success.

Context

Planning for the demonstration project coincided with a structural and functional reorganization of DCS, commanding resources and focus. It is important to keep in mind that although Arizona selected an intervention to reduce the number of children placed in congregate care, other reform efforts were occurring within the Department and outside through partner agencies, as well as legislative changes that had a potential impact on the manner in which families were engaged by DCS, and the number of children entering care and the length of time to permanency. These changes serve as significant context for the implementation and evaluation of the demonstration project and may shape outcomes. Information to describe the context was collected through interviews with 15 key stakeholders (see Appendix C), attendance at waiver-related meetings, and review of published materials available over the demonstration project period. Twelve significant contextual factors are described below.

1. Child Family Service Review (CFSR) and Program Improvement Plan (PIP)

Following the most recent CFSR in 2015, DCS specified in its PIP an expanded kinship search and foster family recruitment process so that more children would be placed quickly in family-like homes. The PIP included data monitoring, training on Family Finding, enhanced kinship search, LLC TDM meetings, and technical assistance from the National Resources Center for Diligent Recruitment to include foster family recruitment, engagement and retention. Consistent with the PIP, targeted permanency activities were included in the annual DCS Strategic Plan from FY 2017 through FY2020.

2. SAFE AZ Model

The SAFE AZ model renovation began in 2015 with the statewide rollout occurring in summer 2017 and concluding in spring 2018. The model aims to make the right safety decision for every child, using clearly defined process guidelines focused on accuracy, consistency and transparency resulting in the best outcomes for children and families. The SAFE AZ model should impact entries, living arrangements, and permanency as it attempts to increase family involvement, whether it is for connections and caregivers, or through empowerment to make decisions, set goals based on family strengths and access-needed resources by understanding the family's unique strengths and needs.

3. Community Engagement

Community engagement includes both the ongoing development of a community-based service array that meets the needs of children and families, and the active engagement of community supports such as faith-based organizations and other community organizations. The following community engagement initiatives were developing prior to and during the demonstration project.

- Safe Reduction Initiative: For two years (2014 – 2016) Casey Family Programs led an initiative that involved DCS, judicial, attorney, and stakeholder workgroups to promote community engagement, consistent decision-making, targeted services, and other related efforts to safely reduce the number of children in out of home care in Maricopa County (Community Alliance Consulting, 2020).
- Glendale Strong Family Network (GSFN): Part of the Safe Reduction Initiative, this network was developed by a community engagement subgroup that focused its efforts on prevention and connecting families to services in the Glendale area (Community Alliance Consulting, 2020).

- Arizona CarePortal: Launched in Pima County, December 2015, and in Maricopa County September 2016 during the demonstration project's pre and initial implementation phase, the CarePortal provides a means for Department staff to submit online requests for resources to meet specific needs for children and families (e.g. clothes, crib, home repair etc.). In turn, an alert is sent to participating church community partners to fill the need based on available resources. Since its initial launch, the CarePortal has recruited over 100 churches that have assisted meeting the needs of thousands of children in Arizona (CarePortal, 2020; Office of the Arizona Governor, 2020).
- Arizona Families Thrive: Launched in April 2018 (Year 2 of the demonstration project), this monthly online newsletter provides information pertaining to community supports, articles of interest to foster and adoptive parents, in addition to promising practices in the field of child welfare. Information from these newsletters were brought to a wider audience through implementation of a statewide Arizona Families Thrive Conference in June 2018 and October 2018 to enhance community collaboration around child welfare topics and innovation (Miller, 2018).

4. Placement Administration

In the spring of 2016, Placement Administration began efforts to move children from congregate care settings, primarily shelters and group homes, into family-like living arrangements. Initially the focus was finding foster care for young children age 10 and under. Given considerable success, the focus expanded to older youth and youth with higher level needs, including pregnant and parenting teens. The Placement Administration Specialist has found success through building relationships with licensing agencies and making placements with foster parents. In addition to looking through the lists of children living in shelters and group homes, Placement Administration also receives referrals from DCS Specialists for specific children and youth. Since these efforts began, Placement Administration has moved 464 children to family-like settings, with six children pending moves to family-like settings (A. Fox, personal communication, 4/21/2020).

5. Clinical Supervision

Strengthening clinical supervision techniques for supervisors positively influences employee satisfaction and outcomes for children and families (Collins-Camargo & Millar, 2012). Enhanced clinical supervision was a focus of practice improvement during Year 1 of demonstration project implementation as the Department began tracking the use of already developed tools (e.g. Supervisory Case Progress Review tool and the Clinical Supervision section in the Child Safety and Risk Assessment). A Supervision Coach Program began July 1, 2019. Trained Supervision Coaches meet with DCS Program

Managers and Supervisors monthly with the intent of increasing fidelity of practice. The Supervisors and Program Managers identify elements of clinical and/or administrative practice that they wish to work on in the coaching sessions (L. Milden, personal communication, 5/4/2020).

6. Pre-CORE and CORE Training

Developing a highly trained workforce is essential to the mission and vision of the Department in ensuring the safety, well-being, and timely permanency of children involved with the state's public child welfare system. The Department collaborated with ASU and ACTION for Child Protection to revise and develop training curriculum to improve engagement with child welfare-involved families and system partners to assess safety. For example, during Year 1 of the demonstration project implementation, the Department and Arizona State University revised Pre-Service CORE and the CORE training curriculum to orient employees to DCS's mission and added an overview of FSC. During Years 1 and 2 of the demonstration project, ACTION for Child Protection facilitated the SAFE AZ safety assessment model training to provide employees knowledge and practice in safety assessment, safety management, and family engagement. Training on family engagement, comprehensive safety decision-making, and least restrictive safety planning may impact length of stay in congregate care because staff are now educated on family finding and engagement activities to promote reunification and placement with relatives. Enhanced clinical supervision has helped to ensure these practices are in place.

7. Hotline Report Decision Tool

The centralized State of Arizona Child Abuse Hotline is the first point of contact into Arizona's public child welfare system. Arizona engaged in an improvement effort at the Child Abuse Hotline to standardize screening decisions so that screened-in communications are those with a current or recent concern of child maltreatment and sufficient information to locate the child and family. The Department also developed a standardized report decision-making tool with support of internal staff and community stakeholders. The new Hotline decision-making tool was implemented on February 1, 2016 (B. Guillen, personal communication, October 12, 2018). Reduction of wait times for callers was a secondary benefit of this change.

Furthermore, the Arizona Child Abuse Hotline modified internal practices pertaining to the implementation of investigation response times focusing on the vulnerability of young children in determination of report response criteria. With the redefinition and the

internal modification of practice the number of higher priority reports with faster response windows ultimately increased, and simultaneously the number of lower priority reports with longer response time windows decreased.

Arizona Child Abuse Hotline staff continue to work diligently on maintaining fidelity of practice through on-going assessment of inter-rater reliability measured through the standardized quality assurance system (Arizona Auditor General, 2017). Through implementation of innovations at the level of the Hotline such as the standardized decision-making tool, wait times remain low and consistency with decision-making remain a prioritized focus with continuous quality improvement efforts. In turn, such an improvement addresses capacity issues of caseload size. Therefore, allowing for child welfare staff to better engage with families, to refer families to the right services at the right time to help them succeed, and to reduce waitlists when services are needed to prevent child removal and reentry into out-of-home care, such as congregate care (ADCS, 2017).

8. Kinship and Foster Parent Training and Licensure

Kinship caregivers are not required to be licensed (ADCS, 2020). The requirements to be an unlicensed kinship caregiver are: an approved home study by the court, at least 18 years of age, all adults in the home must clear DCS and criminal background checks; and meet basic health and safety requirements (ADCS, 2017). Kinship caregivers are encouraged to become licensed in order to receive additional funding and support that comes with licensure; however, licensing standards may sometimes pose barriers to kinship caregivers (Beltran & Epstein, 2013). In previous years, the licensing process required potential foster parents to attend 40 hours of in-person training, which became a “roadblock” for those that could not attend due to busy schedules (DaRonco, 2018). In an effort, to eliminate barriers to fostering, in early 2018 and during Year 2 of the demonstration project implementation, the Department began to offer a streamlined pre-training program known as Foster Parent College. The Foster Parent College offers potential foster parents the ability to complete 11 online courses via computer, tablet, or smartphone (DaRonco, 2018). Potential foster parents are still required to attend 15 hours of in-class training, but have greater flexibility in how to complete them (DaRonco, 2018). Increasing flexibility, and streamlining the training program needed to obtain licensure may result in an increase of kinship and foster home availability and decrease in the congregate care population.

9. Diligent Recruitment and Retention of Foster Home Placements

In an effort to improve the placement of children in least restrictive and family-like settings, DCS has partnered with Foster Licensing Agencies to recruit the "right number and right profile of families" to provide children in out-of-home placements with stable, healthy, and safe homes (ADCS, 2018; G. Vanasse, personal communication, January 4, 2019). Recruiting and retaining foster parents in Arizona has been an on-going effort of the Department in coordination with community-based providers and child welfare stakeholders. DCS continues to coordinate internally and with community-based providers and stakeholders to increase awareness and interest in foster parent licensing through the community. For example:

Arizona Kids Consortium is comprised of a group of foster care and adoption agencies in Maricopa County who work together to educate the community about the growing need

for foster and adoptive parents, as well as offer informational orientations throughout the community (Foster Arizona, 2020).

AdoptUSKids educates families about foster care and adoption, connects children to families, and gives child welfare professionals information on service array (AdoptUSKids, 2020).

Further, the Department continues active diligent recruitment strategies to increase the number of children in family-like settings. For example:

Recruitment Estimator is a tool that uses historical data to project the number of homes likely to be needed in the following year and then to break that number down by location and child demographics (G. Vanasse, personal communication, January 4, 2019).

Children's Heart Gallery (CHG) seeks permanency for children by featuring those who are not able to return home and are most challenging to place, and brings together community volunteers to assist in the process (e.g., photographers, hairstylists, etc.). In 2017, 119 children were photographed for the CHG, and 29 children featured in the CHG exited care to adoption (ADCS, 2018).

Community partnerships and recruitment strategies have shown to be an opportunity to raise awareness and gain participation in licensed foster care. Increasing foster parent

licensing awareness may decrease the congregate care population and increase children living with families.

10. Child Specific Recruitment (CSR)

Kinship care is the preferred living arrangement for children entering out of home care (Lee, Choi, Lee, & Kramer, 2017). Relatives and fictive kin provide many benefits for children separated from their parents, often providing support and frequent contact with birth parents and siblings. Relative and fictive kin are able to provide increased stability for children in their care, as there are fewer placement disruptions (Lee et al., 2017; Rosenthal & Villegas, 2011). Additionally, children in kinship care are less likely to re-enter foster care upon reunification disruptions (Lee et al., 2017; Rosenthal & Villegas, 2011). The Department increased active efforts to ensure placement with relatives or fictive kin when children enter out-of-home care and to avoid congregate care placements through collaborative efforts with contracted agencies.

The Child Specific Recruitment (CSR) program is one such effort, as it explores past connections for children and attempts to reconnect them with those connections and to find adoptive homes for children whose permanency goal is adoption (H. Medina-Mora, personal communication, November 19, 2018).

Arizona Children's Association (AzCA), a contracted provider for the Department, implemented the CSR program in July 2013. AzCA immediately begins looking for natural connections for permanency, whether it is a relationship or an adoptive home in the future, using search tools and the Family Finding model developed by Kevin Campbell (H. Medina-Mora, personal communication, November 19, 2018). Once AzCA exhausts all efforts with family finding and a caregiver has not been found through the natural connections, the agency may use community recruitment efforts, which includes profiles, videos, and postings of youth to find an adoptive home from the community who are licensed or certified to adopt (H. Medina-Mora, personal communication, November 19, 2018).

11. Peer Mentor Program

A Peer Mentor Program was implemented with FSC in January 2019. FSC data revealed that in 2018, 22% of youth engaged in the Family Finding intervention who had relative or kinship caregivers identified chose to remain in congregate care. The FSC Peer Mentoring Program was designed to provide the youth resources to assist them in making informed decisions to improve their well-being, support permanency, and

nurture meaningful connections. The Peer Mentor program was implemented with a relatively small sample of youth who had family living arrangements identified through FSC but chose to remain in congregate care. The Peer Mentor assisted youth with information about resources including education, employment, transportation, housing, advocacy, and how they could continue to receive those same services while living with identified families.

12. Youth Thrive™

The overarching goal of Youth Thrive™ is to achieve positive outcomes by mitigating risk and enhancing healthy development and well-being of youth (ages 11-26). In April 2019, select DCS staff and community members were trained as trainers in Youth Thrive™. They offered their first training in June 2019 and to date have trained 248 individuals including 192 DCS staff. Developed by the Center for the Study of Social Policy (CSSP), Youth Thrive™ is an approach that uses science to identify protective and promotive factors that increase the likelihood that adolescents can develop into healthy, thriving adults. Youth Thrive™ is a framework that functions as a 'lens' for assessing current efforts and for making changes to the policies, programs, training, services, partnerships, and systems that impact young people. The five protective and promotive factors of Youth Thrive™ include: 1. Youth Resilience, 2. Social Connections, 3. Knowledge of Adolescent Development, 4. Concrete Support in Times of Need, and 5. Cognitive and Social-Emotional Competence.

Summary

The process study sought to answer two questions: 1. Was the intervention implemented as designed? and 2. Did the child welfare system support implementation of the intervention in a manner that optimized short, intermediate, and long-term outcomes?

With regard to the first question, children referred to FSC received specialized services to enhance family/fictive kin search and engagement activities, and expanded meeting types to identify ways that significant individuals could become involved with them in meaningful ways. Discovery and engagement activities with the children appeared to be completed earlier over time, and a broader range of family finding tools were utilized as the demonstration project matured. The monitoring of BPMs and LLC TDM meetings was necessary to encourage fidelity to the model. The Statewide Coordinator's efforts at quality improvement helped to ensure the intervention was implemented as designed,

and also augmented to overcome barriers such as the addition of the Peer Mentor program to encourage reluctant youth to transition into a family-like settings.

With regard to the second process question, the implementation science approach adopted by DCS for the demonstration project helped to support implementation of the intervention. Layers of accountability and monitoring were set up to address concerns as they arose, and to carry out essential tasks related to communication and program/policy development. The use of survey tools such as the Wilder Collaboration Inventory and the Organizational Readiness for Change survey helped to identify and address potentially problematic areas early in implementation. The Drivers Best Practices Assessment facilitated a comprehensive approach to monitoring implementation and action planning. The case-based fidelity tool proved difficult to monitor. However, the FSC workbook was developed, improved upon, and provided timely metrics for communication and review. The Statewide Coordinator position was also instrumental in identifying concerns and improving fidelity (i.e., standardizing practice at the site-level) through attendance at SBT meetings and observing BPMs and LLC TDM meetings.

As is common across the human service fields, it can be difficult to encapsulate the many contextual factors potentially influencing the implementation of a new intervention. The goal of the process study was to describe known non-waiver demonstration project related practices at DCS, as well as community efforts, that might impact the congregate care population over the same time-period as FSC. As presented, there were multiple efforts complimentary to the demonstration project undertaken within DCS and the community to connect youth with family, and to support families in order to reduce out-of-home care, and specifically congregate care. These efforts have continued as DCS prepares to implement the federal Family First Prevention and Services Act (FFPSA) in October 2021. Similar to many of the contextual initiatives described above that took place just prior to and during the demonstration project, the FFPSA Act promotes prevention of entry to out of home care, and when out of home placement is deemed necessary, promotes a preference for family-like living arrangements over congregate care. The success of FSC implementation is reflected in the very high ratings on engagement and satisfaction among involved youth and caregivers. Although the child welfare system's support of implementation as described in this section had the potential to optimize outcomes for the intervention, it also had the potential to confound the long-term outcomes by enhancing outcomes for the comparison group.

Outcome Study Findings

The outcome study has nine domains. Each domain is described below along with the respective findings. The first domain, identification and involvement of family/fictive kin was included in the FSC logic model under short term outcomes (see Figure 2).

Family and Fictive Kin Identification and Involvement

Prior to the implementation of FSC, Arizona DCS had search procedures to identify kinship and foster homes for children placed in out-of-home care. However, DCS believed that these practices could be enhanced to increase family engagement, in conjunction with the specialized meeting process and in-home services array. The Department consistently placed children with kinship or foster families at rates higher than the national average. However, children were sometimes placed in congregate care settings directly upon removal. To address this issue, the Department decided to adopt the Family Finding model founded by Kevin A. Campbell.

Using this model, the FES collaborated with the assigned DCS Specialist to mine the electronic and hard-copy case record to identify relatives/kin; engage the child currently in a congregate care placement along with the congregate care staff; encourage the child (age allowing) to talk about important people in his/her life; and reach out to identified relatives and fictive kin found to encourage their emotional support of the child.

To assess the impact on the Family Finding process, a review of FSC workbooks, fidelity tools, and case records was conducted. The review sought to compare family and fictive kin identification and involvement between children/families in the intervention group and treatment as usual (TAU). It was hypothesized that the Family Finding process would result in increased numbers of family and fictive kin identified and involved in the child's case compared to TAU.

Data Sources

Information on family and fictive kin was extracted from three sources. Table 3 summarizes the data sources and data points reviewed from each source.

- **FSC workbook**: data collection spreadsheet completed monthly by the FES, documenting their progress in identifying and involving family and fictive kin.
- **Fidelity tool**: tool completed monthly by the FES Supervisor, documenting adherence to the Family Finding model.
- **Case record**: notes from the child's case record documenting efforts to identify, locate, and contact family and fictive kin.

Three counts were collected from the various data sources. These were:

- **Involved prior to FSC**: the number of family members and fictive kin involved in the child's life in the six-month period prior to the child being enrolled in FSC.
- I**dentified during FSC**: the number of family members and fictive kin found during FSC.
- **Involved during FSC**: the number of family members and fictive kin involved in the child's life after the child was enrolled in FSC until closure.

Table 3. Data Sources and Data Collected for Family/Fictive Kin

	Involved prior to FSC	Identified during FSC	Involved during FSC
FES workbooks	X	X	X
Fidelity tools	X	X	-
Case record	-	-	X

Case Record Review

Information about family members and fictive kin involved during FSC was extracted as part of the case record review mentioned previously. Coders maintained a list of individuals who were identified and contacted in the case record notes and relationship to the child. For intervention children, this included family and fictive kin identified and contacted by the DCS Specialist or the FES within the first eight months of the child's FSC start date, at minimum. For TAU children, this included family and fictive kin identified and contacted by the DCS Specialist after the youth's matched pair's FSC start date.

The case record review also allowed for an examination of the tools FESs used to discover and engage family and fictive kin. As noted in the process study, in the fidelity tools, FESs reported using Mobility Maps and other tools such as interviews, social media, and phone calls most frequently.

The findings as reported in Table 4 indicate that Family Finding did result in a greater number of family and fictive kin identified during FSC compared to before FSC, and a greater number involved in the children's cases compared to TAU. On average, children in the demonstration project intervention had twice as many family and fictive kin involved after their enrollment in FSC than before. In addition, they had three times as many family and fictive kin involved as children receiving TAU. Each element is described in greater detail below.

Involved prior to FSC. The FSC workbooks and fidelity tools both indicate that, on average, four family and fictive kin were involved in intervention children's lives in the six months prior to the start of FSC.

Identified during FSC. The number of family and fictive kin identified during FSC varied considerably in the intervention group. The FSC workbooks indicate that FESs identified between two and 116 family and fictive kin, with an average of 28 family and fictive kin per case. Similarly, the fidelity tools indicate that FESs identified between zero and 115 family and fictive kin, with an average of 25 family and fictive kin identified per case.

Involved during FSC. The FSC workbooks indicate that, on average, seven family and fictive kin were involved in the intervention children's lives after enrollment in FSC. This represents a significant increase from the number involved prior to FSC, $t = 7.84$, $p < 0.001$.

The case record review found that, on average, children in the intervention had over four more family and fictive kin involved in their lives after they were enrolled in FSC than children receiving TAU, $\beta = 4.59$, $p < 0.001$. Youth in the intervention had an average of six family and fictive kin involved, while children receiving TAU had an average of under two family and fictive kin involved.

Discovery and Engagement Tools. Consistent with their reporting in the fidelity tools, FESs noted in their case notes that they frequently used interviews with the children, phone calls with caregivers and other relatives, and social media, particularly Facebook, to identify and engage family and fictive kin.

The FSC workbooks and fidelity tools reported similar numbers of family and fictive kin involved prior to FSC and identified during FSC. Likewise, the FSC workbooks and the case record reviews yielded similar numbers of family and fictive kin involved in the intervention period. The case record review also paralleled reports in the fidelity tools about the types of tools FESs used to identify and engage family and fictive kin. This consistency among the three data sources suggests that the data are reliable across sources.

Table 4. Family and Fictive Kin Involved Prior to FSC, Identified and Involved During FSC

		Intervention			Comparison		
		n	Mean (*SD*)	Range	*n*	Mean (*SD*)	Range
Involved prior to FSC	FSC workbooks	113	3.79 (2.98)	0 - 15		n/a	
	Fidelity tools	104	4.00 (3.36)	0 - 16		n/a	
Identified during FSC	FSC workbooks	113	27.62 (21.23)	2 - 116		n/a	
	Fidelity tools	105	25.02 (21.52)	0 - 114		n/a	
Involved during FSC	FSC workbooks	112	6.87 (3.66)	0 - 20		n/a	
	Case review	72	5.96 (4.93)	0 - 23	67	1.37 (2.04)	0 - 8

Service Needs, Service Referrals, and Service Access

From the point of intake into the child welfare system until permanency, case managers utilize targeted service provision in order to work toward successfully achieving timely permanency for child welfare involved children. Although comprehensive in nature, the effectiveness of the service array is dependent on children and families receiving services that are congruent with their identified needs. Increase in timely service receipt to meet identified needs of the family and child was specified as a short-term outcome on the FSC logic model (see Figure 2).

Prior to the demonstration project, service provision and planning were intended to occur throughout the entirety of a child welfare case, with the DCS family functioning and child safety assessment procedures driving the identification of child and family needs, as well as classification of risk and safety concerns that compromise child safety. These procedures are initiated at initial contact with the family and are continued throughout the investigation and over the life of the case. A reassessment is required whenever major changes in family circumstances occur, at key decision points during the life of a case, and at least every 90 days.

When child and family needs and concerns identified throughout the continuous assessment process are incongruent with referred services, children may remain in restrictive congregate care settings awaiting permanency, and families may experience stagnant progress towards addressing identified needs and concerns. In contrast, when service planning focuses on family engagement and tailored service provision, as within the demonstration project intervention, children may spend less time in restrictive congregate care settings awaiting permanency, and families may experience improved outcomes including reduced re-entry.

With family engagement as a cornerstone of on-going assessment throughout the life of the child welfare case, services are intended to be tailored to each individual family, ensuring that families receive access to timely comprehensive service provision across all identified domains of need. Through the wavier, the Department intended to improve outcomes for children placed in congregate care and their families through enhanced service matching, tailored to the targeted needs and concerns identified throughout the life of the child welfare case. With the use of FESs and expansion of the specialized meeting process as well as Family Finding, team members worked collaboratively with children and their families to identify service needs with increased precision. Enhanced focus and attention to service matching for children in congregate care and their families was intended to identify and subsequently address the child and family's most salient barriers to permanency, safety, and well-being.

To measure the identification of service need, and congruence in service need identification, referral, and access to services, in-depth case reviews of information documented in Arizona's SACWIS system were conducted using the Comprehensive Assessment and Planning Model - Interim Solution (CAPMIS). Reviews were conducted for the entire lifetime of a case.

Specifically, the case reviews sought to:

1. Determine if the identification of service need varied between children/families in the intervention group and comparison group
2. Assess the extent of congruence between service needs, referrals, and access in the intervention group compared to the comparison group
3. Determine if services were accessed more quickly in the intervention group compared to the comparison group

It was hypothesized that participation in FSC would result in better identification of child/family service needs, better matching of needs to services as indicated by referrals, and faster access to needed services compared to the matched comparison group.

Data Sources

Information about service need, service referrals, and service receipt was gleaned from the following components within case records of children in the intervention and comparison groups:

- All reports to the Child Abuse Hotline
- All status communications
- Case notes, Parent Aide notes, Family Preservation and Building Resilient Families Program notes, other service provider notes
- Court reports

CAPMIS Tool

The CAPMIS was developed in Ohio as a standardized, comprehensive procedure for assessing multiple domains of child and family need. The tool was modified to correspond to Arizona's child welfare context. The CAPMIS tool categorizes service needs into four broad areas - maltreatment, adult functioning, parenting practices, and child functioning. Each broad area is then further divided into specific areas of functioning (see Appendix D for the coding tool developed and used in the demonstration project).

Maltreatment considers all types of maltreatment (i.e. neglect, physical abuse, sexual abuse, and emotional abuse) and includes all maltreatment allegations regardless of whether it was an official allegation, a dependency petition was filed, or the allegation was substantiated.

Adult Functioning encompasses the biopsychosocial attributes of the biological parents, caregivers, and other adults that adversely impact the safety, permanency, and well-being of the child. If the child was residing in a congregate care facility such as a group home, this did not include the staff of those facilities. Common attributes in this area include substance abuse, domestic violence, mental health concerns, and history of trauma.

Parenting Practices are those practices that adversely impact the safety and well-being of the child. Parenting practices differ from adult functioning as these are characteristics that are directly related to parenting, rather than adult functioning. Common parenting practice concerns include bonding and attachment, having realistic expectations of the child based on their developmental age and functioning, and the ability to protect the child from harm.

Child Functioning specifically relates to the child engaged in the demonstration project evaluation (i.e. the targeted child). It does not relate to siblings or other children residing in the home. Important components in this area include physical health, cognitive functioning; educational, behavioral and emotional well-being.

Service needs within the areas of functioning were coded for:

- the mother of the targeted child
- the father of the targeted child
- any other fathers to other children residing in the same home as the targeted child
- other adults living in the home
- the targeted child

Coding Procedures

Each case was coded by one reviewer. The reviewer read through the entire case, using the CAPMIS tool to extract information about the date service needs were identified, the services provided to address needs, the dates services were referred, and the dates services were first accessed. A codebook was used to assist reviewers in categorizing the service needs into areas of functioning and a coding guide was developed to assist reviewers in identifying services and referral and access dates.

After completing reviews for the first cohort of children, the reviewers recognized a need for a change in methodology to more accurately capture congruence and time between service needs, referrals, and access to service (i.e., duration).

Year 1 Cohort. Reviewers used the original CAPMIS tool in coding case records for the first cohort of children (*n* = 54). Reviewers first listed service needs in the appropriate area of functioning, noting the date on which each need was identified. Reviewers then listed services and the dates on which the services were referred and first accessed. Lastly, the service needs and referral and access dates were matched. Referrals made within four months of a service need being identified were matched to that service need. In instances where multiple referrals were submitted to address one need, the most relevant and intensive service was matched to the service need. For example, standard outpatient treatment was coded when a parent was referred to standard outpatient treatment and drug testing. A single reviewer did all the matching to ensure consistency across the cases.

Year 2 and 3 Cohorts. A new tool format was developed to code the second cohort of children (*n* = 66). In contrast to the original CAPMIS, the new tool organized service needs by date and not category. Reviewers coded service needs under the month and year in which they were identified. Referrals and service access were coded under the service need that they were intended to address, eliminating the need for matching of needs and referrals post-coding. In instances where multiple referrals were made to address one need, all the services were listed. The same procedure was used to code the third cohort of children (*n* = 19).

Identification, Congruence, and Duration

All three cohorts were used in the analysis of identification of service needs. Given the change in methodology from Year 1 to Year 2 and the completion rate for Year 3, Year 2 was used to examine congruence and duration between service needs, referrals, and access.

Identification. Needs were identified using the categories outlined in the CAPMIS. Needs that met the criteria for multiple categories were coded in all categories whose criteria they met. For example, instances of domestic violence between a mother and father were coded as both Adult Functioning - Domestic Violence Perpetration and Adult Functioning - Domestic Violence Victimization. The analyses presented below include only those needs identified after the FSC start date for the intervention group and after their matched pair's FSC start date for the comparison group.

Congruence. A need was considered to have a congruent referral if at least one referral was submitted to address that need. A referral was considered to have a congruent service if the referred service was accessed. For services that require intakes, such as Parent Aide, attending the intake was considered as accessing the service. On occasion, new needs were identified that could be addressed by a service the child, parent, or family was already receiving. These new needs were coded as having a congruent referral and service. For example, a caregiver may demonstrate unrealistic expectations of her or his children - a Parenting Practice need - during a Parent Aide session. A new referral would not be submitted, as the caregiver was already receiving a service that addresses this need. In this instance, the existing service - Parent Aide - would be coded as the congruent referral and service for the new need.

Percent of services with congruent referrals was calculated for each group by dividing the number of congruent referrals by the total number needs identified. Percent of referrals with congruent services was calculated for each group by dividing the number of congruent services by the total number of referrals.

Duration. Two types of duration were calculated: 1) time between the identification of a need and the submission of a referral, and 2) time between the submission of a referral and the accessing of a service. In instances where more than one referral was submitted to address one need, the referral and access dates corresponding to the most relevant and intensive service were used.

Needs that were addressed immediately, such as admitting a caregiver with suicidal ideation to an inpatient psychiatric facility, had a duration of zero. Additionally, new needs identified that could be addressed by a service that was already in place also had a duration of zero.

Findings

Identification of Service Needs. Tables 5 and 6 summarize findings related to the identification of service needs. Larger *t*-values, and *p*-values less than 0.05, indicate statistically significant differences between groups. As noted above, it was hypothesized that participation in FSC would lead to better identification of service needs (i.e. more service needs identified for issues documented in the case file means that needs are being addressed).

Overall, a statistically greater number of Child Functioning needs were identified in the FSC group than in the comparison group, $t = 1.78$, $p < 0.05$. On average, two Child Functioning needs were identified in the intervention group compared to one in the comparison group. Contrary to expectations, fewer Maltreatment and Adult Functioning needs were identified in the intervention group than in the comparison group. However, these group differences were not statistically significant.

Examining the cohorts individually reveals differences between and within. In the Year 1 cohort, a statistically greater number of Child Functioning needs were also identified in the FSC group than in the comparison group, $t = 3.49$, $p < 0.05$, with over two needs identified in the intervention group on average compared to less than one in the comparison group. More Parenting Practices needs were also identified in the FSC group than in the comparison group, but this difference was not statistically significant.

In the Year 2 cohort, more Adult Functioning and Child Functioning needs were identified in the intervention group than in the comparison group. In the Year 3 cohort, more Maltreatment needs were identified in the intervention than the comparison group. Again, these differences were not statistically significant.

Table 5. Number of Concerns Identified after the FSC Start Date – All Cohorts Combined

	All Cohorts Combined					
	Intervention n = 72		Comparison n = 67			
	M (SD)	**Range**	***M (SD)***	**Range**	***t***	***p***
Maltreatment	0.47 (0.89)	[0 - 6]	0.67 (1.48)	[0 - 9]	-0.97	0.83
Adult Functioning	1.18 (2.17)	[0 - 10]	1.45 (1.90)	[0 - 8]	-0.77	0.78
Parenting Practices	0.46 (0.82)	[0 - 3]	0.43 (0.72)	[0 - 3]	0.08	0.47
Child Functioning	1.93 (2.62)	[0 - 14]	1.21 (2.12)	[0 - 11]	1.78	0.04

Table 6. Number of Concerns Identified after the FSC Start Date – By Cohort

	Year 1					
	Intervention n = 27		Comparison n = 27			
	M (SD)	**Range**	***M (SD)***	**Range**	***t***	***p***
Maltreatment	0.37 (0.49)	[0 - 1]	0.33 (0.68)	[0 - 2]	0.23	0.41
Adult Functioning	1.30 (2.00)	[0 - 8]	1.70 (2.33)	[0 - 8]	-0.69	0.75
Parenting Practices	0.85 (1.03)	[0 - 3]	0.63 (0.74)	[0 - 2]	0.91	0.18
Child Functioning	2.11 (2.04)	[0 - 6]	0.59 (0.97)	[0 - 4]	3.49	0.00

	Year 2					
	Intervention *n* = 33		Comparison *n* = 33			
	M (SD)	**Range**	***M (SD)***	**Range**	***t***	***p***
Maltreatment	0.45 (0.71)	[0 - 2]	1.09 (1.94)	[0 - 9]	-1.77	0.96
Adult Functioning	1.42 (2.59)	[0 - 10]	1.27 (1.53)	[0 - 5]	0.29	0.38
Parenting Practices	0.27 (0.63)	[0 - 2]	0.36 (0.74)	[0 - 3]	-0.54	0.70
Child Functioning	1.85 (3.09)	[0 - 14]	1.39 (2.50)	[0 - 11]	0.66	0.26

	Year 3					
	Intervention *n* = 12		Comparison *n* = 7			
	M (SD)	**Range**	***M (SD)***	**Range**	***t***	***p***
Maltreatment	0.75 (1.71)	[0 - 6]	0.00 (0.00)	[0 - 0]	1.15	0.13
Adult Functioning	0.25 (0.62)	[0 - 2]	1.29 (1.80)	[0 - 5]	-1.85	0.96
Parenting Practices	0.08 (0.29)	[0 - 1]	0.14 (0.38)	[0 - 1]	-0.39	0.65
Child Functioning	1.75 (2.53)	[0 - 7]	2.71 (2.75)	[0 - 6]	-0.78	0.78

Congruence between Service Needs, Referrals, and Access. Tables 7 and 8 summarize the findings for analyses of congruence. It was hypothesized that participation in FSC would increase congruence between identified needs and referrals.

Referrals. The intervention group had all around higher rates of congruent referrals than did the comparison group, with at least 56% of needs in the four areas resulting in a referral. These differences were statistically significant for Maltreatment needs, $t = 1.84$, $p < 0.05$, and Child Functioning needs, $t = 2.79$, $p < 0.05$, indicating that the intervention group was more likely than the comparison group to receive referrals for identified needs in these areas.

Access. Both the intervention and comparison groups had services congruent to referrals being accessed for at least 50% of referrals submitted in three of the four areas. The intervention group also had a statistically higher rate of congruent service access than did the comparison group for Adult Functioning needs, $t = 2.33$, $p < 0.05$, indicating that the intervention group was more likely to access services after a referral was submitted. The intervention group had a lower rate of congruent services than the comparison group in the other three domains but these differences were not statistically significant. It is important to note however, that both the intervention and comparison groups both had very high rates of congruent service access in Child Functioning, 87% and 91% respectively, indicating that in general, a majority of children accessed services after a referral was made. There were several reasons why services were not accessed after a referral was made. For children and youth, it was typically because the caregiver did not follow through to schedule the service or the child/youth moved far away from the service provider. For parents or other adults such as foster parents and kinship caregivers, the reasons for not accessing services varied for example from not following through or declining services, to busy schedules and difficulty with transportation.

Table 7. Congruence - Percent of Service Needs with Congruent Service Referrals for Needs Identified after the FSC Start Date

Year 2

	Intervention		Comparison			
	n	***%***	***n***	***%***	***t***	***p***
Maltreatment	15	66.67	36	38.89	1.84	0.04
Adult Functioning	47	63.83	42	57.14	0.64	0.26
Parenting Practices	9	55.56	12	33.33	0.99	0.17
Child Functioning	61	75.41	46	50.00	2.79	0.00

Table 8. Congruence - Percent of Referrals with Congruent Service Access for Needs Identified after the FSC Start Date

	Year 2					
	Intervention		**Comparison**			
	n	***%***	***n***	***%***	***t***	***p***
Maltreatment	10	50.00	14	57.14	-0.33	0.63
Adult Functioning	30	60.00	24	29.17	2.33	0.01
Parenting Practices	5	40.00	4	50.00	-0.27	0.60
Child Functioning	46	86.96	23	91.30	-0.53	0.70

Duration between Service Needs, Referrals, and Access. Tables 9 and 10 summarize the findings for analyses of duration. It was hypothesized that participation in FSC would decrease duration between service need and referral, and referral and service access.

Referrals. After a service need was identified, a referral was submitted more quickly for the intervention group for needs relating to Adult Functioning and Parenting Practices compared to the comparison group. However, these differences were not statistically significant.

Services. After a referral was submitted, services were accessed more quickly in the intervention group than in the comparison group for needs relating to Adult Functioning and Child Functioning. These differences were not statistically significant but the difference in Adult Functioning did approach significance (i.e., the *p*-value was close to 0.05). For Adult Functioning needs, it took 16 days on average for individuals in the intervention group to access services after a referral had been submitted, compared to 45 days in the comparison group.

Variation in Duration. In both the intervention and comparison groups, there was a lot of variation in referral and service duration as evidenced by large standard deviations and wide ranges.

Table 9. Time in Days between Identification of Service Need and Referral for Needs Identified after the FSC Start Date

	Year 2							
	Intervention			Comparison				
	n	*M (SD)*	Range	n	*M (SD)*)	Range	*t*	*p*
Maltreatment	10	27.00 (27.39)	[0 - 68]	14	15.36 (21.68)	[0 - 58]	-1.16	0.87
Adult Functioning	30	13.80 (25.08)	[0 - 86]	24	25.71 (86.57)	[0 - 424]	0.72	0.24
Parenting Practices	5	0.20 (0.45)	[0 - 1]	4	0.50 (1.00)	[0 - 2]	0.61	0.28
Child Functioning	46	31.52 (76.89)	[0 - 380]	23	14.78 (45.79)	[0 - 220]	-0.96	0.83

Table 10. Time in Days between Service Referral and Access for Needs Identified after the FSC Start Date

	Year 2							
	Intervention			Comparison				
	n	*M (SD)*	Range	*n*	*M (SD)*	Range	*t*	*p*
Maltreatment	5	6.80 (6.22)	[0 - 12]	8	1.75 (3.24)	[0 - 9]	-1.94	0.96
Adult Functioning	18	15.89 (34.90)	[0 - 129]	7	44.71 (49.43)	[0 - 140]	1.65	0.06
Parenting Practices	2	9.00 (12.73)	[0 - 18]	2	0.00 (0.00)	[0 - 0]	-1.00	0.79
Child Functioning	40	9.90 (34.45)	[0 - 154]	21	21.19 (35.99)	[0 - 153]	1.20	0.12

Summary

Overall, participation in FSC resulted in better identification of Child Functioning service needs, better matching of needs and services for Maltreatment and Child Functioning, and faster access to services for Adult Functioning needs.

Identification. On average, more needs relating to Child Functioning were identified in the intervention group than in the comparison group. As part of the Family Finding process, FESs reviewed the family's case, interviewed the DCS Specialist, and interviewed the child. The additional review of the case and the DCS Specialist interview may have served to highlight concerns that had not previously been addressed. The interview of the child also provided another point of contact during which additional needs and concerns could be raised.

Congruence. *Referrals*. In the intervention group, referrals were submitted to address a majority of needs - between 56% and 75% of needs across the four areas. In two areas – Maltreatment and Child Functioning – the intervention group was significantly more likely than the comparison group to have a referral submitted after a need was identified. As with the identification of needs, having an additional review of the case and additional contacts with the child and family provides additional opportunities to highlight and address needs that had not previously been addressed.

In areas with lower levels of congruence, factors outside of the DCS Specialists' control may have played a role. For example, in some instances, the DCS Specialist was not able to locate the family and consequently was not able to refer the family to services.

Services. In both the intervention and comparison groups, a majority of referrals resulted in services being accessed, indicating that children and families were for the most part getting access to the services they needed. Referrals addressing Child Functioning needs, such as internalizing and externalizing behaviors, were especially likely to result in services being accessed. This is to be expected given DCS's Rapid Response policy, which requires that children placed in out-of-home care be assessed upon removal.

In one area – Adult Functioning – the intervention group was significantly more likely than the comparison group to access services after a referral was submitted. This may reflect the benefits of having an additional worker focused largely on engaging parents and caregivers. As parents and caregivers noted in the Engagement survey, they felt

the FESs involvement genuinely benefited their children and gave them hope. This buy-in from parents and caregivers may make them more likely to participate in recommended services. In areas with lower levels of congruence, factors outside of the DCS Specialists' control may again be at play. Family members and kin caregivers must be willing and able to participate in services for services to be accessed. For example, after a referral for substance use disorder treatment is submitted, the adult must follow up to schedule an intake appointment. Although the DCS Specialist may submit a referral, services will not be initiated without the adult taking the initiative to do so. It was not uncommon to find in the case review that noncustodial adults "no showed" to intakes and appointments or failed to contact service providers after a referral had been submitted.

Duration. *Referrals*. Referrals were not submitted more quickly in the intervention than the comparison group, largely because, on average, referrals were submitted quickly for both groups. The average time between a need being identified and a referral being submitted for both groups was less than one month across the four areas of need.

Services. For concerns relating to Adult Functioning, services were accessed more quickly in the intervention group than in the comparison group after a referral was submitted. As with congruence, this may reflect increased caregiver engagement. Services were not accessed more quickly in the other areas largely because services were accessed quickly in general. The average time between a referral being submitted and a service being accessed was less than one month for both the intervention and comparison groups.

Despite this overall trend, there was a great deal of variability in duration. For example, in the comparison group, duration for adult functioning ranged from zero to 140 days. A number of factors likely contribute to this variation. Duration will vary by type of service as some services can be accessed immediately while others take longer to initiate. Adults with service needs related to substance use can begin drug testing or a 12-step program immediately. In contrast, adults with mental health concerns must often wait for their referral to be assigned to an agency and for the agency to assign a counselor.

Duration was also affected lack of engagement and the need for re-referrals. For example, one agency's terms dictated that a referral would be closed after three unsuccessful contact attempts. Adults seeking to engage with that agency after a referral closed needed to be re-referred, leading to a longer time between the initial referral and the service being accessed.

Limitations. The findings summarized above are limited in that they represent only what was included in case records. DCS Specialists may have submitted additional referrals and children and families may have accessed additional services that were not noted in the case notes. Families may have self-referred to services or accessed community services on their own, which may also not be captured in their case record.

Similarly, the findings related to duration are limited by the amount of detail in the case notes. In many instances, the dates used to calculate duration were approximations.

Social Emotional Well-Being

The use of standardized well-being instruments with strong psychometric properties allows for the collection of valid and consistent data to identify needs, inform case planning, monitor change over time, and evaluate the impact of interventions and placements on children residing in out-of-home care settings. For measures used with child welfare involved children, inclusion of multiple informants to examine well-being is important, as it allows for the ability to triangulate responses, and comprehensively identify strengths and challenges experienced throughout a child's life course that contribute to well-being.

The standardized measures of social emotional well-being administered for the demonstration project evaluation included the Behavioral and Emotional Rating Scale (BERS-2) (Epstein, Mooney, Ryser, & Pierce, 2004) for children ages 5-18 years old and the Youth Quality of Life Instrument-Short Form (YQoL-SF) (Patrick, Edwards, & Topolski, 2002) for children ages 13-18 years. These measures were chosen based on criteria that they were strengths-based, covered a wide age span, and had established rates of validity and reliability.

The BERS-2 and YQoL-SF were used in the demonstration project evaluation to:

1. Compare child and caregiver ratings of child social emotional well-being
2. Assess the sensitivity of standardized social emotional well-being scales to change over time
3. Examine the impact of FSC on child social emotional well-being

BERS-2

The BERS-2 is a strengths-based measure that focuses on five aspects of well-being, including:

- Interpersonal Strength (IS): the ability to control emotions and behaviors in social situations
- Family Involvement (FI): the child's relationship with his or her family
- Intrapersonal Strength (IaS): personal perceptions of functioning and self-efficacy
- School Functioning (SF): the child's performance in school
- Affective Strength (AS): the ability to give and receive on an affective level

The BERS-2 is available in three formats, including a Youth Rating Scale (YRS), Parent/caregiver Rating Scale (PRS), and Teacher Rater Scale (TRS). The YRS and PRS were used for this study.

The YRS and PRS are each composed of 57 Likert scale items that are rated from 0 (not at all like me) to 4 (very much like me). Item responses are summed to calculate raw scores for the five subscales, and then translated into normed and standardized scaled scores. The scaled scores are summed to create an overall Strength Index. The BERS-2 manual provides general guidelines, shown in Table 11, for interpreting the scaled scores (Epstein et al., 2004). Interpretations range from Poor to Very Superior.

Table 11. Guidelines for Interpreting BERS-2 Subscale Standard Scores and Strength Index

Behavioral and Emotional Strength	Subscale Scaled Scores	BERS-2 Strength Index
Very Superior	17-20	>130
Superior	15-16	121-130
Above Average	13-14	111-120
Average	8-12	90-110
Below Average	6-7	80-89
Poor	4-5	70-79

YQoL-SF

The YQoL-SF is a brief measure consisting of 15 items assessing overall quality of life in children ages 13-18 years. The YQoL-SF includes items about social relationships (e.g., “I am happy with the friends I have”), sense of self (e.g., “I am pleased with how I look”), environment (e.g., “I feel safe when I am at school”), and general quality of life (e.g., “I feel my life has meaning”).

Items are rated on a scale from 0 (not at all) to 10 (a great deal or completely). The individual item scores are summed into a Composite Score with higher scores representing high quality of life and lower scores representing low quality.

Method

Children and caregivers were surveyed about once a year for the duration of the project. Trained interviewers administered the BERS-2 YRS and YQoL-SF to children and youth. Caregivers completed the BERS-2 PRS on their own – when the youth was residing in out of home care, the caregiver requested to complete the measure was the individual most familiar with the child/youth.

As children and youth were enrolled in the study in phases, they had a varying number of total well-being assessments. Those enrolled in Year 1 of the demonstration project had between one and four assessments, those enrolled in Year 2 had between one and three assessments, those in Year 3 had one or two assessments. Children enrolled in Year 4 of the demonstration project evaluation were not administered the BERS-2 or YQoL given that the period was only 3 months in duration. Given that a majority of children and youth had at least two assessments, data from the first two assessments, henceforth referred to as Time 1 and Time 2, were used for this portion of the evaluation report.

Sample. At Time 1, 180 children, 116 males and 64 females, completed the BERS-2 YRS. They ranged in age from 5 to 18 years with an average age of 13.46 years (*SD* = 3.01). Of these, 144 also completed the YQoL-SF. One hundred and eighty caregivers completed the BERS-2 PRS at Time 1.

At Time 2, 124 children completed the BERS-2, and 101 children completed the YQoL-SF. There was an average of 10.72 months (*SD* = 2.48) between Time 1 and Time 2 assessments.

Comparison of Child and Caregiver Ratings. The BERS-2 interpretation guidelines outlined above were used to compare child and caregiver ratings at Time 1. First, the number and percent of child and caregiver ratings that fall within each behavioral and emotional strength category was calculated for each subscale. Second, each child's rating was compared to his or her caregiver's rating. The ratings were considered to be in agreement if the child's and caregiver's ratings fell within the same behavioral and emotional strength category.

Sensitivity to Change. Children's scores on the BERS-2 YRS and YQoL-SF at Time 1 and Time 2 were compared using paired sample t-tests to assess the sensitivity of the measures to change over time.

Impact of FSC. To examine the impact of FSC on social emotional well-being, a change score was calculated for each of the BERS-2 subscales, the BERS-2 Strength Index, and the YQoL-SF Composite Score by subtracting the child's score at Time 1 from their score at Time 2. Given that many children moved, and therefore did not have the same caregiver from Time 1 to Time 2, only child ratings were used for this analysis. Linear regressions were then run on the change scores to examine differences between the intervention and comparison groups. Age, gender, race, restrictiveness of living arrangement, and time in care were controlled for in these analyses.

Findings

Comparison Child and Caregiver Ratings. Table 12 summarizes findings from the comparison of child and caregiver ratings on the BERS-2 at Time 1. Across subscales, children rated themselves higher than did their caregivers. The majority of children's self-ratings fell within the Average or Above Average category for each of the subscales. In contrast, fewer caregivers rated children as Average, and in many instances, rated them as Below Average or Poor. For example, 67% of children rated themselves as Average or Above Average in Interpersonal Strength compared to 52% of caregivers. In that same subscale, 17% of children rated themselves as Below Average or Poor, compared to 41% of caregivers. This difference in ratings was also evident in the Strength Index, where the average child score (M = 103.49, SD = 15.94) was significantly higher than the average caregiver score for the child (M = 88.25, SD = 17.41), t = 8.76, $p < 0.001$.

Children and caregiver ratings had mid to low rates of agreement. The greatest degree of agreement was for Interpersonal Strength (39% agreement), and the lowest for School Functioning (27% agreement).

Table 12. Comparison of Child and Caregiver Ratings on the BERS-2 (N = 180)

		Poor	Below Average	Average	Above Average	Superior	Very Superior	% Agreement
Subscale	Rater	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	
Interpersonal Strength (IS)	Child	13 (7.3)	17 (9.6)	87 (49.2)	34 (19.2)	17 (9.6)	9 (5.1)	39.4
	Caregiver	33 (18.3)	41 (22.8)	79 (43.9)	14 (7.8)	11 (6.1)	0 (0.0)	
Family Involvement (FI)	Child	3 (1.7)	16 (8.9)	112 (62.2)	29 (16.1)	16 (8.9)	2 (1.1)	35.6
	Caregiver	39 (21.7)	53 (29.4)	75 (41.7)	6 (3.3)	5 (2.8)	0 (0.0)	
Intrapersonal Strength (IaS)	Child	8 (4.4)	16 (8.9)	106 (58.9)	37 (20.6)	11 (6.1)	0 (0.0)	35.6
	Caregiver	27 (15.0)	33 (18.3)	89 (49.4)	17 (9.4)	12 (6.7)	0 (0.0)	
School Functioning (SF)	Child	11 (6.1)	17 (9.4)	87 (48.3)	50 (27.8)	13 (7.2)	0 (0.0)	27.2
	Caregiver	32 (17.8)	45 (25.0)	82 (45.6)	12 (6.7)	7 (3.9)	0 (0.0)	
Affective Strength (AS)	Child	15 (8.3)	16 (8.9)	117 (65)	19 (10.6)	12 (6.7)	0 (0.0)	37.2
	Caregiver	37 (20.6)	41 (22.8)	84 (46.7)	17 (9.4)	0 (0.0)	0 (0.0)	
Strength Index	Child	*M* = 103.49 (*SD* = 15.94)						
	Caregiver	*M* = 88.25 (*SD* = 17.41)						

Sensitivity to Change. Table 13 summarizes children's scores on the BERS-2 YRS and YQoL at Times 1 and 2. Larger *t*-scores and *p*-values less than 0.05 indicate statistically significant differences between the two groups being compared. There were no significant differences on the BERS-2 YRS subscales, BERS-2 Strength Index, or YQoL-SF Composite Score, indicating that children rated themselves similarly at Time 1 and Time 2. However, two BERS-2 YRS subscales, Family Involvement and School Functioning, did approach significance (i.e., their *p*-values were close to 0.05). On average, children reported increased family involvement from Time 1 to Time 2, and decreased school functioning.

Table 13. Time 1 and Time 2 BERS-2 YRS and YQoL-SF Scores

	Time 1 *n* = 180		Time 2 *n* = 124			
	M (SD)	**Range**	**M (SD)**	**Range**	***t***	***p***
Interpersonal Strength (IS)	10.77 (3.50)	[2 - 18]	10.98 (3.22)	[1 - 18]	-0.96	0.83
Family Involvement (FI)	10.67 (2.70)	[3 - 17]	11.19 (2.89)	[3 - 17]	-1.93	0.06
Intrapersonal Strength (IaS)	10.58 (2.72)	[2 - 15]	10.72 (2.53)	[4 - 15]	-0.36	0.72
School Functioning (SF)	10.46 (3.06)	[4 - 16]	10.10 (2.96)	[3 - 16]	1.93	0.06
Affective Strength (AS)	10.23 (2.88)	[3 - 16]	10.54 (3.08)	[4 - 16]	-0.98	0.33
Strength Index	103.49 (15.94)	[56 - 139]	104.75 (14.84)	[71 - 143]	-0.63	0.53
YQoL Composite Score	136.27 (20.42)	[56 - 160]	136.77 (20.48)	[67 - 160]	-0.22	0.83

Although the overall group means were quite stable, a closer look at the individual scores showed the following changes from Time 1 to Time 2 for the BERS-2 Strength Index, indicating that the measure is both stable, and sensitive to individual change (See Table 14).

Table 14. Comparison of Children's Scores from Time 1 to Time 2 on the BERS-2

Direction of Change	**Total** *N* = 123	**Intervention** *n* = 67	**Comparison** *n* = 56
	n (%)	*n* (%)	*n* (%)
Increased	60 (48.78)	28 (41.79)	32 (57.14)
Decreased	58 (47.15)	36 (53.73)	22 (39.29)
No Change	5 (4.07)	3 (4.48)	2 (3.57)

Impact of FSC. Table 15 summarizes findings related to change in well-being over time by group. Betas (β) represent the magnitude and direction of the difference between the groups. For example, β = 0.45 means that, on average, the change score for the intervention group was 0.45 points higher than the change score for the comparison

group (i.e. the intervention group had more positive change). *p*-values less than 0.05 indicate statistically significant differences. On average, children in both the intervention and comparison groups reported little change in their well-being from Time 1 to Time 2.

BERS-2 YRS Subscales. The average change scores on the BERS-2 YRS subscales were less than one for both the intervention and comparison groups. In addition, there were no significant differences or differences approaching significance between the intervention and comparison groups on change in the subscales.

IS: Children in both the intervention and comparison groups reported small increases in interpersonal strength but the intervention group reported a slightly greater increase.

FI: Children in both the intervention and comparison groups reported small increases in family involvement but the comparison group reported a slightly greater increase.

IaS: Children in the intervention group reported small decreases in intrapersonal strength while children in the comparison group reported small increases.

SF: Children in the intervention and comparison group both reported decreases in school functioning. Intervention children reported a slightly greater decrease than comparison children.

AS: Children in the intervention group reported small decreases in affective strength while children in the comparison group reported small increases.

Overall, children in the intervention group reported decreases in their well-being from Time 1 to Time 2 as indicated by the negative change score on the BERS-2 Strength Index and YQoL-SF composite score. Conversely, children in the comparison group reported increases in their well-being. These differences, however, were not statistically significant, $\beta = -2.41$, $p > 0.05$ and $\beta = -2.11$, $p > 0.05$.

Table 15. Results of Linear Regressions Examining Differences in Time 1 to Time 2 Change Scores for Children in the Intervention and Comparison Groups

Scale	Group	M (SD)	Range	β	*p*
Interpersonal Strength (IS)	Intervention	0.37 (3.23)	[-8,7]	0.45	0.19
	Comparison	0.14 (2.97)	[-11,5]		
Family Involvement (FI)	Intervention	0.36 (3.46)	[-8,8]	-0.46	0.26
	Comparison	0.89 (3.55)	[-11,9]		
Intrapersonal Strength (IaS)	Intervention	-0.12 (2.65)	[-5,7]	-0.48	0.38
	Comparison	0.33 (2.84)	[-6,7]		
School Functioning (SF)	Intervention	-0.78 (3.4)	[-9,7]	-0.48	0.5
	Comparison	-0.30 (3.01)	[-9,6]		
Affective Strength (AS)	Intervention	-0.13 (3.6)	[-9,8]	-0.77	0.09
	Comparison	0.81 (3.08)	[-7,7]		
Strength Index	Intervention	-0.40 (17.58)	[-33,34]	-2.41	0.21
	Comparison	2.55 (15.58)	[-56,37]		
YQoL-SF Composite Score	Intervention	-0.82 (21.66)	[-62,47]	-2.11	0.06
	Comparison	2.14 (18.55)	[-36,50]		

Summary

A majority of children/youth at entry to FSC rated themselves as Average or Above Average on the five BERS-2 subscales, indicating they considered their strengths to be on par with children/youth in general. The children/youth also consistently reported higher social emotional well-being than their caregivers' ratings of them. Overall, children reported little change in their social emotional well-being from Time 1 to Time 2. This may be due, in part, to a ceiling effect, as many had already rated themselves positively at Time 1.

Turning to the question of the impact of FSC on child social emotional well-being, children and youth in the intervention group did not report greater improvement in well-being than children in the comparison group. In fact, children in the intervention group reported small, albeit not significant, decreases in overall well-being. This finding is consistent with prior research. In a review of 13 evaluations of Family Finding conducted in recent years, only one examined impact on well-being and found that treatment group youth were more likely to exhibit internalizing behavior problems than control group youth (Vandivere & Malm, 2015).

Differences between the groups as a result of FSC may emerge at a later time. One goal of FSC is to identify family and fictive kin who may serve as lifelong supports for children as they exit out-of-home care. Further evaluation of the Family Finding model should examine the social emotional well-being after children in the intervention group have had more time to establish a new normal with new or renewed family relations and places of living outside of the child welfare system.

Lastly, there was variation in change scores within the intervention and comparison groups as indicated by large standard deviations and wide ranges. The mean scores, therefore, provide a summary of the group's overall performance but are not indicative of how individuals within the group are doing. It may be that subgroups of youth are reporting improved well-being but their changes are being obscured by group trends.

Legal Permanency

The analyses of legal permanency utilized data from the matched sample. From Table 16 it is shown that the proportions of each group, intervention and comparison, achieving permanency was similar; approximately 29% of the intervention group and 32% of the comparison group had achieved permanency by February 2, 2020. The between group differences were not statistically significant as hypothesized ($X^2 = 0.20$, $df = 1$, $p = 0.66$).

Table 16. Legal Permanency Achievement by Group

		Intervention *n* = 107	Comparison *n* = 107		
		n (%)	*n* (%)	χ^2	*p*
Permanency	Yes	31 (28.97)	34 (31.78)	0.20	0.66
	No	76 (71.03)	73 (68.22)		

As noted in the process study, one component of FSC is specialized meetings – BPMs and LLC TDM meetings – that among other aims, seek to identify family and fictive kin who can serve as supports for the child and to plan for legal permanency. Increased family support and a focus on legal permanency were expected to increase the likelihood of legal permanency. It was not recorded how many children were eligible for the specialized BPM meetings; however, fewer than half of the intervention children in the study sample had a BPM or LLC TDM meetings (n = 41).

Examining the relationship between this intervention component and permanency for only the intervention group, we see that those children who had a BPM and/or a LLC TDM meeting had a higher percentage of permanency achievement, however, the difference was not great enough to be statistically significant (X^2 = 2.25, df = 1, $p.$ = .13). Approximately 34% of the children who had a specialized BPM or LLC TDM meeting did achieve permanency, compared to 21% of those who did not have these specialized meetings.

Table 17. Legal Permanency Achievement by Specialized Meeting Component

		BPM or LLC TDM n = 41	No BPM or LLC TDM n = 79		
		n (%)	n (%)	X^2	p
Permanency	Yes	14 (34.15)	17 (21.52)	2.25	0.13
	No	27 (65.85)	62 (78.48)		

These findings are consistent with those from prior experimental evaluations examining the impact of Family Finding. Previous studies have shown mostly null results on the achievement of legal permanency. As cited by Vandivere and Malm, 2015, p. 5, "Overall, among studies in four sites testing programs serving a combined population of youth new to care and already in care, only one (Iowa's study) identified favorable impacts on legal permanency."

Safety

Safety was operationalized as the absence of a re-entry to out-of-home care within the 12-month period following the end date of the child's removal, including exits to reunification, adoption or any other reason. Children in the Year 4 cohort were excluded

from this analysis – and the analysis of stability and days in care – as Year 4 was from July 1, 2019 through September 2019. All other children who achieved permanency were included in the analysis (n = 63).

The findings on re-entry are shown in Table 18. Overall, about 16% of children who achieved permanency re-entered out-of-home care. There was no statistically significant difference between the intervention and comparison groups in the proportion of children re-entering out of home care within 12 months post permanency (X^2 = 0.00, *df*= 1, *p* = 0.96).

Table 18. Re-entry within 12 Months of Achieving Legal Permanency by Group

		Intervention *n* = 31	Comparison *n* = 32		
		n (%)	*n* (%)	X^2	*p*
Re-entry	Yes	5 (16.13)	5 (15.63)	0.00	0.96
	No	26 (83.87)	27 (84.38)		

Stability

The evaluation also examined impact on outcomes that might precede permanency, such as out-of-home care placement stability. For the purpose of this analysis, stability was defined as number of living arrangements following the FSC start date. The same start date was applied for each matched pair. The average number of living arrangements prior to achieving permanency varied between intervention and comparison groups, however, the difference controlling for length of time between start date and permanency was not statistically significant between groups *(F = .25*, *p* = 0.67). As can be seen from Table 19, intervention children had an average of just over two different living arrangements compared to almost three for the comparison group. The comparison group had a larger variation, ranging from one to 14 living arrangements compared to one to six for the intervention group.

Table 19. Number of Placements for Youth who Achieved Legal Permanency by Group

	n	*M (SD)*	Range	*F*	*p*
Intervention	31	2.32 (1.22)	[1 - 6]	.25	0.67
Comparison	32	2.91 (2.63)	[1 - 14]		

Previous findings from evaluations on the impact of Family Finding on placement stability have shown mixed results. Of five studies, two showed no impact on stability, one an unfavorable impact, and two a favorable impact (Vandivere & Malm, 2015).

Days in Care for New Entries During the Waiver Demonstration Project

Table 20 describes the length of time in out-of-home care for children who entered out-of-home care for the first time after the start of the demonstration project, July 1, 2016. Days were counted until the children exited care or to February 2nd, 2020 if the children had not exited care. The analysis revealed no statistically significant difference in out-of-home care duration by intervention or comparison group (t = -1.59, df = 72, p = 0.94). On average, children in the comparison group spent 856.02 days in care (SD = 221.33), slightly lower than the average number of days in care for children in FSC, 944.73 days (SD = 252.96).

Table 20. Days in Care for Children who First Entered Out-of-Home Care Post FSC

	n	*M (SD)*	Range	*t*	*p*
Intervention	30	944.73 (254.43)	[420 – 1,340]	1.59	0.94
Comparison	44	856.02 (221.33)	[471 – 1,304]		

A similar analysis of children who entered out of home care prior to the FSC start date (legacy children) was also conducted, and revealed no statistically significant differences between groups. Previous findings from evaluations on the impact of Family Finding on length of out-of-home care have shown a mix of favorable, unfavorable and null impacts (Vandivere & Malm, 2015).

Restrictiveness of Living Environment

Restrictiveness of out-of-home care setting was determined based on the children's living arrangement using a modification of the Children's Restrictiveness of Living Environment Instrument (CRLE) developed by Thomlison and Krysik (1992). The Restrictiveness of Living Environment instrument provides a ranking in terms of restrictiveness based on out-of-home care setting type, with higher scores given to settings that are more restrictive. Care settings were associated with a particular rank to reflect level of restrictiveness with "detention" indicated as the most restrictive and living independently as the least restrictive. A change in care setting restrictiveness score was calculated for each child/youth dependent on their initial care setting at the beginning of the waiver demonstration project.

Based on these scores, youth were then classified as having had no change in care setting restrictiveness, an increase in restrictiveness, or a decrease in restrictiveness. Youth who were on runaway were included in the no change group, although living independently is considered low in terms of restrictiveness, it is also not a positive outcome. As shown in Table 21, there was no statistically significant difference in restrictiveness change by group, intervention or comparison (X^2 = 1.41, *df* = 1, *p* = 0.49). The majority of children/youth in both groups experienced a decrease in restrictiveness of living environment, 67.44% for the intervention and 66.67% for the comparison group.

Table 21. Change in Care Setting Restrictiveness by Group

	Intervention *n* = 86	Comparison *n* = 84		
	n (%)	*n* (%)	χ^2	*p*
Decrease	58 (67.44)	56 (66.67)		
No Change	18 (20.93)	22 (26.19)	1.41	0.49
Increase	10 (11.63)	6 (7.14)		

*Children who did not experience a change in placement were excluded (*n* = 44)

The evaluation also examined the impact of decreasing restrictiveness while in out-of-home care on legal permanency. A decrease in restrictiveness while in care, e.g., stepping down from a group home placement to a family-like setting, was significantly associated with the achievement of legal permanency. Of those who achieved permanency, 83% had a prior decrease in restrictiveness, whereas only 16.9% of those

who achieved permanency had no change or an increase in restrictiveness prior to exiting to care (see Table 22).

Table 22. Permanency by Change in Care Setting Restrictiveness

		Permanency			
		Yes *n* = 65	No *n* = 105		
		n (%)	*n* (%)	χ^2	*p*
Restrictiveness Decreased	Yes	54 (83.08)	60 (57.14)	12.22	0.00
	No	11 (16.92)	45 (42.86)		

*Children who did not experience a change in placement were excluded (*n* = 44)

Cost Study Findings

The cost study focused on the financial impacts of the demonstration project at the individual level. At the individual level, the cost study sought to

1. Determine the change in placement cost associated with an increase or decrease in restrictiveness, and
2. Determine the difference in placement cost over time associated with the intervention

It was hypothesized that a decrease in placement restrictiveness would be associated with a decrease in cost. Additionally, it was hypothesized that participation in the intervention would be associated with a lower total placement cost over time.

Data Source

Individual level placement cost data was extracted from CHILDS. The data was organized by child by month and included out-of-home care setting type, number of days in that month that the child resided in the setting, care setting daily rate, and total amount paid for that month.

Analysis

Change in Placement Cost. Individual cases were selected to illustrate changes in cost associated with changes in placement restrictiveness. Four cases were selected from each cohort year:

1. Child with the highest cumulative placement cost over time and an increase in placement restrictiveness
2. Child with the lowest cumulative placement cost over time and an increase in placement restrictiveness
3. Child with the highest cumulative placement cost over time and a decrease in placement restrictiveness
4. Child with the lowest cumulative placement cost over time and a decrease in placement restrictiveness

The change in placement cost was calculated by subtracting the cost of the second placement from that of the first placement.

Placement Cost over Time. Cost over time for each child was calculated by adding the cost of all the placements from the child's FSC start date to their exit date or until April 30, 2020 if they had not exited care. For children in the comparison group, their matched intervention pair's FSC start date was utilized. A one-way ANOVA was used to examine differences in placement cost over time between the intervention and comparison groups.

Findings

Change in Placement Cost. Tables 23 and 24 summarize the cases selected to examine the change in placement cost associated with a change in placement restrictiveness. As shown in Table 23, regardless of placement cost over time, a decrease in placement restrictiveness is accompanied by a considerable decrease in cost. Among the six cases selected, the decrease in placement cost ranged from $80 to $200 per day, with a move from a shelter placement to an unlicensed kin placement being associated with the greatest decrease.

Similarly, an increase in placement restrictiveness is associated with a considerable increase in cost, regardless of placement cost over time. Among the six cases selected, the increase in placement cost per day ranged from $88 to $326, with the move from a kinship care setting to a specialized group home being associated with the greatest increase.

Table 23. Change in Placement Cost Associated with Decrease in Placement Restrictiveness

Year	Placement Cost over Time	Placement 1	Cost per Day	Placement 2	Cost per Day	Change in Cost
1	$149,748.40	Shelter	$145.00	Unlicensed Kin	$2.47	-$142.53
1	$18,886.40	Group Home	$100.00	Foster Home	$19.68	-$80.32
2	$106,888.33	Group Home	$136.00	Unlicensed Kin	$0.00	-$136.00
2	$17,021.75	Group Home	$115.00	Unlicensed Kin	$0.00	-$115.00
3	$111,927.00	Shelter	$200.00	Unlicensed Kin	$0.00	-$200.00
3	$20,335.68	Group Home	$120.00	Foster Home	$19.68	-$100.32

Table 24. Change in Placement Cost Associated with Increase in Placement Restrictiveness

Year	Total Placement Cost	Placement 1	Cost per Day	Placement 2	Cost per Day	Change in Cost
1	$135,208.35	Foster Home	$27.15	Group Home	$120.00	$92.85
1	$21,371.00	Foster Home	$19.68	Group Home	$136.00	$116.32
2	$112,035.00	Foster Home	$27.15	Group Home	$115.00	$87.85
2	$22,479.80	Unlicensed Kin	$0.00	Group Home	$110.00	$110.00
3	$143,600.64	Unlicensed Kin	$2.47	DDD Group Home	$328.54	$326.07
3	$10,883.00	Unlicensed Kin	$0.00	Shelter	$121.00	$121.00

Placement Cost over Time. Table 24 summarizes the findings regarding placement cost over time. Overall, the children in the comparison group had a higher average placement cost over time than children in the intervention group. However, this difference was not statistically significant.

Contrary to the overall trend, in Year 1, children in the intervention group had a higher average placement cost over time but again this difference was not statistically significant. The average for the comparison group, however, is highly skewed by one youth who was placed with unlicensed kin and hence had a cost of $0.00 for the period being examined.

In Year 2 and Year 3, children in the comparison group had a higher average placement cost over time than children in the intervention group. In Year 2 the difference in average cost between the two groups was just under $9,000 but was not statistically significant. In Year 3, the average difference in cost was just under $15,000 and was statistically significant, $F(1, 59) = 4.21$, $p < 0.05$.

Table 25. Placement Cost over Time by Year and by Group

	Group	*n*	*M (SD)*	Range	*F*	*p*
All Years	Intervention	90	$66,047.03 ($37,552.43)	[$16,573.05.00 - $161,358.70]	0.51	0.48
	Comparison	90	$69,887.00 ($34,514.01)	[$0.00 - $180,860.00]		
Year 1	Intervention	27	$75,774.95 ($47,162.49)	[$18,886.40 - $161,358.70]	1.38	0.24
	Comparison	27	$61,078.21 ($44,580.09)	[$0.00 - $180,860.00]		
Year 2	Intervention	33	$63,812.83 ($36,798.75)	[$17,021.25 - $142,487.80]	1.23	0.27
	Comparison	33	$72,799.15 ($28,579.66)	[$32,882.72 - $146,470.00]		
Year 3	Intervention	30	$59,749.53 ($26,543.63)	[$16,573.05 - $103,463.50]	4.21	0.04
	Comparison	30	$74,611.52 ($29,457.30)	[$10,883.00 - $143,600.60]		

Summary

As expected, placing children in family-like settings (i.e. decreasing placement restrictiveness including achieving permanency) is associated with a decrease in placement cost while placing children into congregate care settings (i.e. increasing placement restrictiveness) is associated with an increase in placement cost. Additionally, participation in FSC was associated with a considerable decrease in placement cost over time, saving the agency about $15,000 on average per child for the Year 3 cohort of children who participated in the intervention, a statistically significant reduction.

Owing to the success of FSC, DCS Executive Leadership supported its continuation and expansion beyond the waiver period. FSC was implemented statewide in October 2019. Any unit from any office may now refer children/youth to FSC. An RFP was created and a contract awarded to Arizona's Children Association in February 2020. The Statewide Coordinator has made presentations on FSC to DCS offices that were not part of the demonstration project intervention and a communication on FSC was sent out via e-mail to all DCS staff. The FSC workbook is still used to track metrics and the Statewide Coordinator position continues to monitor fidelity and work on process improvement.

Well-Being Sub-Study Findings

Public child welfare agencies in the United States are responsible for ensuring the safety, permanence, and well-being of children in out-of-home care. Among these three primary aims, well-being is the most conceptually vague, without an agreed upon operationalization. Well-being has remained an elusive area of practice, particularly when compared to permanence and safety which are commonly measured as outcomes (Axford, 2008). Measurement of social emotional well-being has lagged as an important area of child welfare practice, as the construct is not easily defined or conceptualized, consisting of more subjective than concrete dimensions. One of the challenges in the measurement of social emotional well-being has been the difficulty obtaining both youth and caregiver perspectives (Anthony, Krysik, & Kelly, 2017). Further, standardized measures tend to focus on diagnostic criteria and clinical cutoff scores that reveal more about deficits rather than strengths. Purely qualitative measures, on the other hand, are subjective, and make it difficult to provide comparative information. For the purposes of operationalizing social emotional well-being for youth in congregate care settings, we employed two non-diagnostic, strength-based quantitative measures, and subjective qualitative interviews with youth and caregivers, to see how they would compare and to further operationalize social emotional well-being for this population of children and youth.

The demonstration project evaluation provided a unique opportunity to build knowledge in this under-developed area of child welfare practice, specifically to further the understanding of child well-being for children and youth living in congregate care. Through existing data collection for the process evaluation (parent/caregiver and child/youth interviews), and the outcome evaluation (measurement of social emotional well-being), three research questions were addressed for the demonstration project sub-study:

1. How do children, age 12 and older, conceptualize their own well-being?
2. How do parents/caregivers define well-being for the children under their care?
3. What are the content validity, face validity, and sensitivity of a measure of child well-being for children living in congregate care?

Method

Semi-structured interview questions (see Appendix E) were asked to obtain the perceptions of adult caregivers and children/youth on social emotional well-being. All of the interviews conducted in Years 1 and 2 were with non-parental/non-custodial kin who

were not placements for the child/youth at the time of the interview, but who had ongoing relationships. There was limited ability in the early years of the intervention to identify kinship caregivers, given that many children and youth were residing in group home settings. The decision to not interview group home staff as caregivers was made early in the study. However, in Year 3, kinship caregivers of children and youth who had previously been in group home settings were able to be identified. It should be noted that although these are two distinct populations of kin (noncustodial and custodial), analysis of their interview data revealed common themes, thus their data were combined for this analysis.

Nineteen interviews were conducted with non-custodial kin who were involved with the child/youth even though the youth resided in congregate care. These interviews were conducted by one, master-level, social work interviewer who had experience as a child welfare practitioner. Five semi-structured interviews were conducted with kinship caregivers who were providing custodial care. Custodial kinship caregivers were asked to describe their perceptions of social and emotional well-being for the youth in their care during a time in the recent past when the young person was residing in a congregate care setting. These interviews were also conducted by a single, master-level social work interviewer, also experienced as a child welfare practitioner. The youth interviews were conducted by these same two interviewers. For each interview, adults were provided a $20 gift card for appreciation of their time and information. Youth also received compensation in the form of a $5 gift card or something of comparable value from a grab bag of gifts, e.g., journals, earbuds, water bottles, gel pens, etc.

For Year 1, 10 qualitative interviews were conducted with children and youth, age 12 and older and four interviews with non-parental kin. For Year 2, 10 qualitative interviews with children and youth and 15 interviews with non-parental kin were completed. At the end of Year 2, the goal was met for 20 youth interviews, and was one short of the goal of 20 adult caregiver interviews. One adult interview was scheduled and rescheduled and not completed. For Year 3, 10 qualitative interviews with youth were completed, and five kinship caregiver interviews. At the end of Year 3, the goal was met for 30 youth interviews, and was six less than the goal of 30 adult caregiver interviews due to a number of caregivers declining to participate. Recruitment ended when it was determined that saturation had been reached in both child/youth and caregiver interviews, i.e., no new insights were being gained with additional interviews.

Early in the study planning stages it was noted that the perception of well-being may differ for youth residing in a single congregate care setting for a short period of time and youth who have resided in multiple congregate care settings over an extended period of time. This potential was dealt with in the sampling plan by purposefully selecting

children/youth for maximum diversity in regards to the length of time they were placed in out-of-home care.

The interviews were audio recorded, transcribed, and the data were analyzed using constant comparative analysis (Lincoln & Guba, 1985) to provide an understanding of how youth and caregivers conceptualize “doing well.” The transcripts were coded in Atlas-Ti, version 8 (Muhr, 2015). For verification purposes the coding was conducted by two coders, one was a researcher who conducted the interviews and the second a researcher who did not conduct any of the interviews (Creswell, 2009).

Youth Conceptualization of Social Emotional Well-Being

Analysis of the qualitative interview data resulted in identification of seven subthemes: 1) Ability to Cope with Adversity 2) Achieving Academic Success, 3) Maintaining Hope for the Future, 4) Learning to be Happy During Difficult Times, 5) Managing Emotional and Behavioral Expression, 5) Cultivating and Maintaining Relationships, 6) Dependency on Adult Perceptions, and 7) Establishing Normalcy.

Ability to Cope with Adversity. This theme described a number of quotes regarding the role of support in assisting youth to cope with adversity. Specifically, youth identified the need to receive additional support from adults in their lives outside of the traditional family system. Several quotes referenced a loss of support upon entering an out-of-home care setting and a desire to experience family-like closeness and support from out-of-home care providers. One particular youth discussed his difficulty in coping as it relates to variation in the type of supports received in his congregate care setting: “Family is different. The staff here are okay, but they are not family. I really need more support. I need the staff to be more like family that helps me no matter what.” As this quote suggests, this theme builds upon our knowledge of social-emotional well-being for youth residing in out-of-home care settings to enhance the conceptualization of social and emotional well-being in terms of the unique coping needs among this population. Progression towards autonomy is a hallmark of normal developmental trajectory during adolescence (Cicchetti & Cohen, 1995), with caregiver support associated with greater consistency in adolescent’s adjustment across social domains (Bronstein, Ginsburg, & Herrera, 2005; Joussemet, Koestner, Lekes, & Landry, 2005). For youth residing in out-of-home care settings, environmental contextual considerations including caregiver instability and rigid placement restrictions create obstacles on the path towards development of autonomy and independence. Many youth referenced a paucity of caregiver support within their contextual environmental setting, ultimately disrupting their ability to cope and thrive during a chaotic and difficult time of their lives.

Achieving Academic Success. “Things are going really well right now. I just finished summer school and got my credits back, so I’m not behind on my credits anymore at all. Things are really looking good.” This theme augments knowledge of the social-emotional well-being needs of youth residing in out-of-home care settings in terms of educational achievement. Specifically, the thematic focus on academic achievement highlights normal adolescent development as it pertains to the linkage between an adolescent’s home and school environment. Within these two developmental contexts, adolescence is a particular period of development in which the interface of the school and home contexts gain critical importance (Steinberg & Silk, 2002). For youth living in out-of-home care settings, parental relationships are frequently disrupted because of placement. Despite this disruption, youth living in congregate care settings referenced experiencing an enhanced linkage between their out-of-home care provider and school environment. Many youth reflected that this linkage clearly prioritized academic achievement in their out-of-home care setting, leading to renewed career aspirations, refinement of academic goals, and improved academic performance. Facing a future without a secure safety net, many of these youth interpreted improved academic success as the primary key to successful and secure independence after leaving the child welfare system.

Learning to be Happy During Difficult Times. This theme involved quotes that describe an overall feeling of happiness as identification of optimal social-emotional functioning. Several quotes discussed feelings of happiness as the pinnacle of achieving emotional regulation. Others described feelings of pride for life accomplishments and healthy decision-making that contributed to internalized feelings of happiness and contentment. One youth provided insight on the importance of happiness in the face of adversity: “I’m happy when I’m making progress with myself and the things I’m doing. It’s something that I just feel inside, I feel good about my life and I feel proud of what I’m doing. That is what it feels like to be doing well. I just feel it inside.” This theme enhances knowledge of the developmental context of youth residing in out-of-home care settings through the parallel prioritization of happiness for youth in achieving favorable social and emotional well-being outcomes. From a developmental systems perspective, adolescence is classified by developmental theorists as a period of “normative crisis” (Erikson, 1968), and thus well-being is often overlooked as an important component of normal adolescent development. Despite anecdotal assumptions that youth residing in out-of-home care settings struggle to achieve consistent mood stabilization, many youth indicated feeling happiness in their everyday lives despite adversity. This developmental achievement is consistent with normal adolescent development, in that youth described that optimal social and emotional well-being included being satisfied with their life, and to experience more positive than negative affect.

Maintaining Hope for the Future. This theme represents quotes from the youth that involve conceptualizations of social-emotional well-being as having something to look forward to in the future, and having hope that adversity is circumstantial, and can be

overcome. Specifically, several quotes discussed future goal setting as an important component of social-emotional well-being, as many youth perceived goal setting as a leading indicator that change was on the horizon. One youth shared her perspective on achieving hopes and dreams in the context of uncertainty: “I would like to be a surgeon. I guess I just don’t know where I’ll be when I turn 18 though or what I need to go do. I’m not like the other kids in school who know what they’re doing. I need more help.” This theme focusing on hopes and dreams enhances the conceptualization of social-emotional well-being among youth residing in out-of-home care settings in terms of development and preparation for adult roles through anticipatory socialization (Erikson, 1968). During the transition from adolescence to adulthood, anticipatory socialization supports young people in preparing for future life roles (Simpson, 1962). For youth residing in congregate care settings, many do not have a consistent caregiver or supports across ecological domains. This unpredictability in caregiving results in a disruption in anticipatory socialization. Consequently, many youth residing in congregate care settings expressed that explicit support of the transition to traditional adult roles was absent, creating difficulty in accessing knowledge and information about transitioning to adulthood.

How I Know My Needs are Met. This theme represents an array of ways in which children perceive that their needs are being met within multiple social-emotional domains. Specifically, youth discussed ways in which satisfaction with having their basic needs met and maintaining a sense of normalcy in out-of-home care transcended across social-emotional well-being domains. Several quotes discussed both safety and security needs as well as difficulty in obtaining concrete physical well-being needs. Others described a desire to feel a sense of normalcy in their out-of-home placement, with access to resources equivalent to those available to their peers. One youth discussed difficulties in obtaining resources and navigating restrictions at the group home that brought her the comforts of home: “Having something simple like the food I like to eat at home would go a long way. Not every kid likes the same stuff…It would be nice if I could have friends over to the house like other kids or go to the mall. I can’t even have a cell phone.” This theme pertaining to the obtainment of perceived needs enhances the conceptualization of social and emotional well-being of young people residing in congregate care settings in terms of identity formation and social connectedness during adolescence. During the course of normal development, two key tasks in adolescence are to develop individuality, and to gain acceptance from peers (American Psychological Association, 2002). For many youth residing in out-of-home care settings, achievement of these developmental tasks are difficult when living in an environment with varying degrees of contextual responsiveness. Many youth residing in congregate care expressed a desire to have increased flexibility and control in regards to their environmental circumstances. For instance, youth expressed an explicit connection between their social-emotional well-being and accessibility of a range

resources that affect normalcy in their day-to-day lives including access to foods they like to eat, to restrictions on their use of electronics and social media.

Managing Emotional and Behavioral Expression. This theme represents quotes that include the youth's perception of efforts to navigate their own social-emotional well-being by engaging in actionable steps to manage and control their responses to life's challenges and successes. Specifically, several youth discussed their awareness that managing anger and emotional regulation was an important component of their social-emotional well-being. Others discussed trouble avoidance through intentionality and selectivity in participation in activities that have the potential to lead to adverse consequences. One youth described his struggle with self-regulation, and an inability to regulate his emotions in the absence of adult involvement: "I'm doing well when there's no problems. Everything is just normal, and I'm not getting myself into any trouble. I know I am controlling my anger management when I am not getting into any trouble. That's the only way to know." This theme pertaining to engagement in regulation enhances the conceptualization of the social and emotional well-being of youth residing in out-of-home care settings as it pertains to the developmental task of self-regulation. Self-regulation plays an important role in adolescent development, predicting success in multiple domains including social and school relationships (Blandon, Calkins, Grimm, Keane, & O'Brien, 2010; Masten & Coatsworth, 1998). For adolescents residing in out-of-home care settings, development of self-regulatory skills is critical, as failure to achieve this developmental task has the potential to result in consequences that can be life altering, including placement disruption and regressive case plan determinations. Many youth residing in congregate care settings expressed that placement in out-of-home care had limited their access to resources and caregiver supports necessary to enhance skill development in navigating self-regulation.

Cultivating and Maintaining Relationships. This theme includes quotes that discuss the youth's recognition of the loss of previous relationships, and the desire to continue to keep those connections strong. Several youth recognized the double bind situation involved in maintaining family supports while simultaneously building and strengthening new relationships outside of the family-like setting. Specifically, several quotes from the youth focused on their desire to have more family-like relationships with their congregate care providers, whereas others reflected positively on the influence of the increased structure and accountability offered by the group home environment. One youth discussed her struggles with developing a stronger bond and attachment to her adult caregivers: "Nobody feels like family, and I feel like I am something that could be thrown away. I just need to know that I matter ya know? The staff always cook dinner, but what about how I'm feeling?" This theme pertaining to didactic relationships provided evidence to support the conceptualization of social and emotional well-being of young people residing in congregate care settings through development and maintenance of attachment in the caregiver-adolescent dyad. These dyadic interactions across the course of normal adolescent development are persuasive mechanisms,

influencing developmental trajectories for adolescents as they enter adulthood (Branje, 2018). For many youth residing in out-of-home care settings, placement into a congregate care setting creates a disruption in the didactic caregiver-adolescent relationship. Many youth discussed restrained relationships with their out-of-home care providers, and a subsequent desire to develop more informal relationships with their caregivers characterized by warmth, attachment, and unconditional regard. Simultaneously, many youth reflected on the positive influence that involvement in the rigid environmental context of the out-of-home care environment had on their ability to achieve academic and prosocial behavioral success.

Dependency on Adult Perceptions. This theme represents quotes from the largest segment of youth including a perception of positive social-emotional well-being as a reflection of the interpretation from adults in their lives. Specifically, an overwhelming number of youth discussed conceptualizing their social-emotional well-being by the number of times they were regularly redirected by their adult caregivers. This resistance by caregivers was identified by many youth as an important component in gaining insight into their actions and recognizing that they were not doing well. Alternatively, youth discussed the use of positive reinforcement by caregivers as a method of verification and encouragement that resulted in feelings of pride for their accomplishments and reinforced parenting relationships between youth and their caregivers. One youth discussed her desire to experience more positive reinforcement in her life: “I know I’m doing well when adults see me do something good. If I do something as simple as my chore, like, “good job” or when I bring my grades home and I have good grades, “good job.” The influence of the parent-child relationship on children’s adjustment transcends into adolescence, and is necessary for the successful mastery of developmental tasks such as autonomy and identify formation (Longmore, Manning, & Giordano, 2013; Raudino, Fergusson, & Horwood, 2013). This theme highlights parallels across normal adolescent development pertaining to the critical influence of the parent-child relationship on adolescent adjustment and perception of self. Youth residing in congregate care settings confirmed the importance of family for providing critical reinforcement and redirection in their development of positive perceptions of self during adolescence. However, for youth living in out-of-home care settings, this relationship is disrupted. This disruption in the parent-adolescent relationship limits opportunities for perceived parental acceptance; subsequently reducing positive perceptions of self. Many of the youth living in an out-of-home care setting recognized the critical role their caregivers played in helping navigate important developmental tasks, and expressed a desire to develop enhanced relationships with their out-of-home care providers with caregiving messages that provided both redirection as well as positive reinforcement.

Establishing Normalcy. From the voices of youth in the study, we heard how the failure to communicate on a personal, non-transactional level across multiple domains left them feeling disconnected, disempowered, and with a reduced sense of social and

emotional well-being. When the congregate care placement integrated normalcy through embedded practice guidelines and connection to community supports, young people described a sense of autonomy, self-worth, and hope for the future. In many ways, academic achievement, interpersonal relationships and having hope for the future were interrelated, as the young people interviewed overwhelmingly described a relationship between academic achievement and future goal attainment. In particular, youth with high levels of hope for the future were able to identify a support system outside of the congregate care setting that they could rely on in times of need. Having the ability to explore independence and autonomy from this secure base, these young people overwhelmingly recognized that although there were many contextual circumstances outside of their control given their involvement in the child welfare system, they believed they were capable of achieving their dreams and becoming healthy and productive adults.

Caregiver Conceptualization of Youth Social Emotional Well-Being

The perspective offered by kin is important, as these adults in many instances had developed relationships with young people that began prior to the youth entering out-of-home care, and thus was important in understanding the longitudinal well-being needs of children and youth in the child welfare system. The qualitative findings related to social and emotional well-being at a time youth were residing in congregate care were largely convergent with youth perceptions across several domains. The analysis of the qualitative interview data resulted in six social-emotional well-being subthemes: 1) Becoming Part of the Group Home Family, 2) Torn Between Two Worlds, 3) Achieving Academic Success, 4) Managing Emotional and Behavioral Expression, 5) Maintaining Hope for the Future, and 6) How Youth Feel about Themselves. Based on many years of lived experience providing support to young people while they were in congregate care and beyond, these caregivers conceptualized social and emotional well-being as understood within the context of the residential setting, and as an interrelated process that had the potential of promoting other core elements of well-being.

The kin interviewed for the sub-study described the maintenance of relationships for young people in congregate care settings as critical to their social emotional well-being. In particular, caregivers described that while in a congregate care placement, the extent to which the youth perceived a sense of belonging and support through well-functioning and close relationships with their biological/adoptive families was an important indicator of social and emotional well-being. These relationships were often recognized as challenging, resulting from nuanced complexities unique to congregate care settings, including logistical challenges in maintaining contact, legal restrictions, and loyalty conflicts perceived by the youth. It was largely hypothesized that when young people were able to maintain relationships with kin, they were better able to cope with their

involvement with the child welfare system, adjust to new living environments, and more effectively manage the social and emotional consequences associated with navigating competing relationships. Thus, the family relationships were seen as protective for child/youth well-being.

Kinship caregivers felt strongly that many components of well-being built upon one another, and were highly inter-related. For example, kin described difficulties of young people integrating into the congregate care setting environment in the absence of a traditional family structure. The young person's ability to integrate was described as being indirectly related to behavioral expression, academic achievement, self-identity, and having positive aspirations for the future. Many kin noted that as the young people were able to more successfully integrate into the congregate care structure, their school performance improved, leading to enhanced self-esteem and hope for the future. Notably, kin described that they perceived youth as having improved social and emotional well-being when they had improved self-perception resulting from a prioritization of normalcy in the congregate care setting. When young people were able to participate in extracurricular activities, were active in their community, or felt connected to their school, kin perceived that they were able to feel in control of their experiences and have hope for the future beyond the boundaries of the child welfare system.

Content Validity of the Social Emotional Well-Being Measures

The validity of a measure refers to how well it measures what it was designed to measure. There are different approaches to assessing validity. Two nonempirical approaches are content and face validity. Content validity assesses whether the items in the measure relate to the different domains represented by the construct. For example, an important area of social and emotional well-being is interpersonal relationships. A measure of social emotional well-being absent items related to interpersonal relationships would not be considered content valid. To examine the content validity of the two standardized measures used for the sub-study, we compared the themes from the qualitative interviews with youth and kin to the subscales and items on the measures. Table 26 shows the congruence of the themes discerned from the qualitative interviews, cross referenced with the content domains of the BERS-2 and the YQoL-SF.

The qualitative findings provided an opportunity to examine the content validity of the BERS-2 and YQoL-SF by exploring how young people and kin subjectively operationalize social and emotional well-being for children/youth in congregate care. When analyzed together, the qualitative themes appear aligned with the five standardized domains in the BERS-2 and the 15 items on the YQoL-SF. However, important distinctions emerged within the domains that identified gaps in the quantitative interpretation of social and emotional well-being for youth in congregate care. These gaps primarily included a restricted definition of family that does not account for the complexity of relationships youth in out-of-home care experience, including their family and the group home residents and staff; disruption in schooling as many youth move schools, and inadequate prioritization of normalcy important to the operationalization of social and emotional well-being for youth in congregate care.

Table 26. Alignment of Social-Emotional Well-Being Results

Qualitative Interviews	Standardized Measure Domains	
Youth and Adult Kin Themes	BERS 2 Youth	YQoL-SF-SF
Ability to Cope with Adversity (Youth)	Affective Strength	I feel alone in my life
Achieving Academic Success (Youth and Kin)	School Functioning	I am able to do most things as well as I want I feel I am getting a good education
Maintaining Hope for the Future (Youth and Kin)	Career Strength	I look forward to the future
Learning to be Happy During Difficult Times	Intrapersonal Strength	I am happy with the friends I have
How Youth Feel About Themselves (Youth and Kin)	Intrapersonal Strength	I feel good about myself I feel good about how I look
Managing Emotional and Behavioral Expression (Youth and Kin)	Interpersonal Strength	I feel safe when I am at home I am satisfied with the way my life is now
Cultivating and Maintaining Relationships (Youth) Becoming part of the group home family (Kin) Torn between two worlds, i.e., competing loyalties between family and group home families (Kin)	Family Involvement Affective Strength	I feel I am important to others I feel I am getting along with my parents or guardians People my age treat me with respect
Dependency on Adult Perceptions	Family Involvement	I feel understood by my parents or guardians
Establishing Normalcy		I feel I can take part in the same activities as others my age I feel my life is full of interesting things to do

Face Validity

Face validity refers to the degree to which a measure appears to address what it was designed for. For instance, if a measure is designed to address interpersonal relationships, are the items recognized as such? With regard to social emotional well-being, without exception, the youth appeared to enjoy the opportunity to answer questions and talk about themselves in an open-ended question format. They also reacted positively toward the questions on the selected standardized measures and appeared to understand them well. Only one question had wording that often-required additional explanation by the interviewers. This question was on the BERS-2: “I accept criticism.” Youth under the age of 16 years often did not know what this concept meant. Because the initial interviews with youth were conducted in group homes, the wording of six items on the BERS-2 and three items on the YQoL-SF had to be re-phrased to fit the context. These items included the wording “parent” and “siblings” that were re-worded to “group home staff” and “other youth in the group home” respectively.

Overall, the YQoL-SF instrument was found to engage youth and proved to be a means to build rapport at the beginning of the interview process. At the end of the interview, many youth thanked the interviewer and appeared to enjoy the process. In interviews with youth in subsequent years of the study, they often remembered the interviewer and their body language relayed that they were happy to see the individual again. At times, the group home staff demonstrated the use of similar types of questions to the youth in the presence of the interviewers. For instance, many interviews occurred immediately after the youth returned home from school. Staff were instructed to complete the BERS-2 parent survey by answering items within the context of the group home. Following the interview, staff were often observed trying to engage the youth in similar types of questions. The experience of administering the BERS-2 and YQoL-SF supports the face validity of the measures.

Sensitivity

One of the purposes of measurement is to observe change over time. For this reason, a measure is required that is sensitive to tapping into change. Without a sensitive measure, progress may go undetected. However, the measure must also be stable, as an indicator of reliability. A measure that fluctuates from day-to-day is not reliable or useful. An ideal measure is stable unless actual change has occurred, and then sensitive enough to reveal that change. Youth in care often experience transitions (placements, schools, case managers, services, etc.) that are likely to impact how they respond to questions on well-being. Measurements of well-being, therefore, can fluctuate from day-to-day or week-to-week. Overall, children reported little change in their social emotional well-being from Time 1 to Time 2.

Summary

Conceptualizing social-emotional well-being among youth residing in out-of-home care settings has challenged the field of child protection. Many instruments currently utilized in child welfare systems to assess the social-emotional well-being do not include a strong youth component, and others have poor reliability. Children who are residing in out-of-home care because of child welfare involvement face unique developmental challenges in social emotional well-being compared to their peers. Not only do these youth struggle with the circumstances that led to their removal from their families, but they must also navigate the complexity of adolescence within the boundaries of the child welfare system. Understanding the conceptualization of social emotional well-being for youth residing in out-of-home care settings presents opportunities for enhanced measurement.

This sub-study provides an innovative contribution to the literature in applying qualitative methodology to the conceptualization of social-emotional well-being from a youth perspective. Through analysis of youth narrative voice, a number of important findings emerged from the study. First, several youth described conceptualizing their well-being through a sense of individualization in their basic needs and foundation of normalcy in their congregate care setting. This cohort of youth expressed that they were assured that while residing in congregate care their basic needs of housing, medical care, and clothing would be met; however, they lacked a feeling of community, familiarity, and connection they once experienced prior to out-of-home placement. As a result, many youth expressed feeling restricted in their ability to access a variety of resources ranging from variation in food to access to cell phones and electronic devices, many of which brought a sense of normalcy and familiarity of home. Youth expressed frustration in feeling as if their voices were not heard when decisions were being made about their needs, suggesting that even small variations in support could provide comfort, and allow the congregate care environment to feel more like a family-like setting.

Second, several youth described a shift in their coping strategies upon entering out-of-home care, with a new prioritization of managing the difficult feelings they were now experiencing because of involvement with the child welfare system. Specifically, youth reflected that building relationships with peers in their out-of-home care setting was important to coping, as friends from school and the larger community had difficulty relating to the complexity of living in a congregate care setting under the constraints of the child welfare system.

Third, most of the youth identified relationships as an important component of their social-emotional well-being. Youth articulated a strong desire to maintain prior relationships with adults and youth, while simultaneously recognizing that building and sustaining new relationships with peers and caregivers was important to their well-being. Many youth described feeling as if their caregivers in the congregate care setting

assisted them in meeting their basic needs; however, the depth and breadth of these relationships were lacking equivalence to relationships experienced in family-like settings.

Fourth, a number of youth described the prioritization of managing periods of dysregulation in a manner that avoided attracting punitive attention from their caregivers. These youth identified ways in which existing self-regulation strategies were ineffective at times, however described difficulty in identifying periods of positive self-regulation other than in the absence of redirection.

Fifth, the majority of youth identified holding on to hope and dreams for the future as an important component of their social-emotional well-being. Consistent with existing literature on the conceptualization of adolescent well-being (Ciarrochi et al., 2015), youth discussed having a sense of purpose and direction in life that allowed them to feel as if they were moving forward, towards a future when they were no longer involved in the child welfare system. Many of the youth in the study expressed interest in a specific career direction, however many further clarified that they were not sure they had the skills and resources to be successful, or were certain of the necessary steps to take to achieve forward momentum.

Sixth, several youth identified tangible educational outcome indicators as a method of enhancing their self-esteem through positive reinforcement from adults in their lives. Many of these youth discussed the cascade of events that transpired prior to their entry into out-of-home care; resulting in poor academic achievement. The young people described that the structure and support offered by the congregate care setting allowed them to catch-up academically, instilling a sense of pride, accomplishment, and hope for the future.

Seventh, all of the youth in the sample described relying heavily on the opinion of adults, specifically on the congregate care staff and child welfare case managers, to identify instances in which they were doing well. The youth described frequent redirection by adults in their lives for maladaptive behavior, and generalized feelings of disappointment for not meeting the expectations of their caregivers or their child welfare case managers. In contrast, several of the youth described the absence of redirection and inclusion of positive reinforcement as an indicator that they were able to manage themselves more effectively, and were meeting the standards expected of them.

Exploring social and emotional well-being from a developmental-systems lens, this study provides insight into the intersection of social-emotional well-being and contextual environmental variations for youth residing in out-of-home care settings. It is clear that many of these youth possess a desire to improve their social-emotional well-being, however disruptions in developmental trajectories are common in this population as a result of environmental contextual considerations. The findings of this study illustrate

the social and emotional well-being needs of youth residing in out of home care settings; enhancing our understanding of how variations in the relationship between the youth and their contextual environment impact developmental trajectories, and subsequent specific social-emotional well-being needs.

In addition, other factors that impact well-being must be considered when assessing children in congregate care. For example, children's school functioning will be impacted by changing schools or falling behind in credits because of frequent moves. These limitations suggest a need for a measure of social emotional well-being specific to the context of children in congregate care. The measures used to assess well-being may also not be appropriate for children in congregate care. Children in congregate care may form family-like relationships with other residents and staff while also maintaining relationships with their families of origin. The family involvement subscale of the BERS-2 is not designed to assess two types of families with whom a child may have different levels of involvement. A revised measure that takes into account the context of group care is warranted.

Implications

The purpose of this sub study was to identify factors important to the conceptualization of well-being from the perspective of youth residing in congregate care and their adult family connections. The findings crossed multiple domains of social-emotional well-being, and may hold part of the solution in identifying effective modifications for youth residing in congregate care as they transition to adulthood. In particular, youth residing in group homes have restricted access to their family members and communities of origin, and by default, lack stable parental figures in their lives. The findings indicate the powerful influence of caregivers on promoting social-emotional well-being. Specifically, the youth in this study clearly rely on their care providers to provide information pertaining to their well-being, as well as supportive direction pertaining to ways in which they can improve their current circumstances. Despite recognition that placement in congregate care settings are often interim placement stops, the youth expressed an overwhelming desire to strengthen and deepen their relationships with their care providers. The two standardized measures, although not nuanced to the congregate care setting and child welfare involvement, presented skill building opportunities for caregivers employed in congregate care settings on how to better connect with youth on an emotional level. This relates to the implementation of Public Law 113-183 in terms of promoting normalcy and implementation of the reasonable and prudent parent standard as it relates to congregate care.

A further implication of this sub study involves the necessity for youth to adapt existing coping strategies to meet the new expectations, challenges, and restrictions of living in congregate care settings. Specifically, the youth in the study discussed recognizing the importance of self-regulation, however many did not feel as if they had the skills to

accomplish this on their own without constant redirection from their caregivers. Still others described having restrictions on items that provided familiarity at home, further deepening their desire for normalcy, resulting in on-going patterns of dysregulation. This mismatch of frequent dysregulation met with redirection and restriction from their caregivers likely creates a frustrating and ineffective cycle of behavior management. Ensuring that youth are matched with appropriate interventions when necessary to build effective coping strategies coupled with coaching and mentoring for caregivers working in out-of-home care settings may prove to be an efficacious practice approach.

A final important implication of this sub study involves incorporating conversations with youth placed in out-of-home care settings about future goal planning and instilling hope for the future. The majority of the youth interviewed discussed the importance of future goal planning as a means of persevering through adversity. The youth had strong ideas about what they wanted their futures to look like after their involvement with the child welfare system ended, however many expressed uncertainties about their ability to achieve these goals because of contextual environmental instability. Connecting youth to peer mentors and academic career services earlier may prove effective in assisting them to better visualize a path to adulthood that meets their own unique circumstances, allowing them to hold onto hope for the future, and instilling confidence that they have the knowledge and skills to accomplish their goals. To the extent that these easy to implement measures promote and structure these types of conversations with residential staff and child welfare specialists, they should be considered for adoption.

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APPENDIX A. ENGAGEMENT AND SATISFACTION INTERVIEW SCHEDULES

FSC Engagement Survey

(Adult Version)

Instructions to Interviewer:

Below is a script to use in preparing the client for completing this survey. It is important that you write in the specific name of the client's Family Engagement Specialist in the blank lines below.

"We're interested in your feelings about your involvement with your Family Engagement Specialist (FES),_____, and the Department of Child Safety. There are no right or wrong answers to any of our questions. Please answer as honestly and openly as you can. Your answers will be kept absolutely confidential."

"Here are some of the ways youth may feel about having a Family Engagement Specialist and the Department of Child Safety in their lives. Some are positive and some are negative. You may have both positive and negative feelings at the same time. Please read (listen to) the following statements carefully. Then, thinking about how you feel right now about your involvement with _____, and the Department of Child Safety, please indicate how much you agree or disagree with each. Thank you!"

	Strongly Agree (1)	Agree (2)	Neutral or Not Sure (3)	Disagree (4)	Strongly Disagree (5)
1. My FES understands me.	○	○	○	○	○
2. My FES understands my child and my family.	○	○	○	○	○
3. My FES took the time to get to know me and my circumstances.	○	○	○	○	○
4. My FES helped me by advocating for me or giving me information.	○	○	○	○	○
5. My FES understands the importance of my cultural or ethnic background.	○	○	○	○	○

6. I really want to make use of the services (help) that my FES is coordinating for me.	○	○	○	○	○
7. I believe my family will get the help we really need.	○	○	○	○	○
8. It's hard for me to work with the FES.	○	○	○	○	○
9. There's a good reason why the FES is involved with my case.	○	○	○	○	○
10. Working with my FES has given me more hope about how my life and my child's life is going to go in the future.	○	○	○	○	○
11. I think my FES and I respect each other.	○	○	○	○	○
12. I'm not just going through the motions. I'm really involved in working with my FES.	○	○	○	○	○
13. My FES and I agree about what's best for my child.	○	○	○	○	○
14. I feel like I can trust my FES to be fair and to see my side of things.	○	○	○	○	○
15. I think things will get better for my children because my FES is involved.	○	○	○	○	○
16. What my FES wants me to do is the same as what I want.	○	○	○	○	○
17. There were definitely some issues in my family that my FES saw.	○	○	○	○	○
18. My FES doesn't understand where I'm coming from at all.	○	○	○	○	○
19. My FES is helping me take care of some issues in our lives.	○	○	○	○	○
20. I don't think my FES is doing me or my child(ren) any good.	○	○	○	○	○

21. I feel like I can tell my side of the story and be heard.	○	○	○	○	○
22. If I need to talk to my FES, I just call, and we talk.	○	○	○	○	○
23. I put a lot of time and effort into working with my FES.	○	○	○	○	○
24. I think things will get better for my children because of my involvement with my FES.	○	○	○	○	○
25. I see the same issues in our family that my FES does.	○	○	○	○	○

Notes:

Questions 1-5 are adapted from the Parenting Partnering Fidelity and Satisfaction Survey, Questions 6-25 are adapted from the Five-Factor Model for Client Engagement (Yatchmenoff, D., 2005).

FSC Engagement Survey

(Youth Version)

Instructions to Interviewer:

Below is a script to use in preparing the client for completing this survey. It is important that you write in the specific name of the client's Family Engagement Specialist in the blank lines below and reference this person.

"We're interested in your feelings about your involvement with your Family Engagement Specialist (FES) and the Department of Child Safety, _____. There are no right or wrong answers to any of our questions. Please answer as honestly and openly as you can. Your answers will be kept absolutely confidential."

"Here are some of the ways young people may feel about having a Family Engagement Specialist in their lives. Some are positive and some are negative. You may have both positive and negative feelings at the same time. Please read (listen to) the following statements carefully. Then, thinking about how you feel right now about your involvement with _____, please indicate how much you agree or disagree with each. Thank you!"

	Strongly Agree (1)	Agree (2)	Neutral or Not Sure (3)	Disagree (4)	Strongly Disagree (5)
1. My FES understands me.	○	○	○	○	○
2. My FES took the time to get to know me and what is going on in my life.	○	○	○	○	○
3. My FES helped me by being supportive or giving me information.	○	○	○	○	○
4. My FES takes my cultural or ethnic background seriously.	○	○	○	○	○
5. It's hard for me to work with the FES I've been assigned.	○	○	○	○	○
6. Working with my FES has given me more hope about how my life is going to go in the future.	○	○	○	○	○

7. I think my FES and I respect each other.	○	○	○	○	○
8. My FES and I agree about what's best for me.	○	○	○	○	○
9. I feel like I can trust my FES to be fair and to see my perspective.	○	○	○	○	○
10. I think things will get better for me because my FES is involved.	○	○	○	○	○
11. I don't think my FES is doing me any good.	○	○	○	○	○
12. If I need to talk to my FES, I just call, and we talk.	○	○	○	○	○

APPENDIX B. SITE-BASED TEAM MEETING OBSERVATION AND GROUP INTERVIEW SCHEDULE

Site Specific Interview Protocol

[Insert office name/location] Office Interview Notes

[Insert name of observer/interview]

[Insert date of observation]

Present:

Main questions are numbered. Possible probes appear beneath each question.

1. What do you see as FSC's strengths (or strengths of the implementation of FSC)?

2. What challenges have you encountered with FSC (or the implementation of FSC) and what, if any, solutions have you considered or tried?

3. Has FSC affected your work and if so, how?
    a. Workload
    b. Duties
    c. Perspectives on working with families

4. Has FSC affected your working relationships with others and if so, how?
    a. Interactions with collaborators – social workers, attorneys, others?
    b. Interactions with parent clients?
    c. Interactions with child clients?

5. What else should we know about FSC that we have not asked?

6. Who else should we speak with to gain a better understanding of the implementation of FSC?

APPENDIX C. CONTEXT INTERVIEW SCHEDULE

Individual Interview Schedule

1. Imagine I have never heard of Fostering Sustainable Connections (FSC). How would you describe it?
    a. Goals of FSC
    b. Role of the Family Engagement Specialists
    c. Who is eligible?
2. How have you personally interacted with FSC?
    a. Purpose/types of interaction
3. What do you see as FSC's strengths (or strengths of implementation)?
4. How could FSC improve (or how could implementation be improved)?
5. Has FSC affected your work and if so, how?
    a. Workload
    b. Duties
    c. Perspective on working with families
6. Has FSC affected your working relationships with others and if so, how?
    a. Interactions with collaborators – social workers, attorneys, others?
    b. Interactions with families?
    c. Interactions with children/youth?
7. What else should I know about FSC that I haven't asked?
8. Is there anyone else you think I should speak with to gain a better understanding of the implementation of FSC?

Group Interview Schedule

1. What do you see as FSC's strengths (or strengths of the implementation of FSC)?
2. What challenges have you encountered with FSC (or the implementation of FSC) and what, if any, solutions have you considered or tried?
3. Has FSC affected your work and if so, how?
    a. Workload
    b. Duties
    c. Perspectives on working with families

4. Has FSC affected your working relationships with others and if so, how?
    a. Interactions with collaborators – social workers, attorneys, others?
    b. Interactions with parent clients?
    c. Interactions with child clients?
5. What else should we know about FSC that we have not asked?
6. Who else should we speak with to gain a better understanding of the implementation of FSC?

APPENDIX D. CASE FILE REVIEW CODING TOOL

Completing the Case File Review

EXTENT OF MALTREATMENT

Review the list of items under Extent of Maltreatment prior to reviewing the case in order to familiarize yourself with the various types of maltreatment. What abuse or neglect is or has occurred in the home from a global perspective? Looking beyond the incident (or incidents) that led to DCS involvement (and the subsequent filing of the dependency petition) how are the children in the home being abused or neglected? What underlying factors are contributing to maltreatment? It is important to consider all kinds of maltreatment (neglect, physical abuse, sexual abuse, emotional abuse). These factors extend beyond allegations in reports, petitions, or the use of a substantiated allegation classification looking over the **entire lifetime of a case.**

ADULT FUNCTIONING

What are the biopsychosocial attributes of the caregivers or other adults exposed to the child that are adversely impacting the safety, permanency and well-being of the child? Some commonly contributing influences include substance abuse, domestic violence, mental health concerns, history of trauma, maltreatment as a child.

PARENTING PRACTICES

What are the parenting practices that are occurring in the home that are adversely impacting the safety, permanency and well-being of the child? Parenting practices differ from adult functioning as these are characteristics that are directly related to parenting, rather than adult functioning. Parenting practices include the parent's ability to meet the physical, social, emotional, and educational needs of the child, bonding and attachment, having realistic expectations of the child based on their developmental age and functioning, motivation for parenting, the ability to provide nurturing attention and affection, discipline, ability to identify safe alternative caregivers, and the ability to protect the child from harm.

CHILD FUNCTIONING

Child functioning specifically relates to the child that is engaging in components of the study (i.e. the targeted child). This section does not relate to the other children residing in the home, unless that child's behaviors are impacting the targeted child (i.e. sexual abuse). Important components include physical health and wellness, emotional and behavioral well-being (behavioral health needs, attachment to caregivers), history of trauma, educational well-being and social well-being (how does the child function with peers, in the community etc.).

Where to Find Case Information:

(Over the Entire Life of the Case)

- All Reports to the Child Abuse Hotline
- All Status Communications
- Case Notes, Parent Aide Notes, FPPT/BRF Notes, Other Provider Notes, Court Reports

Who to Include in the Assessment:

- Mother
- Father to the Targeted Child
- Any other Fathers to other Children Residing in the Home
- Other Adults Living in the Home
- Target Child for the Well-Being Study

Participant Identification

Child's Name: _____ Child's Participant ID Number: _____ Date Enrolled in FSC:_____

Participant Initials	Participant ID Number	Relationship to Targeted Child	Date Added to Case	Date Ended in Case	Comments

DATE OF REMOVAL_____

DATE OF RETURN_____

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
Extent of the Maltreatment	Physical Abuse	**Mitigating Circumstances:** Parent uses physical discipline as the primary method of behavior management which inconsistently results in very minor injuries (red marks, very small bruises). Parent acknowledges that this form of discipline is not the most effective method, is supportive of change, and expresses desire for additional psycho-educational support.	BRF, FPPT, Individual Counseling, Family Counseling, Group Treatment, Psycho-Educational Support, Community-Based Parenting Education (no evidence of intervention escalation is necessary if the physical abuse only results in very minor injuries)
		Aggravating Circumstances: Parent uses physical discipline as the primary method of behavior management that consistently leaves bruising injury to the child(ren), or child(ren) experience significant injuries (broken bones, fractures) as a result of the physical abuse. Parent does not acknowledge deficits in parenting practices, and is unwilling to adapt discipline method.	Unit Psychological Consultation, Psychological Evaluation, FPPT, Parent Aide Services (evidence of intervention escalation is necessary if the physical abuse results in consistent bruising injury or other serious injuries (broken bone), or if parent is unwilling to adapt parenting practices)
	Neglect: Inadequate Nutrition	**Inadequate Food/Nutrition:** Parent does not consistently have the ability to meet the financial obligations of the home in terms of providing consistent and nutritious meals (children go without meals, parent watering down formula, failure to thrive diagnosis)	Food Boxes, Community-Based Referral, FPPT, BRF, WIC/SNAP Benefits, Parent Aide (escalation of intervention is necessary if parent is intentionally withholding food from child. See Parent Functioning Emotional/Behavioral Health Functioning or Medical Child Abuse)

	Neglect: Household Maintenance/Cleaning	**Mitigating Circumstances:** Condition of the family's residence is unsafe for young children. For example: condition of the home is very cluttered, dirty, and places young children at risk of harm due to sanitation concerns, children wearing clothes that is inappropriate for the weather, children being dirty/not bathing and/or smelling bad.	Community Intervention, FPPT, BRF, Housing Voucher (evidence of escalating interventions is not necessary if the home can be cleaned without significant intervention, or the family needs psycho-educational support)
		Aggravating Circumstances: Condition of the family's home is uninhabitable for children. For example: the home is deplorable with safety hazards (feces, exposed wiring, unstable residence).	Unit-Based Psychological Consultation, Psychological Evaluation, FPPT, Housing Voucher, Shelter (evidence of escalating intervention is necessary if the home poses a significant safety threat to the children)
	Neglect: Supervision	**Mitigating Circumstance:** Caregiver does not provide supervision appropriate for the child's age and developmental capacity, however children are not injured (i.e.: inadequate supervision occurs for short periods of time, isolated incidents, accidental lapse)	BRF, Child Care, Community Parenting Support (escalation of interventions is not necessary if lapse in supervision is short, is an isolated occurrence, accidental due to miscommunication, and child does not experience any harm)
	Neglect: Supervision	**Aggravating Circumstance**: Caregiver does not provide supervision appropriate for child's age or developmental capacity, and child(ren) are subsequently injured (i.e.: left home alone for extended periods of time, drowning in pools/tubs, burning accidents from the kitchen, hit by traffic)	FPPT, BRF, Child Care, Community Based Support, Parent Aide Services (escalation of interventions is necessary if lapse in supervision is lengthy, persistent, or children are injured (burning, drowning etc.) during incident)

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
Extent of the Maltreatment	Neglect: Medical Treatment	**Mitigating Circumstances:** Parent does not follow-up on medically recommended treatment for mental or behavioral health needs, which places child at risk for future harm	Medicaid/AHCCCS/DES Referral, BRF, FPPT (escalation of interventions is not necessary if resources (transportation, medical insurance) and education are primary barrier to compliance, and can be easily remedied with interventions)
		Aggravating Circumstances: Parent does not follow-up on medically recommended treatment for mental or behavioral health needs resulting in further impairment or unreasonable risk of harm to the child	Out of home placement (inpatient psych, skilled nursing facility), home- health nursing, parent aide, FPPT (escalation of interventions is necessary if child is in imminent risk of danger (i.e.: actively suicidal, complicated medical needs)
	Neglect: Housing	**Mitigating Circumstances:** Family has unstable housing.	Community Intervention, FPPT, BRF, Housing Voucher
		Aggravating Circumstances: Family has no safe housing	Community Intervention, FPPT, BRF, Housing Voucher
	Medical Child Abuse	**Mitigating Circumstances:** Parent displays characteristics of medical child abuse (i.e.: secondary gain from child's medical condition), however parent has not experienced unnecessary medical procedures, and child has not been harmed.	Unit-Based Psychological Consultation, BRF, Individual Community-Based Counseling, Support Groups (evidence of escalating intervention is not necessary if the child has not been harmed, and has not received unnecessary medical procedures)
		Aggravating Circumstances: Parent actively engages in activities to purposefully make	Unit-Based Psychological Consultation, Psychological

		child ill, insists that unnecessary medical procedures be performed on child, and child has been harmed through on-going invasive medical intervention.	Evaluation, Individual Community-Based Counseling (evidence of escalating intervention is necessary-i.e.: (psychological consultation and evaluation) if the child has experienced multiple unnecessary medical procedures, and there is evidence of intentionality)
Area Identified	**Area of Functioning**	**Aggravating/Mitigating Circumstances**	**Services to Consider**
Extent of the Maltreatment	Emotional Abuse	**Mitigating Circumstances:** Evidence of emotional abuse is minor, and/or does not consistently occur. Child has an appropriate caregiver at home with whom he/she can seek support, the abusive parent is remorseful and seeks support, and there is no evidence of serious psychological consequences of the emotional maltreatment.	Psycho-Educational Support, Community Based Intervention, FPPT, BRF, RBHA Case Management (evidence of escalated intervention is not necessary if the emotional/mental abuse is minor, has not been long lasting, and has not resulted in emotional impairment)
		Aggravating Circumstances: Evidence of emotional abuse is severe, and occurs consistently. There is no parent/caregiver with whom the child can seek support, and the abusive parent does take responsibility for his/her actions. The emotional abuse causes difficulty in psychological functioning of the child(ren), and disrupts the normal parent-child relationship.	Unit Psychological Consultation, Psychological Evaluation, FPPT, Parent Aide, Family Counseling, Individual Counseling, Crisis Intervention, SSI/SSD (evidence of escalated intervention is necessary if emotional abuse is long-lasting, results in emotional impairment, or is exceptionally severe and emotionally devastating to the child(ren) Refer to Child Functioning for additional interventions)

	Sexual Abuse	**Mitigating Circumstances:** Sexual abuse has occurred within the family system in the past, however the perpetrator no longer has access to the child, and the non-abusive parent/caregiver believes and demonstrates the ability to protect the child.	Community Based Intervention, BRF, FPPT, Individual Counseling, Family Counseling, Legal Support, Support Group/Group Treatment (no evidence of escalating intervention is necessary if the perpetrator has no contact with the child, and caregiver is able and willing to protect the child)
		Aggravating Circumstances: Sexual abuse has occurred within the family system, and perpetrator continues to have access to the child, family members/other caregivers do not believe the child, and there is no adult willing or able to protect the child from the perpetrator	Unit Psychological consultation, Psychological Evaluation, Psychosexual Evaluation, FPPT, Legal Support (evidence of escalating interventions is necessary if the perpetrator continues to have access to the child, no parent/caregiver is willing or able to protect the child, or perpetrator continues to have access to the child)
Adult Functioning	Emotional/Mental Health	**Mitigated Circumstance:** Minor mental health symptomatology (does not directly impact parenting or impact child safety i.e.: mild depression/baby blues or anxiety)	Individual Counseling, Group Treatment, RBHA Case Management, FPPT, BRF (evidence of escalated intervention including a unit psychological consultation or psychological evaluation may not be necessary)

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
Adult Functioning	Emotional/Mental Health	**Aggravated Circumstance:** Severe impairment of functioning (i.e.: hallucinations, erratic behavior, post-partum psychosis, SMI symptomatology, historical mental health or SMI diagnosis, personality disorders, extreme violence or aggression)	Unit Psychological Consultation, Individual Counseling, SSI/SSD, Crisis Intervention, Psychological Evaluation, Psychiatric Evaluation, Medication Monitoring (evidence of escalated intervention and evaluation is necessary- i.e.: unit psychological consultation and psychological evaluation)
	Response to Stress/Coping	Difficulty coping with everyday life challenges or situational circumstances, difficulty coping with DCS intervention, inability to "bounce back" after periods of adversity	Community-Based Treatment, FPPT, BRF, RBHA Case Management (if difficulty with coping is unresponsive to interventions or co-occurs with mental health symptomatology: Refer to Emotional/Mental Health)
	History of Trauma	**Mitigated Circumstance**: Parent/caregiver reports unresolved trauma concerns that appear to cause mild difficulty for the parent, but do not impair parenting	Individual Counseling, Group Treatment, Community Support Group, FPPT, BRF (evidence of escalated intervention may not be necessary if trauma concerns are resolvable through community treatment and are not an underlying factor of a more severe mental health concern which requires intervention)

		Aggravated Circumstance: Parent exhibits severe unresolved trauma issues that appear to be the underlying source of externalizing/internalizing behaviors, and significantly impair parenting	Unit Psychological Consultation, Psychological Evaluation, Individual Counseling, Group Treatment, Community Support Groups, FPPT (evidence of escalated intervention and evaluation is necessary-i.e.: Unit Consultation and Evaluation)
	Cognitive Development/Abilities	**Mitigated Circumstance**: Parent has mild developmental concerns that cause difficulty, however do not impact parenting (i.e.: difficulty with employment, difficulty with household management)	Community Supports, FPPT, BRF, DES/DDD Services (evidence of escalated intervention-i.e.: unit consultation or psychological evaluation may not be necessary)
		Aggravated Circumstance: Cognitive abilities/developmental concerns that impact ability to parent (i.e.: engage in consistent parenting tasks, provide age appropriate supervision, participate in nurturing/bonding activities)	Unit Psychological Consultation, Psychological Evaluation, DDD Services, SSI, Community Supports, FFPT (evidence of escalated intervention is necessary-i.e.: (consultation, psychological evaluation)

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
Adult Functioning	Psychiatric Concerns	**Mitigating Circumstances**: Minor mental health symptomatology where parent has historically been prescribed medication or could benefit from prescription and medication monitoring (i.e.: depression, history of anxiety)	Community Medical Monitoring, RBHA Case Management, Support Groups, FPPT, BRF, Peer Support (if psychiatric concerns are minor (i.e.: minor depression or anxiety) that do not impact parenting, unit consultation or evaluation may not be necessary)
		Aggravating Circumstances: Severe psychiatric concerns (i.e.: SMI diagnosis, hallucinations, extremely erratic or violent behavior, past diagnosis of mental health issues that impairs parenting)	Unit Consultation, Psychiatric Evaluation, Intensive Outpatient Treatment, Intensive Inpatient Treatment, Medication Monitoring, RBHA Case Management (evidence of escalated intervention and evaluation is necessary if psychiatric concerns involve severe impairment-i.e.: (psychiatric consultation and evaluation)
	Substance Abuse	**Mitigating Circumstances:** Historical substance abuse (no current evidence of use) Sale/Manufacturing of Drugs (no evidence of use)	UA/Hair Follicle Testing, Maintenance Program, 12 Step Program or Community Support Group, FPPT, BRF, Parent Aide Services (no evidence of escalated intervention is necessary if UA/Hair Follicle is clean)
		Aggravating Circumstances: Active substance abuse where a parent/caregiver is impaired	Substance Abuse Assessment, Inpatient Treatment, Outpatient Treatment, UA/Hair Follicle Testing

		to the point that it is impacting their ability to safely parent their child	(evidence of escalated intervention is necessary-i.e.: substance abuse assessment/evaluation, inpatient or outpatient treatment is necessary if active substance abuse is occurring in the home by parent/caregiver)
	Substance Abuse Ability to Protect	**Mitigating Circumstances**: Parent is not actively using substances, however other parent/caregiver is actively using in the home. Parent understands the threat, however lacks resources to consistently protect the child.	FPPT, BRF, Community-Based Intervention, Support Group, Child Care (evidence of additional intervention is not necessary if parent is not also using substances and understands the threat, however resources (i.e.: child care) are an issue)
		Aggravating Circumstances: Caregiver demonstrates inability to protect child from the impact of illegal substances (i.e.: allowing adults who are using to supervise the children, exposing children to toxins or manufacturing)	FPPT, Community-Based Intervention, Individual/Group Counseling, Parent Aide, Child Care (Escalation in intervention is necessary if caregiver lacks resources and fails to understand threat by unsafe caregivers)
	Substance Abuse: Substance Exposed Newborn	Child tests positive for substances at birth	Substance Abuse Assessment, Inpatient Treatment, Outpatient Treatment, UA/Hair Follicle Testing, 12 Step Program or Community Support Group, FPPT, BRF, Parent Aide Services
	Substance Abuse: Sale/Manufacturing of Drugs	Sale/Manufacturing of Drugs	Substance Abuse Assessment, UA/Hair Follicle Testing, FPPT, BRF, Parent Aide Services

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
Adult Functioning	Medical/Physical Concerns	Parent has a diagnosed medical condition that is impacting parenting (i.e.: uncontrolled seizure disorder with a vulnerable child, mobility issues resulting in lack of supervision)	Community mental health examination, parent aide services, FPPT, BRF, rehabilitative services, child care) (escalated intervention in the form of SSI/SSD and medical examination are necessary for medical conditions which significantly impair parenting)
	Employment Deficits	Parent lacks backs skill sets in order to obtain gainful employment in order to assist family	DES JOBS Program, BRF, FPPT, Community Supports (if unemployment is resulting in family's inability to meet basic household needs, address this under concrete supports below)
	Violence: Against other Adults	**Mitigating Circumstances**: Violence against other adults that is not out of control- (i.e.: parent has demonstrated ability in the past to use coping strategies, has participated in treatment, recognizes the problem behavior)	Community based psycho-educational supports, individual counseling, group treatment, FPPT, BRF (evidence of escalated intervention is not necessary if violence does not directly impact parenting or ability to protect child from unsafe circumstances)
		Aggravating Circumstances: Violence against other adults that results in law enforcement involvement and is out of control (no caregiver is able to stop it, and children are consistently exposed to violence)	Unit psychological consult, psychological evaluation, individual and group counseling, FPPT (evidence of escalated intervention i.e.: psychological consultation and evaluation is necessary if violence is aggravated

			(use of weapon, significant bodily harm) or out of control)
	Violence: Against Property	**Mitigating Circumstances**: Violence against property that is not out of control- (i.e.: parent has demonstrated ability in the past to use coping strategies, has participated in treatment, recognizes the problem behavior)	Community based psycho-educational supports, individual counseling, group treatment, FPPT, BRF (evidence of escalated intervention is not necessary if violence does not directly impact parenting or ability to protect child from unsafe circumstances)
		Aggravating Circumstances: Violence against other property that results in law enforcement involvement and is out of control (no caregiver is able to stop it, and children are consistently exposed to violence)	Unit psychological consult, psychological evaluation, individual and group counseling, FPPT (evidence of escalated intervention i.e.: psychological consultation and evaluation is necessary if violence is out of control (no intervention has been successful)
	Inability to Protect Child from Violence	**Mitigating Circumstances:** Parent is unwilling or unable to understand the threat posed to the child from living in, or being exposed to a violence environment	FPPT, BRF, Parent Aide, Individual Counseling, Parent Aide (no evidence of escalated intervention is necessary if parent understands the threat and is actively taking steps to protect)
		Aggravating Circumstances: Parent is unwilling or unable to protect the child from violence. Aggravating circumstances exist such as: recurrent violence, law enforcement involvement, engaging in criminal activity with the children present, use of a dangerous weapon	Psychological Consultation, Psychological Evaluation, Individual Counseling, Group Treatment (evidence of escalating intervention is necessary if circumstances are aggravated-i.e.: persistent exposure to violence, law enforcement, use of dangerous weapons (firearm, bat/object)

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
	Interpersonal Relationships: Family Discord	**Mitigating Circumstances:** Family members have tension in their immediate relationship that causes difficulty in everyday interactions, including other adults in the residence, or strained relationship between children and caregivers (i.e.: parent-teen relationship and communication difficulties)	Community-Based Family Counseling, FPPT, and BRF (evidence of escalated intervention- (Refer to Domestic Violence) if tension amongst family members is persistent, violent or controlling).
		Aggravating Circumstances: Family members engage in continual discord (i.e.: verbal abuse in front of children, continual and persistent family court involvement using the children for individual gain)	Couples Counseling in the Community, FPPT, BRF (evidence of escalated intervention- (Refer to Domestic Violence) if family discord is persistent, violent or controlling, or involves law enforcement intervention
	Domestic Violence: Perpetration	**Mitigating Circumstances**: Perpetrator engages in violence towards family members. Violence is not necessarily persistent, children are not involved, no dangerous weapons were used, or law enforcement is not involved	Family Counseling, Individual Counseling, FPPT, BRF, Group Treatment/Support (evidence of escalated intervention is not necessary if the violence is not persistent, does not involve dangerous weapons or law enforcement, or children are not involved/injured
	Domestic Violence: Perpetration	**Aggravating Circumstances**: Perpetrator engages in persistent or aggravated violence towards family members. Violence is persistent and has not responded to intervention in the past, there is an evident cycle of violence and control in the home, children are involved or injured in the violence, dangerous weapon	Psychological Consultation or Evaluation, Group Treatment/support (evidence of escalated intervention is necessary if the violence is persistent, involves law enforcement or dangerous weapons, or if there is a pattern of violence and control in the home)

		(bat, knife, gun) is used, or law enforcement becomes involved	
	Domestic Violence: Victimization	**Mitigating Circumstances:** Caregiver is a victim of domestic violence however understands the threat the perpetrator poses to his/her safety, and the safety of the child(ren). No law enforcement, dangerous weapons, or involvement of children in the domestic violence. Caregiver has minimal supports to develop a safety plan, however is receptive to intervention and support.	Group Treatment, Individual Counseling, Psycho-Educational Support, FPPT, BRF (evidence of escalation of interventions is not necessary if survivor is able to develop a safety plan, and there is no evidence of law enforcement involvement, use of dangerous weapons, or involvement of children)
		Aggravating Circumstances: Caregiver is a victim of domestic violence, and does not understand the threat the perpetrator poses to his/her safety. Domestic violence includes law enforcement, dangerous weapons (bat, gun, knife) are used or children are involved in the violence. Caregiver has minimal/unhelpful supports, and is unable to develop a safety plan.	Unit psychological consultation and psychological evaluation, shelter, legal assistance, individual and group treatment (evidence of escalated interventions is necessary if survivor is unable or unwilling to understand the threat posed by the perpetrator, if law enforcement, dangerous weapons or children are involved in the violence, or if caregiver has minimal/unhelpful supports to develop a safety plan for him/herself and the children)

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
	Domestic Violence: Protection of Children	**Mitigated Circumstance** Parent understands the threat posed by the perpetrator, however cannot consistently protect children. Children have not been physically injured as a result of the DV, exposure to DV is minimal, there is no law enforcement or weapons involvement. Survivor has minimal resources to protect the children.	Individual and Family Counseling, Psycho-Educational Support, FPPT, BRF (evidence of escalated interventions is not necessary if survivor understands the threat posed by the perpetrator and takes steps to protect the children. Children have not been harmed as a result of the domestic violence, and there is no law enforcement/weapons involvement)
		Aggravated Circumstance: Parent is unwilling or unable to see the threat posed to the children by the perpetrator; children have been injured as a result of the domestic violence, or witnessed extensive violence (physical and emotional abuse)	Unit Psychological Consultation, Psychological Evaluation, Shelter/Safe House, Legal Assistance (escalation of intervention is necessary if caregiver cannot consistently ensure the safety of the children, does not understand the threat posed by the perpetrator, or the children have been harmed, law enforcement/dangerous weapons are involved)
	Concrete Supports	**Financial Concerns**: Parent is not able to consistently maintain employment to meet the financial obligations of the family on a consistent basis.	Community-Based Referrals, TANF, DES Jobs Program, FPPT Emergency Funds, FPPT, BRF (if parent is struggling with employment skills: Refer to Employment section)
		Transportation Concerns: Parent is not able to consistently ensure needs of the children are	Bus Passes, Community-Based Transportation (AHCCCS), BRF

		met (i.e.: attending school on a regular basis, medical or behavioral health treatment) because of limited access to transportation	(If client is unable to utilize public transportation, evidence of escalation in intervention is necessary (i.e.: taxi transportation or community provider)
		Social Support: Parent does not have a supportive and healthy social support system to assist during times of need, and enable relationships with healthy adults	Community-Based Referral, Child Care Referral, FPPT, BRF (Evidence of escalation of intervention is necessary if family's level of social support places child at risk of harm: Refer to Extent of Maltreatment: Neglect)

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
Parenting Practices	Expectations of the Child(ren)	**Unrealistic Expectations of the children**: Caregiver does not have an age appropriate understanding of normal child development resulting in inappropriate supervision, children engaging in adult tasks (housekeeping, caring for younger children), etc.	Home-visitation, BRF, FPPT, Parent Aide, Community Parenting Education, Child Care Services (escalation of intervention is necessary if children are experiencing harm due to inadequate supervision, are missing school to care for other children etc. See Extent of Maltreatment: Neglect)
	Bonding/Attachment	**Mitigating Circumstances:** Parent is struggling to form an attachment with child, however recognizes the need for intervention and is receptive to support.	Individual Counseling, Family Counseling, BRF, FPPT (no evidence of escalated intervention is appropriate for minor difficulties with

			bonding where a parent understands the difficulty with bonding)
		Aggravating Circumstances: Parent struggles significantly with bonding/attachment to the child, expresses negative feelings towards child, sees parenting as a function of task completion (child as a burden to the family)	Unit Psychological Consultation, Bonding Assessment, Parent Aide, Therapeutic Visitation (evidence of escalated intervention is appropriate for aggravated concerns with bonding/attachment where the caregiver has ill feelings towards the children, sees parenting as a burden or is unwilling or unable to understand the concerns pertaining to bonding/attachment)
	Deficient Parenting	**Mitigating Circumstances:** Parent/Caregiver exhibits minor deficiencies in knowledge of child development/parenting practices (i.e.: normal developmental milestones, discipline practices, child missing school)	Community-Based Parenting Referral, Home-Visitation, Building Resilient Families (evidence of escalated intervention is not necessary if parenting practices do not significantly impact child, parent recognizes deficiencies and is open to intervention)
		Aggravating Circumstances: Parent exhibits extraordinary deficiencies in knowledge of child development/parenting practices that place the child in danger or results in developmental consequences	Family Preservation, Parent Aide, BRF (evidence of escalated intervention is necessary if parent does not respond to intervention, or deficiencies significantly impact the child)

Child Functioning	Child Physical Health	**Mitigating Circumstances:** Child has medical conditions which require specialized attention, on-going monitoring and parental/medical intervention	Community Medical Examination, Medicaid/AHCCCS (evidence of escalating intervention is not necessary if medical condition can be managed at home, and family has access to supports, however may not be optimizing available resources)
Area Identified	**Area of Functioning**	**Aggravating/Mitigating Circumstances**	**Services to Consider**
Child Functioning	Child Physical Health	**Aggravating Circumstances:** Child has significant medical conditions which require specialized medical treatment, involvement of multiple specialists, and constant monitoring/intervention	Community Health Nurse, Medical Placement (evidence of escalating intervention (i.e.: community health nurse or medical placement) is necessary if other interventions have not been successful)
	Social Functioning	**Mitigating Circumstances:** Child has experienced significant social delay as a result of lack of socialization in the community and/or isolation	Community-Based Referral, Childcare Referral, AZEIP, BRF (evidence of escalating intervention (i.e.: group treatment, psycho-educational support is necessary if social delay is pervasive, or family does not respond to less intensive interventions)
		Aggravating Circumstances: Child has experienced significant social delay and consequently cannot interact with community members (i.e.: socially	Group Treatment, Psycho-Educational Support, Out of Home Placement (Residential Treatment), Individual Counseling)

		inappropriate behaviors, extreme behaviors**)**	(evidence of escalating intervention is necessary if child's social functioning is severely impaired i.e.: Out of Home Placement, Group Treatment)
	Cognitive Functioning	**Mitigating Circumstances:** Child has a mild cognitive delay/developmental disability which requires intervention (including ADHD, autism)	Community Based Support, AZEIP Services, School District Engagement (evidence of escalating intervention is not necessary if delay is mild, and caregiver has the ability to meet child's needs)
		Aggravating Circumstances: Child has a significant cognitive delay/developmental disability that requires intervention	Unit Psychological Consultation, Psychological Evaluation, DES/DDD/ALTCS, SSI/SSD (evidence of escalating intervention is necessary if cognitive delay is severe, and caregiver appears to struggle with meeting child's developmental needs)
	Externalizing Behavioral Functioning	**Mitigating Circumstances:** Child has mild externalizing behavioral characteristics (i.e.: difficult behavioral challenges, developmental delay, aggressive behavior towards children, aggressive behavior towards adults, impulsive behavior, or involvement with the juvenile justice system or legal involvement	Case Management (RBHA), Developmental Assessment, Individual Counseling, Group Treatment, Behavioral Coaching, FFPT, BRF (evidence of escalating intervention is not necessary if the externalizing behavior is mild, does not seriously interfere with the child's functioning and does not place others at risk of harm)

Area Identified	Area of Functioning	Aggravating/Mitigating Circumstances	Services to Consider
Child Functioning	Externalizing Behavioral Functioning	**Aggravating Circumstances:** Child has severe externalizing behavioral characteristics (impulsive behavior that places the child at risk, perpetration against others, or extreme violence that places other at risk of harm, substance abuse, suicide attempts)	Unit Psychological Consultation, Psychological Evaluation, Psychiatric Evaluation, Medication Monitoring, Group Treatment, Safety Planning, FPPT (evidence of escalating intervention is necessary if externalizing behaviors are extremely violent, there is evidence of serious mental health issues with the child, or aggressive perpetration against others)
	Internalizing Behavioral Functioning	**Mitigating Circumstances:** Child has mild internalizing behavioral characteristics (withdrawn, depression, anxiety, suicidal ideation)	Case Management (RBHA), Individual Counseling, Group Treatment (evidence of escalating intervention is not necessary if internalizing behaviors are mild without evidence of self- harm or self-injurious behaviors)
		Aggravating Circumstances: Child has severe internalizing behavioral characteristics (self-injurious behaviors, suicide attempts)	Unit Psychological Consultation, Psychological Evaluation, Psychiatric Evaluation, Residential Treatment, Medication Monitoring (evidence of escalating intervention is necessary when there is evidence of self-injurious behavior/self-harm or risk of self-harm
	Educational Functioning	**Mitigating Circumstances:** Child has specialized educational needs that require an IEP and	IEP, Therapeutic Support: School, Gifted Testing,

		support or intervention at the school level	Programming, After-School Programs, Tutoring (evidence of escalating intervention is not necessary when child's educational concerns are not severe, and are able to be mitigated with supportive services)
		Aggravating Circumstances: Child has specialized educational needs that require specialized educational placement and intervention	Individualized Educational Placement, Law Enforcement Involvement: Delinquency (evidence of escalating intervention is necessary when child is persistently failing to attend school

APPENDIX E. WELL-BEING INTERVIEW SCHEDULES

Measuring Well-Being Among Children and Youth in Congregate Care

Semi-Structured Interview Guide for Qualitative Interviews

Adult Version

Note to Researcher

These questions are general probes and you may need to modify the language or explain further the intention of the question. We are interested in the parent/caregiver/relative's perspective on the well-being of the youth so try to help them understand the concept of well-being and that there is not a right or wrong way to respond.

Introductory Script to Read to the Adult:

You recently answered some questions about how the youth in your care (or youth you are related to) is doing overall (physically show them a blank copy of the BERS-2 and the Youth Quality of Life and walk them through some of the sections/questions). I asked you questions about things that are important to the youth, her/his health, things he/she likes to do, and what makes him/her happy and feel good in life. All of these things together can be considered "doing well" or having a sense of well-being. Different people have different ideas about which of these things are most important in determining well-being.

1. For _____(insert youth's name), how do you know when he/she is doing well?

2. What does "doing well" look like for _____ (insert youth's name)? [This could be many different things but some examples are being healthy, having people who care about her/him, having enough food to eat each day, doing well in school, etc.]

3. Tell me about a time in your life when _____ (insert youth's name) was doing well/things were going well.

4. Tell me about a time in your life when _____ (insert youth's name) was not doing well/things weren't going well.

5. Tell me about people or things that help _____ (insert youth's name) do well. [For example, having someone to call when he/she has a hard day or having a teacher who helps her/him with your homework].

6. How are things different or the same since _____ (insert youth's name) moved to the group home/shelter?

7. What helps_____ (insert youth's name) have hope for the future?

Measuring Well-Being Among Children and Youth in Congregate Care

Semi-Structured Interview Guide for Qualitative Interviews

Youth Version

Note to Researcher

These questions are general probes and you may need to modify the language or explain further the intention of the question depending on the developmental level of the child/youth. We are interested in the youth's perspective so try to help them understand the concept of well-being and that there is not a right or wrong way to respond.

Introductory Script to Read to Youth:

You recently answered some questions about areas of your life in which you might be doing pretty well and areas where you might be having some trouble (physically show them a blank copy of the BERS-2 and the Youth Quality of Life and walk them through some of the sections/questions). I asked you questions about how you feel about a lot of different things such as people who are important to you, your health, things you like to do, and what makes you happy and feel good in life. All of these things together could be considered "doing well" in your life or your sense of well-being. Different people have different ideas about which of these things are most important.

1. For you, how do you know when you are doing well?

2. What does "doing well" look like to you? [This could be many different things but some examples are being healthy, having people who care about you, having enough food to eat each day, doing well in school, etc.]

3. Tell me about a time in your life when you were doing well/things were going well.

4. Tell me about a time in your life when you weren't doing well/things weren't going well.

5. Tell me about people or things that help you do well. [For example, having someone to call when you have a hard day or having a teacher who helps you with your homework].

6. How are things different or the same since you moved to the group home/shelter?

7. What helps you have hope for the future?