STATE OF MAINE
IV-E CHILD WELFARE DEMONSTRATION PROJECT

MAINE ADOPTION GUIDES PROJECT

FINAL EVALUATION REPORT
December 31, 2004

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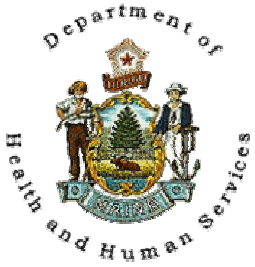


MAINE ADOPTION GUIDES FINAL EVALUATION REPORT: FINAL RESEARCH SUMMARY - December 2004

This research summary was developed to provide information about the Maine Adoption Guides Project and its final research results. Six major research questions from the evaluation were:

- ***What is the Maine Adoption Guides post-adoption services model?***
- ***What issues do parents have before they legalize their adoption?***
- ***What are the characteristics of the children and families in the project?***
- ***What services do parents use the most, or least, and what types of services do they prefer?***
- ***What difference does the MAGS model make in the lives of children and families?***
- ***What are the costs involved in caring for children after legalization?***

The research design was a longitudinal control group design with random assignment and observations both before the intervention and then conducted every six months for the duration of the study. There were four cohorts observed in the study. The outcome evaluation reported on the extent to which the children/families who received the Guided Services Model (experimental group) and the children/families who received Standard Services (control group) differed in regard to a number of outcome measures. The outcome measures included:

- **Rates of Adoption Dissolutions**
- **Number of Days Child in the Home / Displacement Rates**
- **Assessment of Family Functioning**
- **Assessment of Child Functioning / Well Being**
- **Assessment of Access to and Utilization of Services**

This federal Department of Health and Human Services Child Welfare Demonstration Project was the result of planning on the part of the state DHHS agency that originated in the mid 1990s. The guiding principles that drove this initiative were:

- **Adoption is a life-long process.**
- **Most adoptive families experience normal crisis in their development.**
- **Families need more support services post-legalization.**

Following are the final study results, as of the end of the project on March 31, 2004, or approximately 4.5 years of data collection, as they relate to each evaluation question.

1. What is the Maine Adoption Guides Post-Adoption Services Model?

The core principle of this program is that adoption is different. The dynamics of a family created by adoption are different from the dynamics of a family created by birth. Adoption is lifelong and its impact creates unique opportunities and challenges for families and communities. Adoption is mutually beneficial to parent, child and society. Society is responsible for supporting and aiding integration and preservation of adoptive families. The following is the Mission Statement that guided this project.

Mission Statement:

Adoption is a common and acceptable way to create a family. Still, a family formed by adoption has unique dynamics and issues. Bonding and attachment between an adoptive parent and child is not automatic, rather it is a process. And in this process of building a cohesive family, crises are predictable and normal.

A child who is adopted brings to the family a unique history that includes the trauma of separating from his or her birth parents and often includes other life trauma. Adoptive parents also bring unique histories to the relationship. In addition, they have expectations about parenting that are sometimes not met by their adopted child. Siblings, by adoption, birth, or by fostering significantly contribute to the family dynamics.

Communities are responsible for supporting and aiding integration and preservation of adoptive families. The process of building a cohesive family can be supported by community services and extended family, or it may be hindered if the community and/or extended family is not informed about adoption related issues, or is not supportive. Communities may need support in developing adoption competent resources.

Consideration and respect is given to all triad members. The child's birth family as well as adoptive family is vital to the child's development and overall sense of well-being. The type of contact or the amount of information the child has regarding his or her birth family should be based on the child's developmental and therapeutic needs. Adoptive families may need encouragement to increase their comfort with birth family issues so that they can support their child's integration of his or her history.

A child's family of origin may differ culturally from his or her adoptive families'. It is important for a child who is adopted to develop a positive understanding of his or her cultural heritage in order to form a healthy identity. Adoptive parents may need assistance finding ways to facilitate their child's positive identity formation.

Services delivered will be client-centered reflecting families' interest, ability and desires. Parents will be supported in creating a safe and nurturing environment for their children. The Maine Adoption Guides will have the goal of empowering parents to claim their children and maintain hope.

Case Practice Standards:

Assessment

The assessment of an adoptive family will take into account the normal struggles adoptive families are bound to have. Within this "normative crisis" framework, the interplay of the parent/child dynamics and the influence of the community will be assessed.

Child factors will include:

- ability to attach;
- history of trauma;
- stages of normal child development;
- educational, medical, social recreational and psychological needs;
- birth family relationships.

Parent factors will include:

- parenting style;
- the parent's perspective and ability to respond to normative crises;
- parent's history;
- parent's personal strengths;
- parent's ability to seek and use support;
- parent's knowledge and understanding of their child's cultural heritage;
- parent's previous experience with service providers.

Parent-Child Relationship will include:

- degree of family integration;
- parent-child fit;
- assessment of preparedness.

Resources:

- the availability of adoption competent providers;
- the ability to meet the special needs of the child and family;
- extended family support.

Service Plan

- service plans will be individualized and will reflect the assessment of the parent's and child's needs;
- service plans will be re-evaluated regularly to adapt to changing needs and abilities in a family;
- service plans will identify the current community supports;
- service plans will support family connections regardless of whether a child is able to live in the home at any given time;
- service plans will recognize the importance of the adopted child's birth and cultural heritage;

- time frames identified in service plans will be realistic and reflect the family's stage of development;
- barriers to achieving goals and services needed will be identified and documented.
- service plans will be realistic in terms of balancing and prioritizing all family members needs.

Contact with Family

- will occur minimally every six months;
- will occur regularly and will coincide with the normative stages of family development;
- will be driven by family needs.

Use of Community Resources

- referrals will be made to adoption competent providers;
- respite providers will have the knowledge and experience necessary to provide the level of care necessary to meet the child's needs;
- communication between the agencies, providers and families will occur regularly to assure that goals and treatment plans are agreed upon.

Participants were recruited from the overall population of families adopting children with special needs from the Foster Care system of the Maine Department of Health and Human Services (DHHS). Every year, for four years, 140 children and their families were recruited into the project. At the time that families met with state DHHS adoption caseworkers to plan for Title IVE subsidy arrangements, about three months prior to legalization, families were invited to participate in the project. Families were then randomly assigned to either the Standard Services (control) group or Guided Services (experimental) group. Standard Services families received the adoption subsidy from the state DHHS and whatever other supports are provided in their community. Guided Services families received the adoption subsidies, could access other supports in their local community and had access to a Maine Adoption Guide social worker from Casey Family Services. All families who participated in the project committed to a set of interviews once every six months. Families in the Guided Services group committed to being contacted by their assigned social worker at least once every six months. This clinical case-management type of service delivery model was delivered statewide and was provided by a partnership of the state DHHS and Casey Family Services. The Guided Services intervention was designed to be family driven. The adoptive parent(s) was viewed as the expert on their child. The social worker assigned to the family functioned as a guide who consulted with the family through the expected and normal crises in the life of an adoptive family. The long-term plan, based on the positive outcomes of this study, was that these same guided services could be expanded to the general population of adopting families.

Figure 1

Post Legalization Program Model Differences

Program Attribute	Standard Services	Guided Supportive Services
Target Population	Children w/Special Needs, and their Families	Children w/Special Needs, and their Families
Program Goals	- Provision of Adoption Assistance Funds Funds - Assistance with process to Legalization	- Decrease Dissolutions - Increase Family Strengths - Maintain/Increase Child and Family Functioning - Provision of Adoption Assistance Funds
Staffing	D.H.S. Adoption Worker	D.H.S. Adoption Worker and Casey Adoption Staff
Services Provided	- One time Assessment/ Planning Session - Financial Support for Post Adoptive Services as per Entitlements - Annual Financial Planning for Continuance of Adoption Assistance	- Initial and ongoing support based on family needs identified in "Family Permanency Assessment". - Scheduled check-ins with family and Casey staff at least once every six months. - Permanent assignment of Casey staff to family in an empowerment role; clinical case management. - Financial Support for Post Adoptive Services, not limited to services pre-defined in subsidy agreement.
Access to Trained Providers	- Provided with List of Trained Providers	- Provided with List of Trained Providers

Model Description - Focus Groups with MAGS Social Workers

Focus groups with social workers provided valuable information on the project model and its process. Focus groups were held with Adoption Guides social workers and supervisors approximately every six months. Staff members were asked to define their roles in the project and provide general feedback on the project's implementation—how the project model compares to their day-to-day work. Following is a summary of all focus groups held between December 2000 and January 2004.

Defining The Model

In describing the Adoption Guides model, respondents felt strongly that the model is *family-driven*. The model empowers families to identify their own needs, which could be anything from "just checking in" to crisis intervention. Families play an active role in defining what they want. The model supports families and is built on relationships.

Participants mentioned that the model is unique because it is flexible; a moveable structure. Caseworkers are not required to make a certain number of contacts or visits—they fill in gaps depending on what the family wants. The flexibility also allows caseworkers to suspend judgment and have families teach them about their wants and needs. Comments included:

> "You join with families to be co-creators about what suits their needs—there's an element of creativity."
> "It can be more informal contact than formalized meetings; stepping out of the traditional, professional role to just call to say, "How are you doing?"

Adoption Guides is a preventative model—like a safety net for families. Families have someone to turn to before things are at the point of beyond repair, and that helps families develop resiliency.

The focus groups also discussed the process of social workers teaming up to work together. The decision to team up is driven by the needs of the child and the family. If a particular worker doesn't feel that he or she has the needed skills for working with a family, he or she can team up with someone who can help with the family and/or teach the necessary skills. Sometimes a family may have more needs than one worker can assist with and another worker can help provide services. Working in teams helps social workers reflect on their cases and provides opportunities for them to bounce ideas off of each other. Supervision was noted as a key piece of the model. Workers have regular meetings but also have frequent informal supervision where they exchange ideas and ask for advice. That sort of informal supervision doesn't occur in many other agencies because workers need to bill for every hour of work. The social workers in Houlton are not able to team together due to the great distance between where families live.

Initial Work With Families

Participants were asked what the model looked like during the first three months of working with a family. These months were described as a time to build trust with the family, and a time for the family to feel comfortable working with them. It is a period of information gathering, when material for the intake summary is gathered slowly through informal conversations. Some families feel comfortable getting services right away, others need their space initially and want to wait. Workers felt that that flexibility is part of the beauty of the model—workers can do what the families want and follow their lead.

If the child is old enough, the worker may also talk with the child about his/her needs. Workers use this time to do such things as:

"Be a sounding board for parents."
"Develop a warm rapport."
"Hear their story in their own words."
"Help families explore their options and choices."

Work With Families Over Time

After the first three months, the work with families is individualized, and can vary from providing any number of services to just visiting the family once every 6 months. The model allows for workers to plug in different services for different people. Some families use IV-E funds and others don't. Some families find education around the child's behavior resonates for them. For some parents, the social activities are relaxing, and a safe place where they can come and develop relationships—this helps get them in the door. The support groups also help some parents get to know and trust the worker. One worker noted, "They trust me because they can see I can listen to them."

Other ideas about activities after three months were:

- Advocacy in the school system—education around adoption
- Helping families connect to other families who have adopted
- Simplifying tasks (e.g. dropping a duplicate name on a mailing list so they don't receive two copies of everything)
- Helping with communication with other providers/agencies
- Cost-share for recreational activities
- Therapeutic work with one family member or parents as a couple

Stressors For Adoptive Families

Focus group participants were asked to discuss the difficulties adoptive families face, and their thoughts on why some families struggle while others prevail. Participants talked about the expectations of the parent—parents are generally better able to accept a child's behavior if they expect that behavior. Often as a child grows older, parents' expectations change and their tolerance for certain behaviors lessens. In addition, some families talk about how they didn't expect the child's behavior to affect their family life. The flexibility/rigidity of the parents affects how they deal with new behaviors.

Parents who are able to not take behaviors personally also are better able to accept challenging behaviors. One worker commented: "I think it really makes a difference—It's the parents who can see that a lot of their child's behaviors are because of the trauma of their past and not because of them."

Families who accept support also seem to fare better than those who try to go it alone.

Making A Difference

When discussing what it is about the model that makes a difference for families, participants said it's the relationship between worker and family. One worker stated:

> "The ongoing presence. Just knowing we're out there and that they have connected with us in the past, and may connect with us in the future. I think they find security in that."

Participants mentioned that the longer you are with a family, the more they respect your opinions, and the more willing they might be to take recommendations. It was noted that families do not often work with the same person from DHHS over a period of time. Work with parents is delicate, helping them to up open and trust.

Participants discussed how the model has increasingly become focused on the parent compared to other kid-focused programs. The model is family-focused—MAGS allows for the context of the bigger picture beyond the one child. The project is, "Family focused with respect of the parent as the gatekeeper. The person who sets the tone in the family." Workers focus on the relational piece within the context of the families and work hard to support that.

> "We are not just looking at the mental illness or the trauma history of the child but how parents are reacting to it. It is so vital because every parent responds differently to different sets of behavior."

The flexibility of the model is essential. In some cases, the only convenient time to have a conversation with a parent is at night, and the model allows this.

> "Our availability reduces their sense of isolation. Being able to go to their homes and bring the knowledge of what other families are going through, the different crises that can happen and show them it's not just them, they're not crazy. I think that's a big part of what we do."

Workers agreed one major benefit of the Adoption Guides program is that it offers a family access to a variety of resources:

> "One-stop shopping—a multitude of clinical, therapeutic services. I think a lot of our families feel scattered, they go in so many different directions, everyone has a different therapist and so many different needs. For some of them, working with us, they can consolidate the number of providers they see . . . they don't have to start from the beginning and they certainly don't have to educate us about the dynamics of adoption and we already know their history."

"Having clinical level social workers show up and be able to work with whatever is happening in the moment really is less stressful."

Everyone agreed that the parents really enjoy and benefit from support groups. The name of the groups, "Parents of Challenging Children," invites the possibility that other parents are struggling too, which is reassuring to members. Families receive emotional support, community resources, and advice on clinical issues.

Supports For MAGS Work

A major support that helps workers is the flexibility of the model. Workers don't have demands in terms of billable hours—this enables them to be more flexible and creative with their time. There is the opportunity to do prep-work before visiting with a family and time to reflect afterwards. One worker commented, "We don't get burned out and there is time to learn." In addition, the work is not all clinical. The model allows for time to do community outreach.

Another main support behind Adoption Guides work is the group of people involved. Colleagues, supervisors, and the administration are all dedicated and supportive and share a common philosophy. The various backgrounds of everyone on the team are a support. Different people bring different kinds of expertise to the group. Also, the non-cynical attitude of the team is a support. Other supports mentioned were:

"Consultation/access to a psychiatrist."
"The ability to go to conferences."
"Having meetings is a real good support. That they're flexible enough to come up and meet in Bangor—meeting our needs."
"Feeling inspired by the project. I think that we're doing something neat and we're getting recognition from that—national recognition."
"I think we have families that are wonderful and gracious, hard-working and persevering."

Barriers To The MAGS Work

Overall, barriers to the project are the difficulties of coordinating a project statewide. Resources differ in each region and certain DHHS practices differ between district offices. However, caseworkers reported seeing improvements in the coordination of the referral process.

Participants again discussed the barrier of many families' prior negative experiences with social workers, which makes them hesitant to trust another social worker.

Implementation of MAGS Model

Each year of the project, USM research staff conducted an Implementation survey in order to assess the project's implementation. Surveys were administered via email to those involved in the project—56 caseworkers and supervisors from DHHS and 14 from Casey Family Services. In 2003, the return rate was 31% (22 surveys received), in 2002, the return rate was 40% (28 surveys received), in 2001, the return rate was 33% (23 surveys received). The survey was not conducted in 2004 due to the project ending in March 2004. The following table displays the number of surveys received by district each time the survey was administered.

Overall Received Surveys by District
December 2003

	Biddeford	Portland	Lewiston	Augusta/ Rockland	Bangor	Ellsworth/ Machias	Houlton	Total
DHHS Staff 2003	**2**	**1**	**2**	**1**	**2**	**4**	**3**	**15**
CFS Staff 2003		**3**			**4**			**7**
DHHS Staff 2002	**3**	**3**	**1**	**4**	**3**	**2**	**3**	**19**
CFS Staff 2002		**4**		**1**	**2**			**7**
DHHS Staff August 2001		**3**				**2**		**5**
CFS Staff August 2001		**4**		**1**	**3**			**8**
DHHS Staff January 2001	**4**	**4**	**4**	**7**	**3**	**3**	**3**	**28**
CFS Staff January 2001		**3**						**3**

In general, the majority of respondents reported being in support of the project each year. In 2003, 77% were supportive of the project—59% answered "very supportive." In 2002, 89% were supportive of the project—79% answered "very supportive." In January 2001, 81% were very supportive; in August 2001, 92% were supportive. Related comments included that there was a definite need for post adoption services and that the project was a great idea.

The percentage of respondents who agreed the Guided Services model was implemented as intended ranged from 89% in 2003, to 93% in 2002, to 83% in January 2001 to 92% in August 2001. The few respondents who did not think implementation was as intended mentioned that services offered are not the same statewide—Aroostook County had fewer services available than Portland. Other comments were that families were not always informed about the project or that the respondent had not yet had experience with Guided Services. Some workers suggested implementation would improve through better coordination between DHHS and Casey caseworkers.

The majority of respondents at all times of data collection reported being informed about the project, and that the project materials, the video, written forms and other paperwork were helpful in describing the project to families.

Inviting Families

The amount of time it took workers to introduce the project to families and complete the participation/non-participation paperwork ranged between 20 – 60 minutes. The average amount of time was 42 minutes (equal to the 2002 average and down from 58.5 minutes the year prior.) When asked if allotting this time adversely affected their other work, 100% percent in 2003 said no (up from 85% in 2002 and 58% in 2001).

Transition Meetings

Families taking part in the project met with the DHHS Adoption caseworker and the Casey Family Services worker two weeks after agreeing to participate. When asked about this "transition" process, respondents said that this "bridging" was helpful for the families—having both DHHS and Casey invested in a family during legalization. A common difficulty for workers in the transition process was coordinating schedules between DHHS and Casey caseworkers. Needed paperwork was at times hard to gather, and organizing it could be time-consuming.

Forces For and Against Project Implementation

Overall, respondents felt that the most helpful force for the implementation process was the cooperative and committed families. Other forces were clear paperwork, regular management meetings, the video, team and program flexibility, understanding supervisors, and staff willingness to commit extra time.

Forces against the process were timeframes, difficulty coordinating schedules of various players, and lack of communication. Many felt that heavy workloads prevented workers from having adequate time to attend or prepare for transitional meetings. Some respondents mentioned that the families that most needed guided services didn't get them. Other comments included that adoption-savvy therapists were not available, that workers wouldn't know exactly when legalizations would occur, and that there had been problems with support groups. One respondent mentioned that the statewide nature of the project was a force against it.

Respondents were asked if the organizational structure of DHHS, Casey Family Services and/or the USM research unit had enhanced or prevented implementation, and the majority said no. Some respondents mentioned that DHHS workers have large caseloads and aren't able to devote time to the transition meeting or gathering information. Communication was noted as an important factor in the project's development, although it is sometimes challenging and not always clear or in a timely manner.

Overall Comments

Suggestions to improve implementation included offering earlier intervention services pre-adoption, and cutting down on the paperwork families need to complete. Other suggestions included holding quarterly implementation meetings with district offices, inviting adoptive families to an informational meeting where MAGS staff present the project, and provide information to districts on local customer satisfaction. In general, there was widespread support for the project in each year, and at the end of the project's third year, respondents felt positively about its implementation.

Results of Referral Process

During the second year of the project, there was a slow-down in referrals. DHHS investigated the cause and it no longer was a problem. When DHHS caseworkers invited families to participate in the project, they completed a brief questionnaire with families who declined to participate.

Non-Participants by District – Year 4
December 2004

District 1	District 2	District 3	District 4	District 5	District 6	District 7	District 8	Total
12	4	8	10	5	14	13	10	76

The most common reasons for declining to take part in the study were:

1) Enough contact with state agencies/want to be left alone;
2) Being contacted twice a year for questionnaires would be too time-consuming; and
3) Participating in the project may make the adoption process more difficult.

Attrition from the Project

The attrition of families from the project was a concern. Some families chose to drop out of the project and some were asked to leave due to not responding to surveys. The numbers of children dropped from the study were tracked each year by Cohort and Assigned Group, and are as follows:

Attrition from the Project
Number of Children by Cohort and Assigned Group
December 2004

	Guided	Standard	Total
Cohort 1	25	43	68
Cohort 2	27	35	62
Cohort 3	27	31	58
Cohort 4	15	25	40
Total	94	134	228

2. What are the characteristics of the children and families in the project?

Results listed below are from surveys parents completed at baseline, upon entering the study. A Pearson Chi-Square statistic was used to test for differences between groups for nominal/categorical data, and Independent t-tests were calculated for ordinal or continuous data. There was a significant difference between the Guided and Standard groups for "Is Child Attending School?" However, this was not a key variable in the research. There were no other significant differences found between groups. This result verified the project's randomization process.

Children

As of March 31, 2004, the end of the study, there were a total of 117 children in Cohort I (Year One), 128 children in Cohort II (Year Two), 120 children in Cohort III (Year Three), and 134 children in Cohort IV (year Four); **N = 499**.

Age: Mean age of children in the study was 7 years of age.

- Guided Services Group Child Age = 7.35
- Standard Services Group Child Age = 7.19
- Children Currently Adopted – Total Sample = 6.75 years
- Children Previously Adopted – Total Sample = 9.88 years

Gender: 266 female (53%) and 233 male (47%)

Racial Characteristics: 92 % were White; this was in keeping with the general demographics of Maine as a mostly White, non-Hispanic population. African-American was the next highest racial group with 18 out of 499 (3.6%) overall children identified in this category.

Legally Adopted: By six months into the study, 87% of children were legally adopted. By 12 months into the study, 95% of children were legally adopted. By 18 months, 100% were legally adopted.

Type of Adoption: Approximately 89 percent of all children in the study were adopted by current foster parents.

Previous versus Current Adoption: 83 percent of all children in the study were current adoptions.

Number of Previous Placements in Foster Care: Administrative data from state DHHS records was available for 277 child study participants (63% of participants). The number of previous placements refers to permanent placements—long-term placements in locations such as foster family homes, residential facilities and hospitals. As counted since the most recent removal from home, the mean overall was two placements per child (2.21 for Guided and 2.06 for Standard).

Length of Time in Foster Care: Administrative data from state DHHS records was available for 283 child study participants (59% of participants). The average (mean) number of years these children had been in Foster Care to entry to study was approximately 4 (4.12 for Guided and 4.07 for Standard).

Time Child in Home Previous to Entry to Study: For the entire sample, children were in this home on average for 35 months (35.14 months for Guided and 35.13 months for Standard children).

School Age Children: 79 percent of children in the study were attending school (81 percent of Guided and 77 percent of Standard children).

Receives Special Education Services at School: For children who were attending school, 47% overall had an Individualized Education Plan (47 percent of Guided; 47 percent of Standard).

Clinical Diagnosis: Parents reported that overall, 27% of Guided children and 23% of Standard children had a clinically diagnosed disability.

Use of Psychotropic Medication: In the entire sample, 30 percent of children were taking some type of psychotropic medication (30% of Guided children and 31% of Standard children).

Families

Income: Twenty six percent of families reported an annual average income of more than $65,000. Twenty percent earned between $45,000 - $55,000. Only 2% made less than $15,000.

Family Structure: 87% were married couples and 10% were single female-headed households.

Relationship to Child: As reported by parents: 73 percent were Foster Parents. Sixty-seven percent were foster parents who were not related to the child, and only 15 (6%) had been foster parents and relatives to the child. Four percent of respondents were relatives of the child or friends of the family. Twenty-three percent were neither foster parents nor relatives to the child.

3. What issues do parents have before they legalize their adoption?

Results listed below are culled from surveys parents completed at baseline, upon entering the study.

Reasons for Adopting a Child – Most common reasons cited by all caregivers were:

1) Wanted to make relationship legal;
2) Wanted child to feel secure;
3) Felt close to child; and
4) Our other children are attached to child.

Concerns About Adoption – Most common concerns cited by all caregivers were:

1) How to meet child's needs;
2) Child's acceptance of me (caregiver);
3) Other children's (in family) reactions;
4) Ability to afford additional costs;
5) Ability to continue to work; and
6) Effect of adoption on marriage.

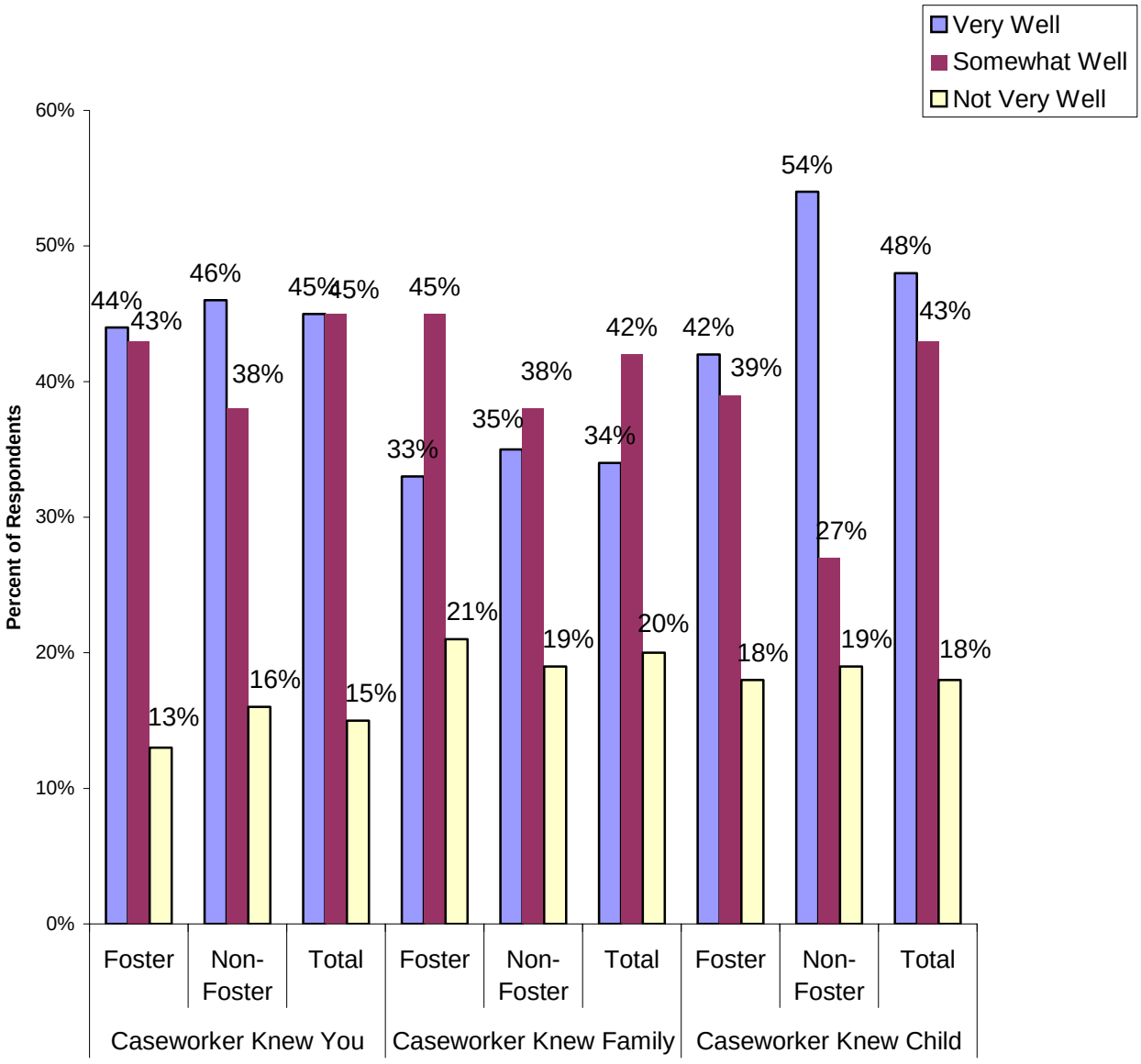
Child Behavior Problems Before Legalization: Parents were asked to choose from one or more of 11 problem type behaviors (including such problems as defiance of rules, destroying property, behavior problems in school, and emotional withdrawal). The scores for all 11 were summed and the mean score for Guided was 3.96, and for Standard was 3.64.

Satisfaction with DHHS Adoption Caseworkers Pre-Legalization:

- Majority of all Caregivers satisfied with DHHS Caseworkers – on a scale 1=Very Satisfied to 4=Very Dissatisfied. Means are:
  - Guided = 1.47
  - Standard = 1.51

- Majority of all Caregivers consistently felt that DHHS Caseworkers knew about them the most and about their family the least. There was a statistically significant difference between the Foster and Non-foster parent groups – a larger percentage of Foster caregivers feel that their caseworker knew their family "very well" or "somewhat well." See chart below.

How Well DHHS Caseworkers Knew Family Members By Foster and Non Foster Families – Prelegalization
December 2004



4. What services did parents use the most or least, and what types of services did they prefer?

Results listed below are culled from surveys parents completed every six months after entering the study.

Types of Services Families Access in the Community – As Reported by Respondents

Percentage of Respondents Who Have Had Contact with a Caseworker in the Past Six Months By Assigned Group December 2004

	6 Months	12 Months	18 Months	24 Months	30 Months	36 Months	42 Months
Guided	77%	60%	49%	41%	32%	40%	17%
Standard	82%	52%	46%	34%	54%	56%	39%

- Families reported contacting DHHS staff for assistance with monthly subsidy issues, adoption legalization questions and a child's new emotional needs.

- Services Sought and Received: Caregivers were asked what type of service did they seek and the top results were:
  1) Individual Counseling Services
  2) Respite Care
  3) Behavioral Specialist
  4) Adoption Support Groups
  5) Other Services*

*The Other Services category included services such as occupational therapy, speech therapy, physical therapy, caseworker consultation, psychiatrists, substance abuse treatments, neuropsychological evaluations, and homeopathic medicine. There were a few children in the study with very significant medical needs and these services required a large number of service hours. Some children had daily services.

- Caregivers were also asked to identify how many hours of service they received from a service provider. The top services by number of hours were:

  1) Respite Care for Adopted Child
  2) *Other Services (see * above)
  3) Counseling for Adopted Child
  4) Behavioral Specialist

- Natural and Professional Types of Supports/Services: Caregivers were asked which types of supports/services are most important and from where they are provided – either naturally through a friend, family or other social network, or paid for from a service provider.

- More than half of caregivers (55%) stated that their most important source of support was *professional* in the forms of:

  (1) Social Workers/Case Management
  (2) Counseling/Therapy
  (3) Respite
  (4) Financial Supports/Subsidy.

- Forty-five percent of the caregivers stated that their most important sources of support were *natural* and included:

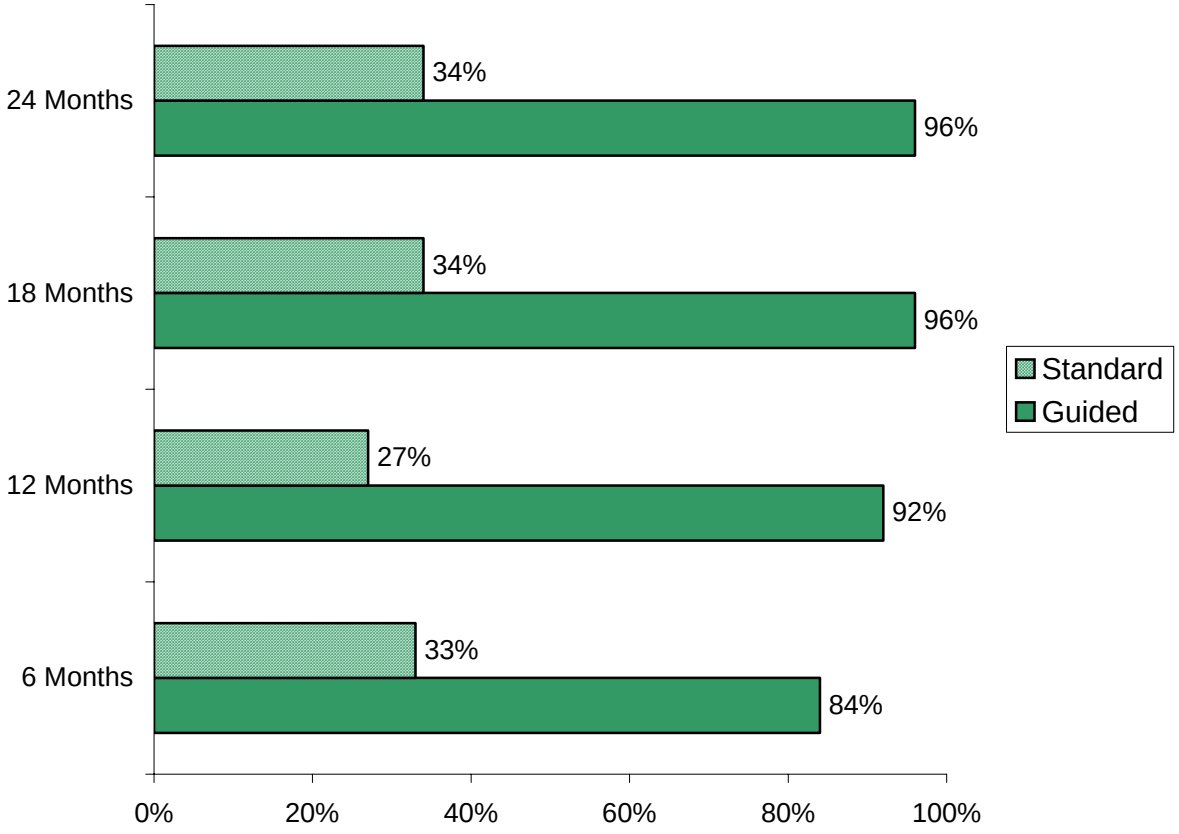
  1) Family Support
  2) Friends
  3) Support Groups.

- Overall, until 24 months in the study, 78% of respondents stated they "routinely" accessed natural forms of support. That percentage increased to 79% at 30 months, 82% at 36 months, and 84% at 42 months.

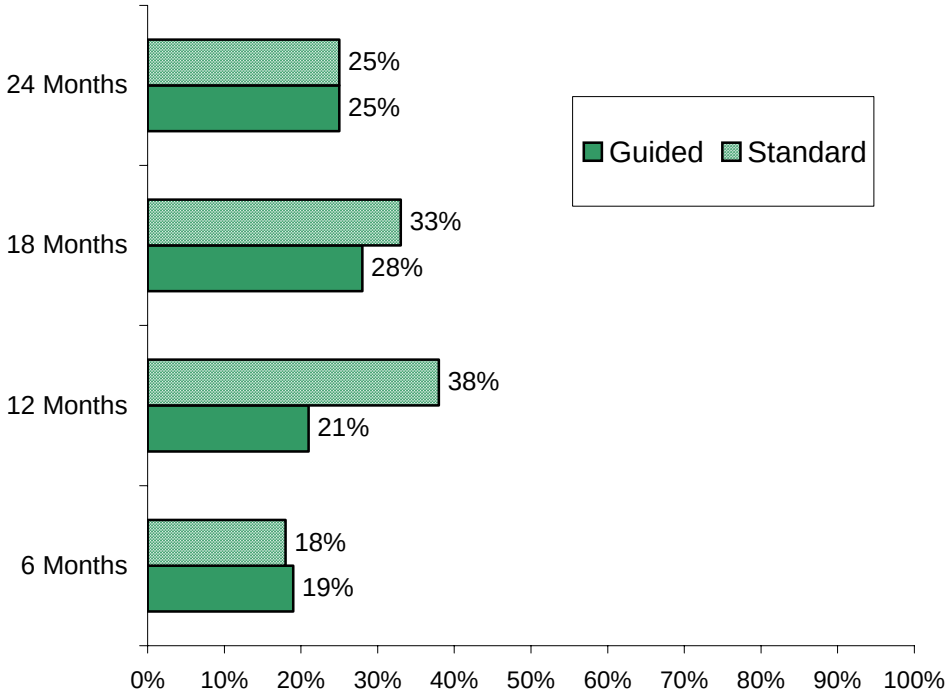
- The most frequently accessed natural supports were:

  1) Family Members other than Spouse (44%);
  2) Friends (32%);
  3) Church/Pastoral (8%);
  4) Support Group (8%);
  5) Other, which includes neighbors, school, other foster parents, co-workers, and other caregivers/parents (9%).

Percentage of Families Who Report They Have a Regular Case Manager
At 6 - 24 Months into Study by Assigned Group
December 2004



Percentage of Families Who Report Having Two or More Caseworkers
At 6 - 24 Months into Study by Assigned Group
December 2004



Services Provided through the Intervention – MAGS

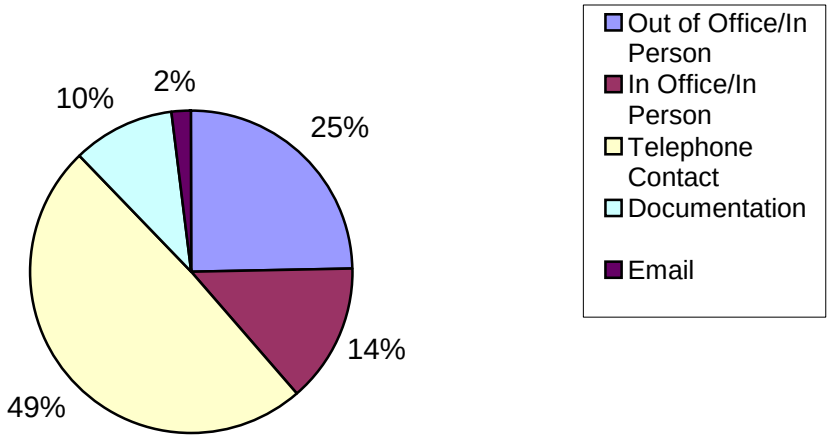
- The most common service provided to families was Parent Education and Support - approximately 25 percent of all the types of services provided. Other frequently provided services were Building/Maintaining Relationships, Collateral Contacts, Individual Child Therapy, and Adult Group Therapy.

- The amount of time spent providing services varied depending on the type of service. Casey social workers spend the largest amount of time (per service) providing group therapy to children (mean 138 minutes per service), and providing non-therapeutic services, or recreational activities (mean 119 minutes per activity). The average minutes for all services in general was 48 minutes per service.

- Overall, Casey social workers provided an average of 170 services per family in Cohort One, an average of 102 services per family in Cohort Two, average of 80 services per family in Cohort Three, and an average of 36 services per family in Cohort Four. (Cohort One families had received the most services due to being in the project for the longest). The amount of time (minutes) spent working with each family differs—ranging from 15 minutes to 486 hours.

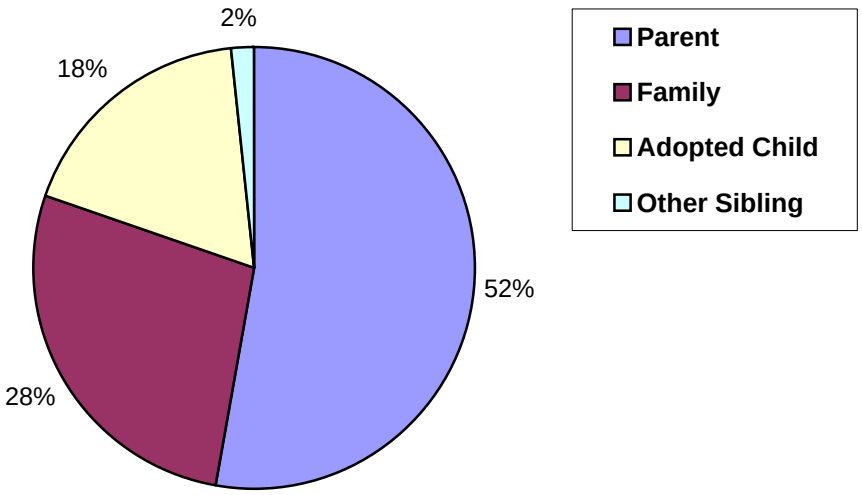
- Families are most frequently provided services through telephone contacts and in-home visits.

Contact Type For Services Provided Reported by MAGS Social Workers December 2004



- Parents were the primary recipients of services, due to the emphasis of work with the entire family and support work done with parents.

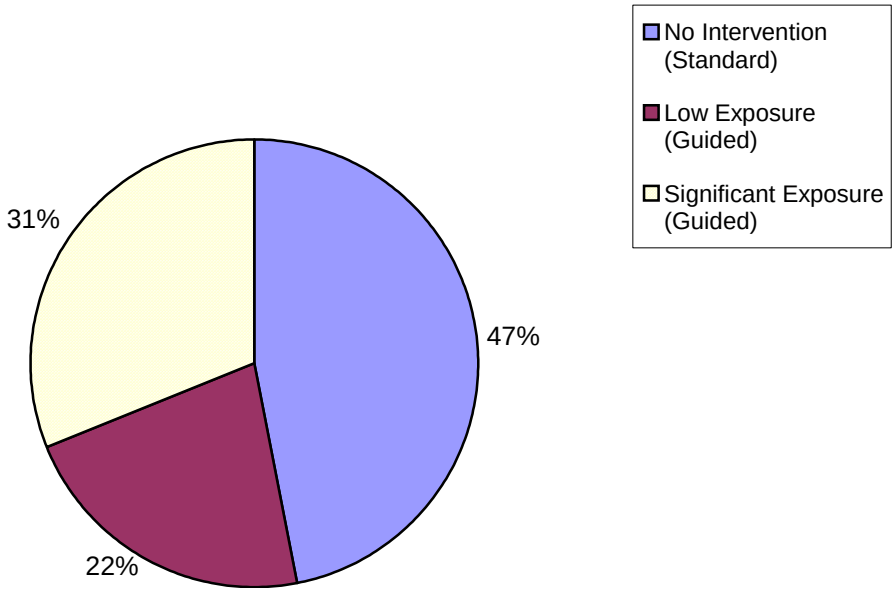
Service Recipients as Reported by MAGS Social Worker
December 2004



- As this was a statewide model, there was an interest in the amount of time the workers needed to travel. Seventy-six percent of services did not require any travel time. Seven percent involved between 15 – 60 minutes of travel and 12% required between one and two hours of travel. Five percent required more than two hours of travel.

- One of the components of the Adoption Guides model was that families decided how much assistance they needed from the Guided social worker. The amount of service time provided was dictated by families. Overall, the amount of service hours varied—from families who only wanted contact once every six months, to families who needed contact almost daily. Analysis was conducted using 3 levels of the intervention—No Intervention [those in the Standard group], Low Exposure [those in Guided who received less than the 50 percentile mark of service hours (based on averages by cohort) provided to families], and Significant Exposure [those in Guided who received the 50 percentile mark or more of service hours provided to families].

Amount of MAGS Intervention Received by Children
December 2004



Parent Support Groups

One important service Casey Family Services also provided as part of the Adoption Guides project was support groups. Support groups offered adoptive families an opportunity to share parenting strategies and struggles with other parents in similar situations. Called "Parents of Challenging Children," these groups helped parents who were raising children with special needs, which included learning disabilities, psychiatric disorders, socialization/behavioral difficulties, or children who were hospitalized, or had received day treatment or residential services. Facilitated by therapists, the groups offered adoptive parents a safe environment to discuss their problems, as well as the opportunity to meet and connect with other adoptive parents. In general, the groups met once a week, or every other week and most groups met on an ongoing basis.

Intended Outcomes:
Goals of the parent support groups included:

- Parents felt more capable to meet the special needs of their child(ren)
- Parents felt more supported
- Parents felt more satisfied with their adoption(s)
- Fewer dissolutions

Target Population:

Parent support groups were open to any adoptive parent of children with special needs (support groups were available to adoptive parents in all agencies, private or DHHS). For the purposes of these support groups, "special needs" were defined mostly as behavioral or psychiatric conditions—not special physical needs.

Adoptive parents contacted Casey if they were interested in joining a group and were then invited into Casey for an interview.

At the end of the project period, Casey Family Services "Parents of Challenging Children" support groups were underway in Lewiston, Augusta and Ellsworth and two groups were meeting in Portland. The parent support group meetings were potluck dinners and included child-care and dinner for children. A Casey Family Services therapist led each group. Many of the current groups have continued past their timeframe and members meet informally on their own.

In addition to the parent groups, two movie groups met regularly in Unity and Lincoln, and there was a monthly movie night in Portland. Creative respite days were also hosted for children on school holidays. Groups of children took part in such activities as horseback riding, rock climbing, yoga and cooking.

Some difficulties occurred in organizing support groups in the northern part of the state. Families lived further apart from each other and although social workers used central locations for group meetings, families would often have to travel an hour to and from meetings. With the added travel time, meetings required families to set aside four hours or more. Sparing four hours during the day was difficult for parents and four hours in the evening often interfered with children's bedtimes. Therefore, attendance at meetings varied and some groups ended. Families, however, expressed their interest in group meetings and social workers began to use a less structured form of groups—meeting at informal, recreational events, rather than weekly meetings. Picnics, outdoor events, or swimming parties offered parents and children the opportunity to gather together and share feelings and experiences in the same way that group meetings did—and families were able to plan for one day/evening at a time without having to commit to driving to meetings every week. In addition, two different 6-week movie groups were established as a recreational outing for parents.

5. What differences did the MAGS model make in the lives of children and families?

The following results were based on data collected at Baseline, until 24 months, and in some cases up to 42 months into the study. Unless otherwise indicated, longitudinal results were analyzed through the use of a 2 x 2 ANOVA statistical procedure comparing outcomes between the Guided and Standard services groups. The number of study participants at each point in time is outlined in the table below.

Table 51
Sample Size by Length of Time in Study
December 2004

TIME IN STUDY	GUIDED SERVICES (E)	STANDARD SERVICES (C)	Totals
Baseline	Child: n = 278 Family: n = 149	Child: n = 221 Family: n = 124	Child: n = 499 Family: n = 273
6 Months	Child: n = 226 Family: n = 124	Child: n = 166 Family: n = 95	Child: n = 392 Family: n = 219
12 Months	Child: n = 170 Family: n = 91	Child: n = 129 Family: n = 73	Child: n = 299 Family: n = 164
18 Months	Child: n = 138 Family: n = 71	Child: n = 105 Family: n = 59	Child: n = 243 Family: n = 130
24 Months	Child: n = 102 Family: n = 54	Child: n = 61 Family: n = 38	Child: n = 163 Family: n = 92
30 Months	Child: n = 69 Family: n = 37	Child: n = 41 Family: n = 27	Child: n = 110 Family: n = 64
36 Months	Child: n = 41 Family: n = 20	Child: n = 28 Family: n = 18	Child: n = 69 Family: n = 38
42 Months	Child: n = 22 Family: n = 12	Child: n = 19 Family: n = 13	Child: n = 41 Family: n = 25

A. Child Level Outcomes

The following is a summary report on a select number of outcomes.

Number of Days Child in Home – Displacement Days: Parents were asked the number of days their child was out of the home due to:

1) Ran away;
2) Hospitalized because of serious behavioral problems including potentially being a danger to themselves or others;
3) Detained in jail, or juvenile correctional facility; or
4) Other.

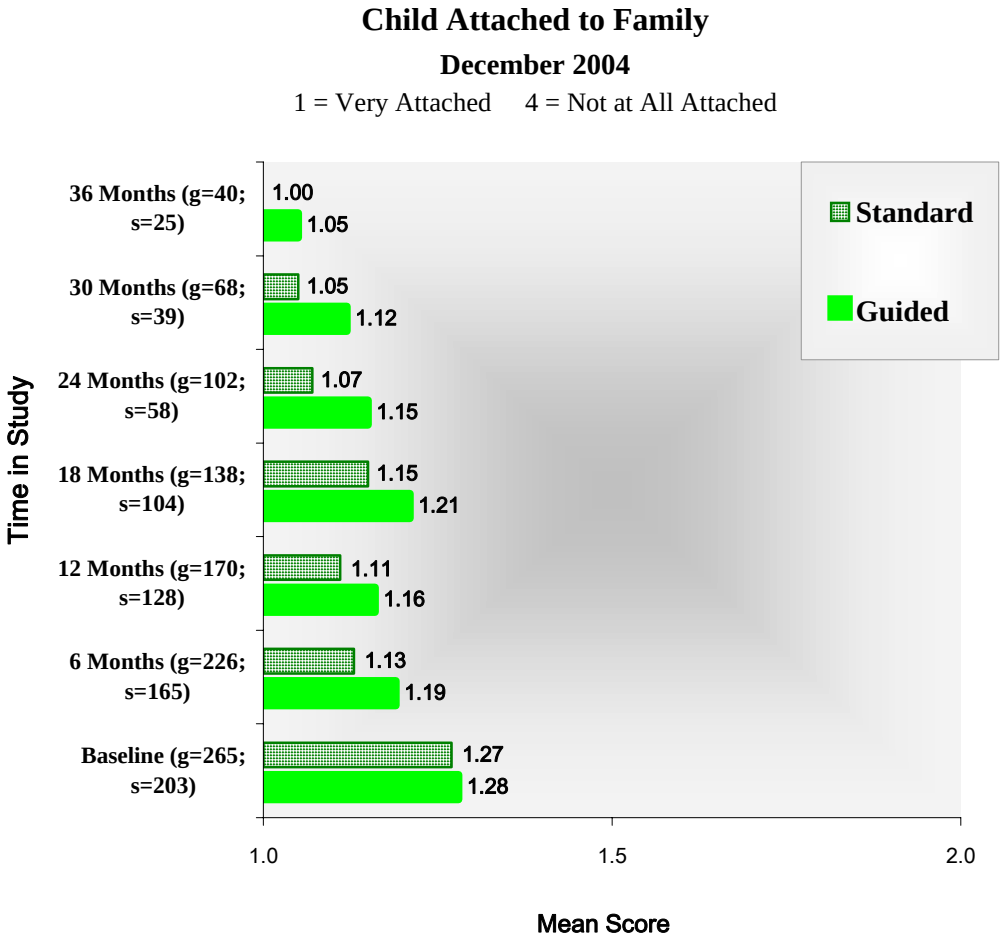
Because the number of days varied greatly, the median number of days is displayed below instead of the mean.

Median Number of Days Child Has Been Out of the Home in Past Six Months by Assigned Group December 2004

Median Number of Days Out of Home

	Baseline	6 Months	12 Months	18 Months	24 Months	30 Months	36 Months	42 Months
Guided	53 (n=6)	11 (n=7)	20 (n=5)	14.5 (n=4)	95 (n=4)	30 (n=3)	5 (n=1)	33 (n=1)
Standard	7 (n=7)	5 (n=5)	3 (n=2)	60 (n=1)	45 (n=3)	44.5 (n=2)	9 (n=3)	27 (n=2)
Overall	14 (n=13)	11 (n=12)	11 (n=7)	21 (n=5)	66 (n=7)	30 (n=5)	7 (n=4)	31 (n=4)

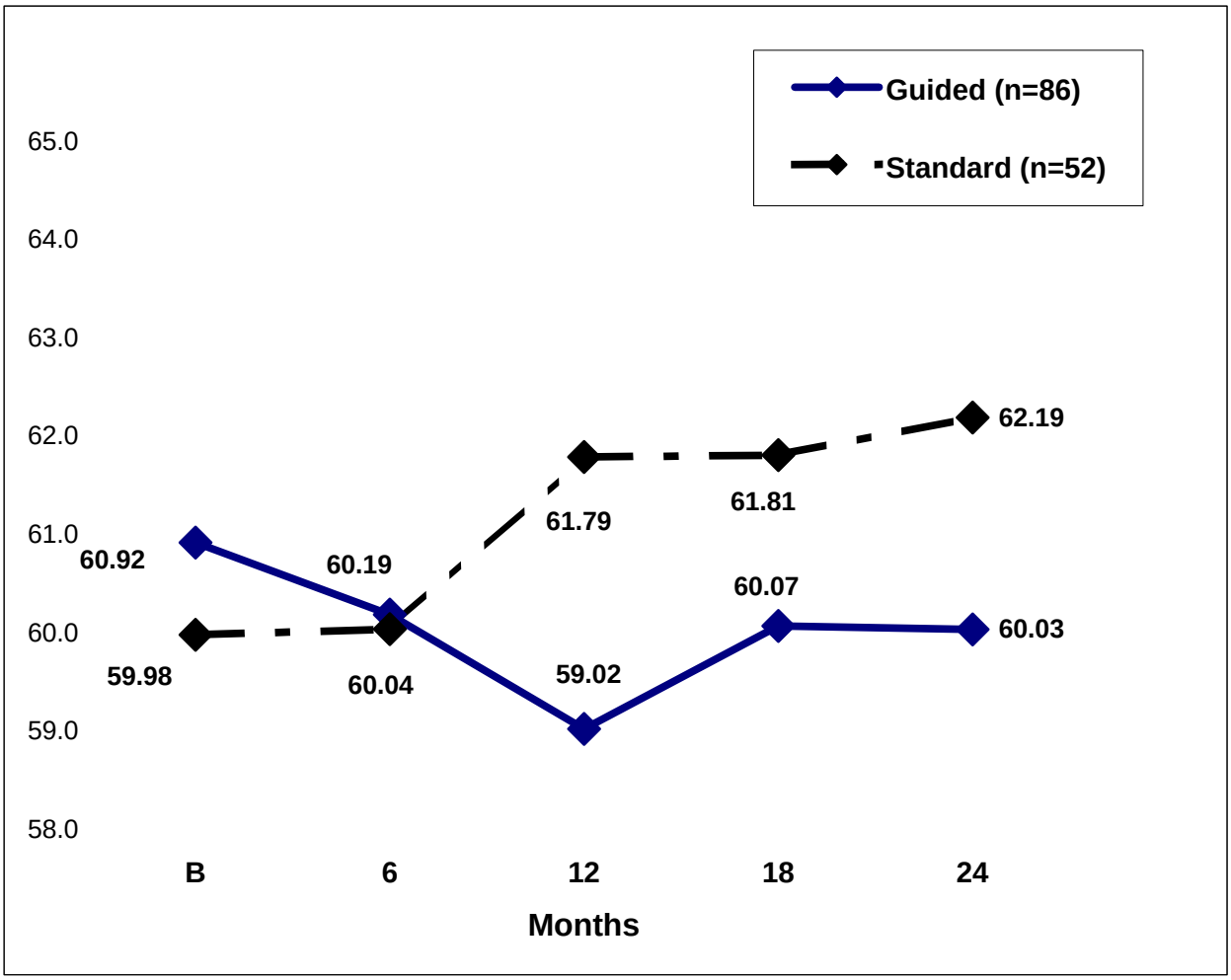
Number of Adoption Dissolutions: During the study period, there were no dissolutions reported by parents in either group. However, anecdotal reports from the State Agency indicated that three of the families that dropped out of the study left due to adoption dissolutions (one Guided family and two Standard families). This would result in a dissolution rate of 1% for this study sample. The official state estimate for adoption dissolutions is 6%.



There is no statistical difference between groups over time. Caregivers in the both groups reported a high level attachment of child to family.

Children's Mental Health – Child Functioning: Levels of child functioning were measured using the Child Behavior Checklist (CBCL), a questionnaire completed by the parent about the child. According to Achenbach et al (1991), the Total Problem score from the CBCL can be used as a basis for comparing problems in different groups and for assessing change as a function of time or intervention. The Total Problem score was computed by summing all problem items except for Sleep Problems. There were 100 problem items on this section of the CBCL.

CBCL Total Problem Scores All Ages Combined 6 – 24 Months

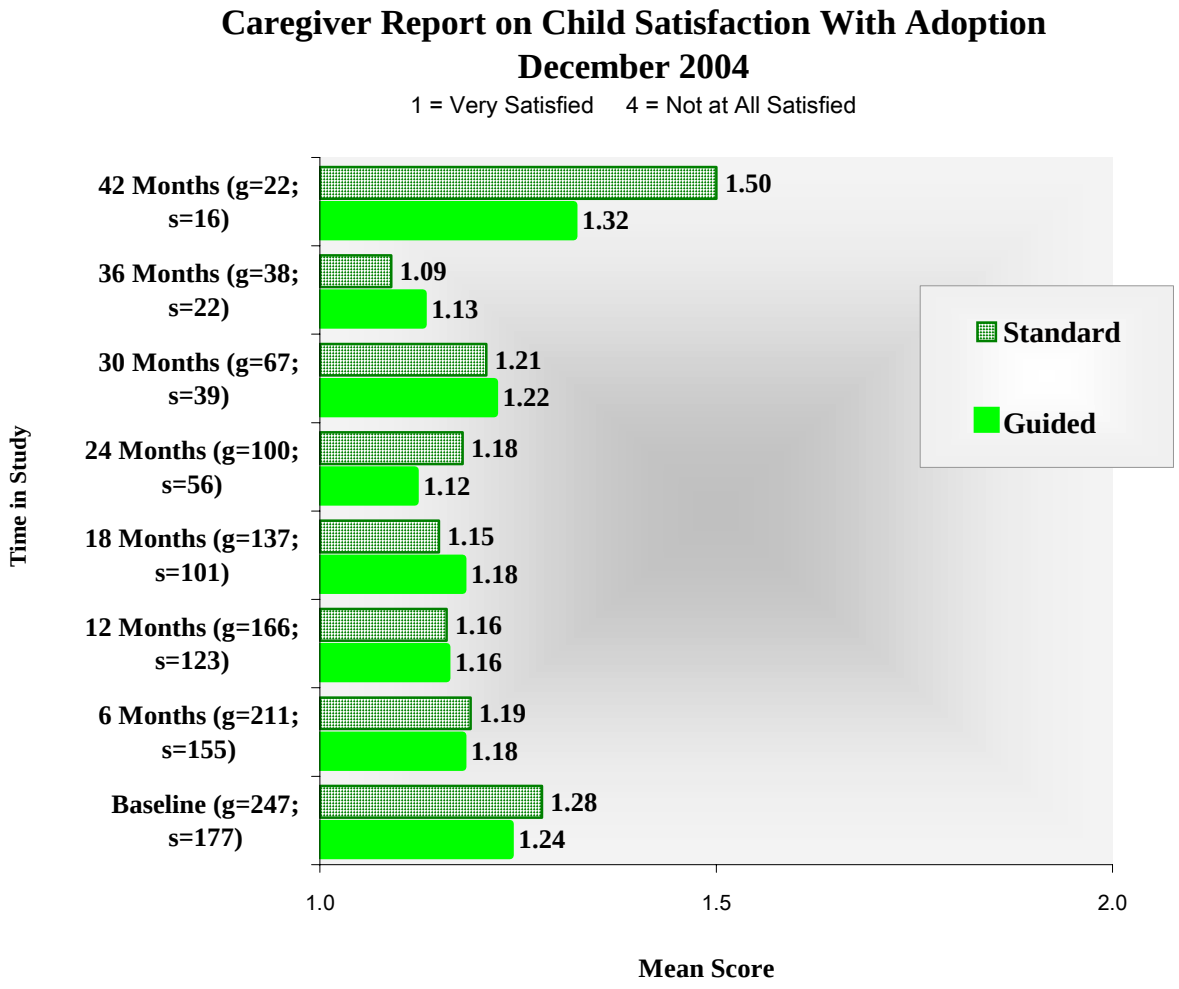


The graph above outlines the average scores of children over time, when data was combined from the 1.5 – 5 year-old, and the 6 – 18 year-old reports.

Repeated measures analysis found a statistically significant difference between groups on this Total Problems measure for all ages combined; F (3.271, 138) 3.037 and p = .025. The Guided Services group had lower average (60.03) Total Problem scores for a 24 month period compared to the Standard Services group (62.19).

Child's Health and Development: For both groups, caregivers rated the child's overall health as positive. There were no statistical differences between groups. When caregivers rated their child's growth and development to other children of the same age, both groups rated their child's growth as being similar to other children.

Child's Satisfaction with Adoption: For both groups, caregivers rated the child as being very satisfied with the process of adoption. There were no statistical differences between groups on these outcomes.



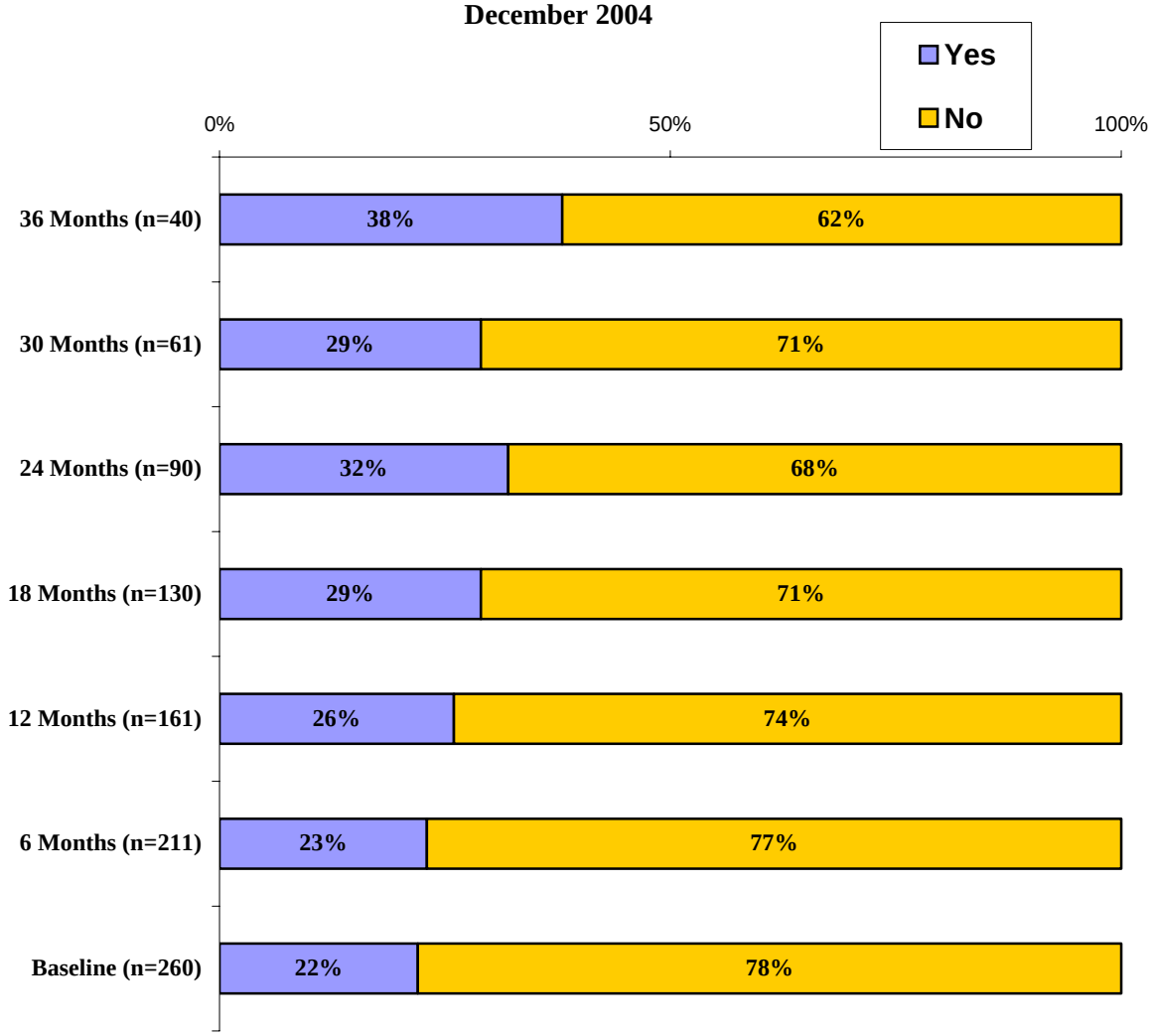
Child's Positive and Negative Traits: For both groups, caregivers rated the frequency in which the child demonstrated positive traits as high and for negative traits, the frequencies were low. There were no statistical differences between groups on these outcomes.

Child Positive Behaviors to Parent: For both groups, caregivers rated the frequency in which the child demonstrated positive behaviors to them as high.

B. Family Level Outcomes

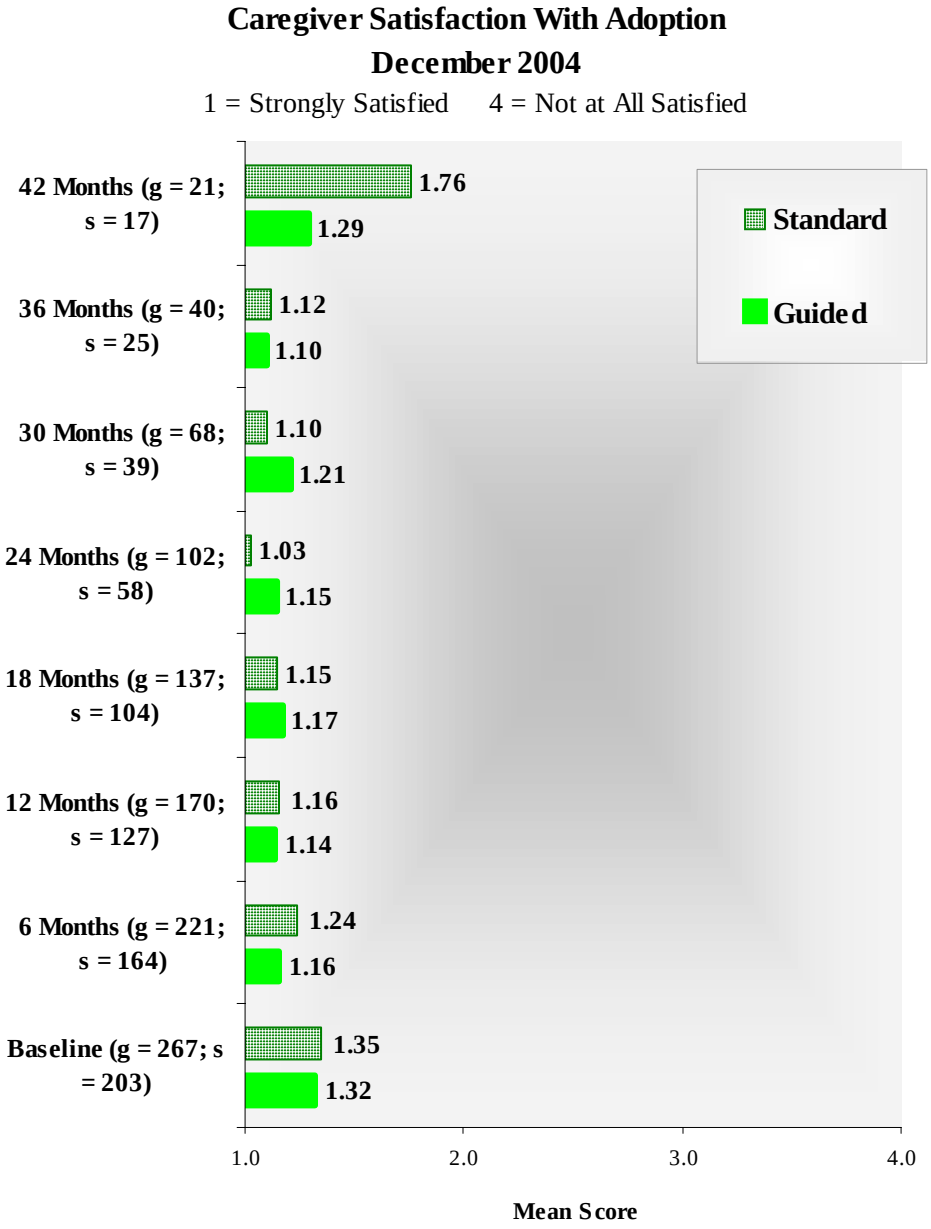
Caregiver Health – Stress: Caregivers were asked, "In the past six months, do you think you had any physical or emotional health problems due to any stress caused by the adopted child/children being part of your family?" The following chart summarizes the responses. As time goes on, a greater percentage of respondents indicated that they were experiencing negative impacts.

Chart 22
Parenting Stress Negative Impact on Health - All Respondents
December 2004



Caregivers also completed a health assessment rating themselves in eight areas. Using a scale of 0 - 100 with a higher score defining a more favorable health state, caregivers reported on aspects of their overall physical and emotional health. There were no statistical differences between groups on these outcomes.

Caregiver Satisfaction with Adoption: For both groups, caregivers rated high levels of satisfaction with the adoption process. There were no statistical differences between groups on these outcomes.

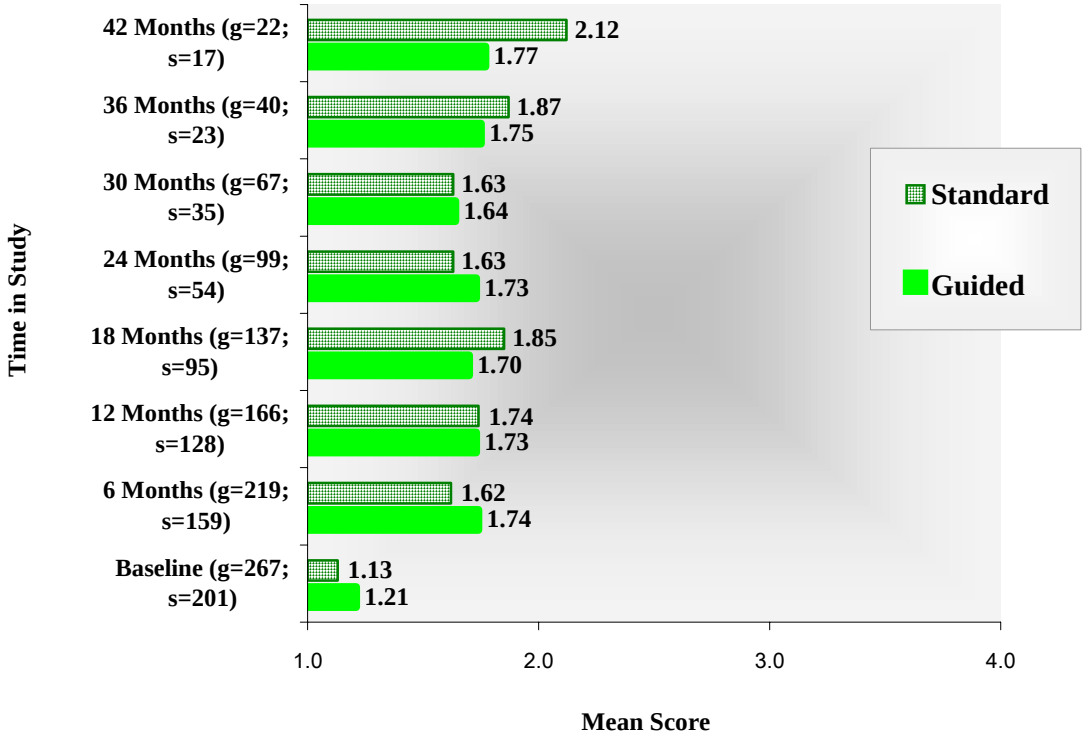


Parenting Practices: Caregivers were asked to rate themselves on a set of parenting behaviors that were classified as either Authoritarian or Authoritative. For both groups, parents tended to view themselves as more Authoritative than Authoritarian in their own parenting style. Authoritative practices included: display of affection towards child; sharing feelings and experiences with child; respect/encourage child's independence; supervision of child; and establishment of family rules and responsibilities. There were no statistical differences between groups on these outcomes.

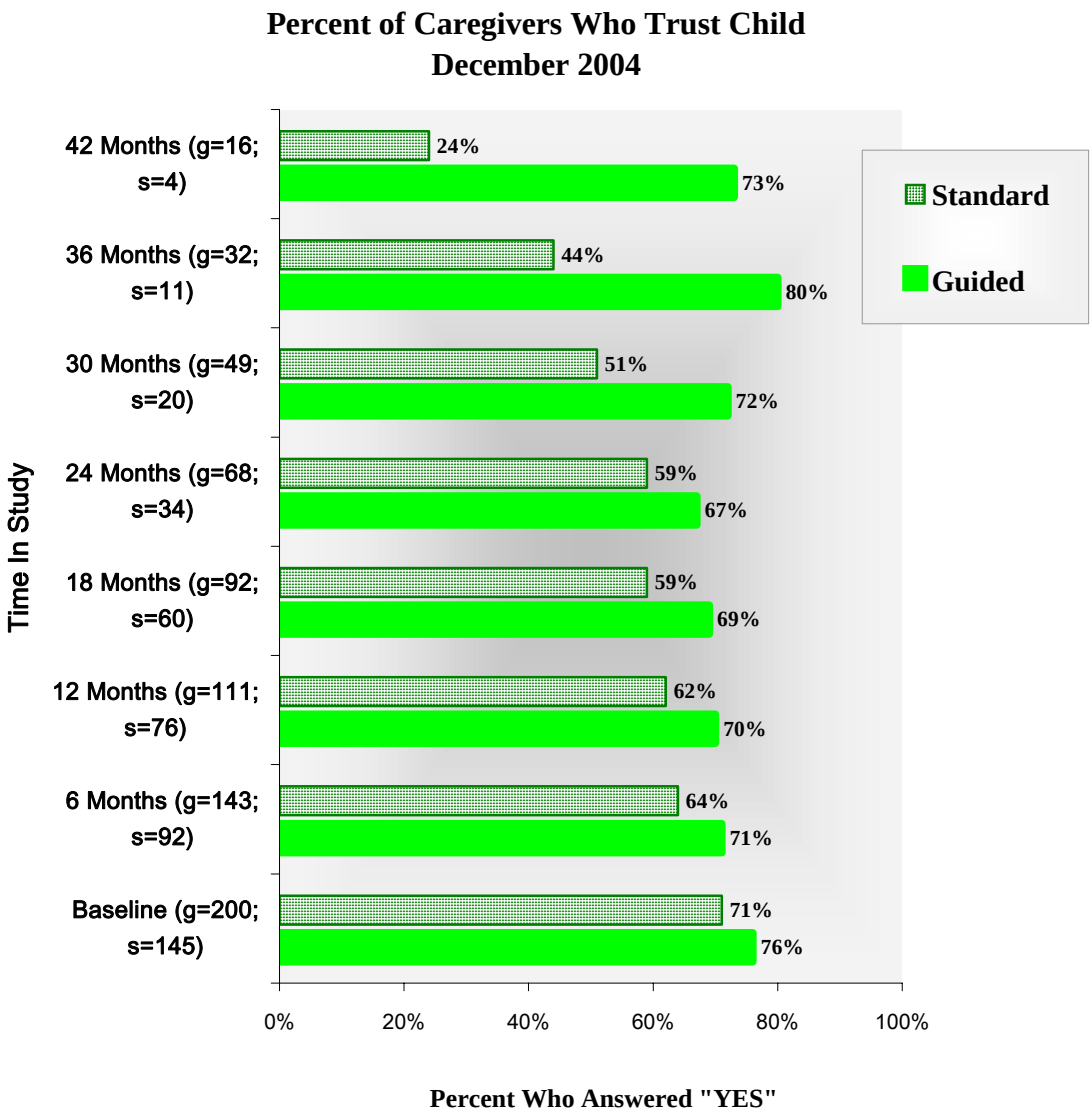
Family Adaptability and Cohesion: Family Cohesion is defined as the emotional bonding that family members have towards one another. Family Adaptability is defined as the extent to which a family system is flexible and able to change. For both groups on both measures, their overall scores were within the moderate/normal ranges. There were no differences between groups on this outcome.

Family Attachment to Child: Both groups of caregivers rated family members attachment to the child as very attached. There were no statistical differences between groups on this outcome.

Family Attached to Child
December 2004
1 = Very Attached 4 = Not at All Attached



Percent of Caregivers Who Trust Child: Caregivers were asked if they trust their child, Yes or No. For this outcome variable at 30 months (chi square 4.67, df=1, p=.031) and 36 months (chi square 8.91, df=1, p=.003) parents in the Guided Services group stated more often that they did trust their child compared to those parents in the Standard Services group.



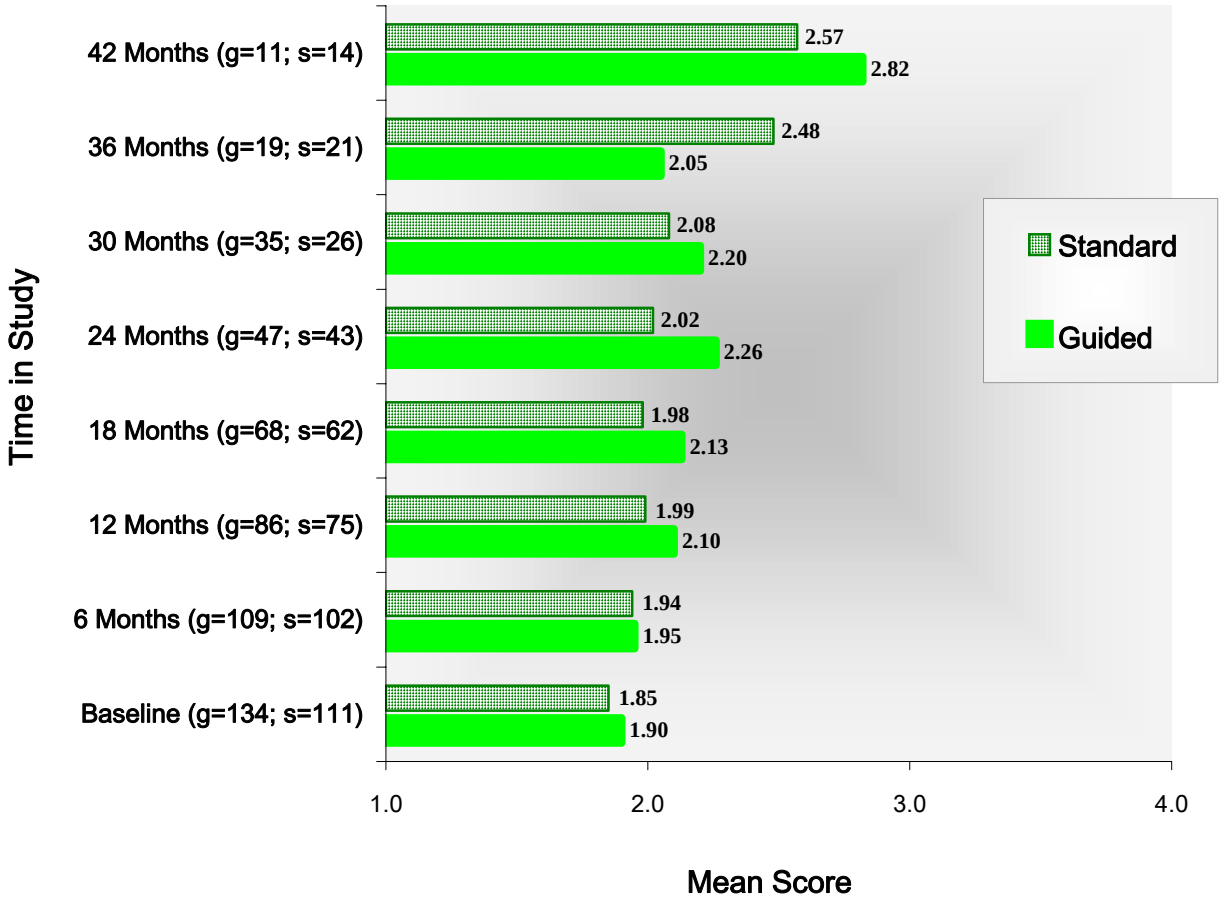
Parent and Child Communication: Both groups of caregivers rated their overall level of communication with their child as very positive. There were no statistical differences between groups on this outcome.

Frequency of Parent and Child Disagreements: Both groups of caregivers appeared to experience very low levels of parent-child disagreements. There were no statistical differences between groups on these outcomes.

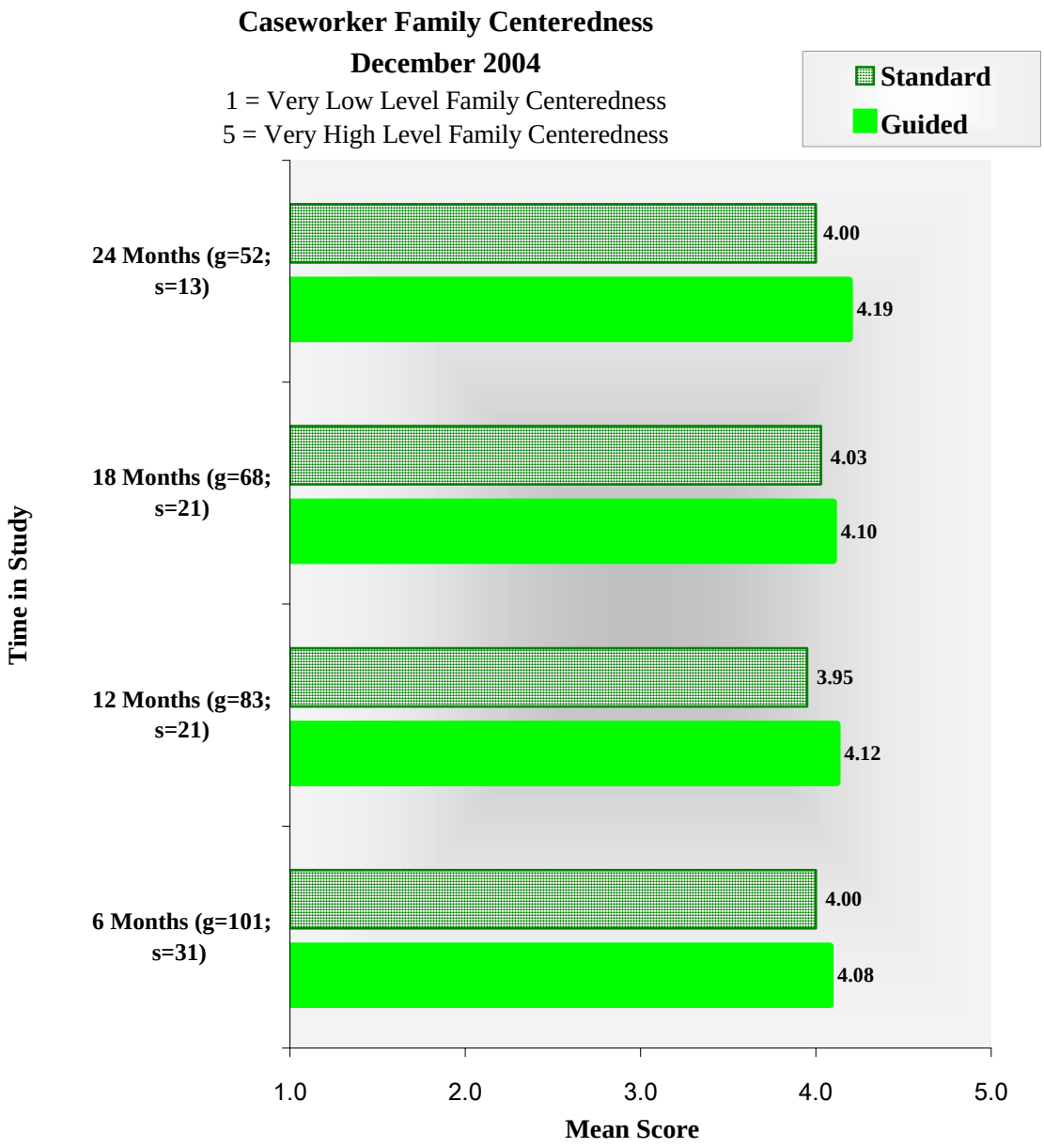
Frequency of Parent to Child Positive Caregiving Behaviors: Both groups of caregivers appeared to demonstrate high levels of positive caregiving behaviors. There were no statistical differences between groups on these outcomes.

Overall Quality of Home Life: Both groups of caregivers rated their overall quality of home life as positive. There was no statistical difference between groups on this outcome.

Caregiver Report on Overall Quality of Home Life
December 2004
1 = Excellent 4 = Poor



Family Empowerment - Caseworker Family Centeredness: In families that were receiving regular case management services, caregivers were asked to assess the family centeredness of those services. Supports were provided based on the family needs and not based solely on the adopted child's needs or professional provider recommendations.



As described earlier, the Guided Services model was implemented with the intent that it be family-centered. The proposition was that the more family-centered the support, the more empowered the family (caregiver) would feel and perhaps be better able to function in support of the family and child. The intent was that the intervention neither be driven solely by the needs of the child nor it be provided from a professional-centered model with the social worker viewed as sole expert on the family. Family-centered models emphasize that children – and adults – grow and develop within family systems. Family-centered service delivery recognizes the centrality of the family in the lives of individuals.

Of those caregivers who reported receiving case management services, the majority reported that their caseworkers provided services in a family-centered manner. In terms of group differences, at 24 months there was a significant statistical difference in scores indicating that families receiving Guided Services were receiving a higher level of family-centered services than those families in the Standard Services group (Kruskis Wallis one-way analysis of variance; chi-square 6.39, df=1, and p = .012).

Due to the small sample size, the non-parametric method Kruskis Wallis one-way analysis of variance was used to analyze the results. The sum of ranks for each group was computed, then an average rank for each group was computed and a comparison made between the two groups. The results indicated that parents in the Guided Services group reported a significantly higher level ($p < .05$) of Family-Centered Behaviors from their caseworker on the following four items:

- The caseworker helped us get all the information we wanted and/or needed.
- The caseworker helped us get the help we wanted from our family, friends, and community.
- The caseworker suggested things that we could do for our child that fit into our family's daily life.
- The caseworker helped my family get services from other agencies or programs as easily as possible.

6. What are the costs involved in caring for children after legalization?

There were three kinds of costs tracked for this study:

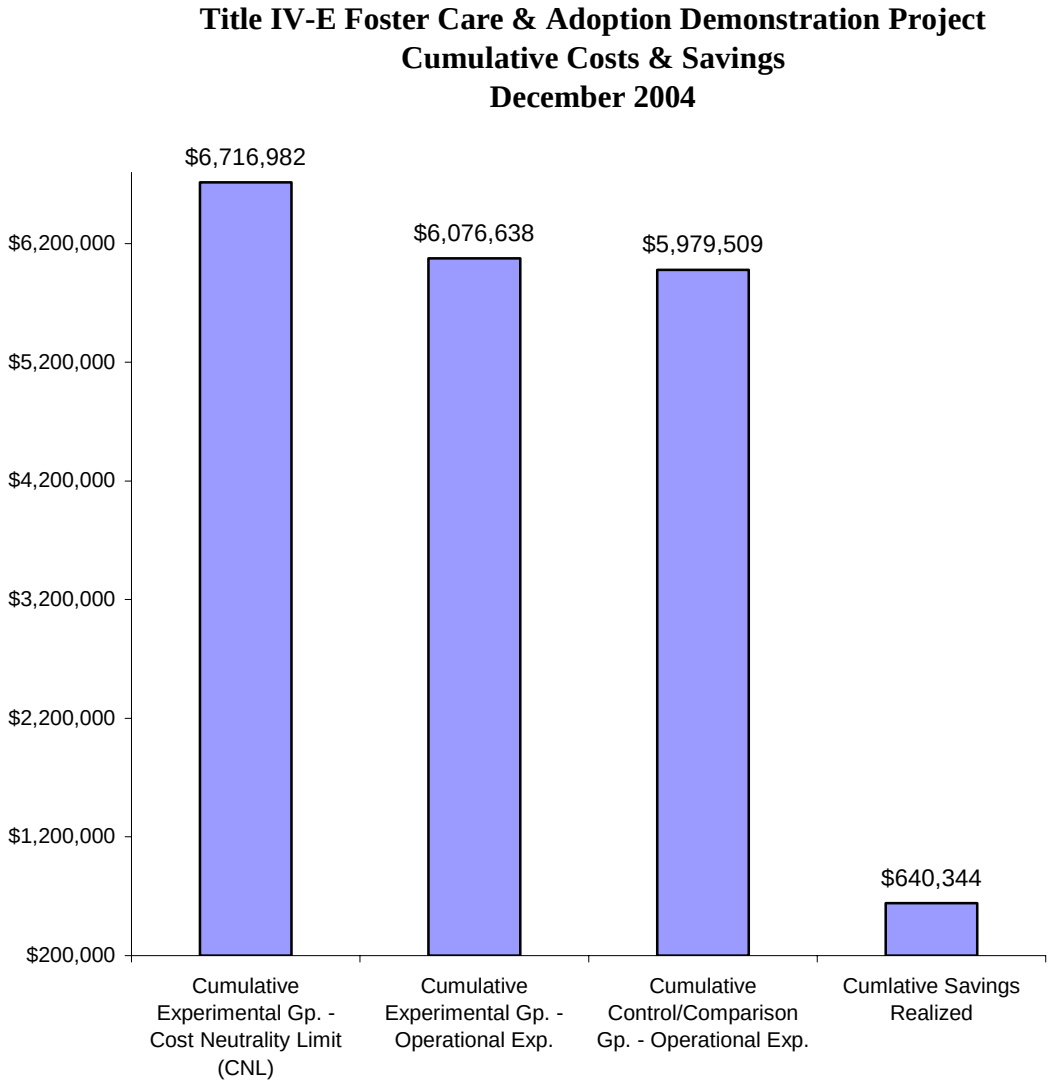
1. **Cost-Neutrality:** DHHS staff tracked Title IV-E costs associated with this Waiver project and reported on cost-neutrality.

2. **Title IV-E Costs – Concrete Services:** Evaluation staff collected information about the Title IV-E dollars provided by the state DHHS to MAGS families for concrete services.

3. **MaineCare (Medicaid) Costs:** Evaluation staff worked cooperatively with DHHS to monitor MaineCare (Medicaid) costs for all children in the study.

COST NEUTRALITY

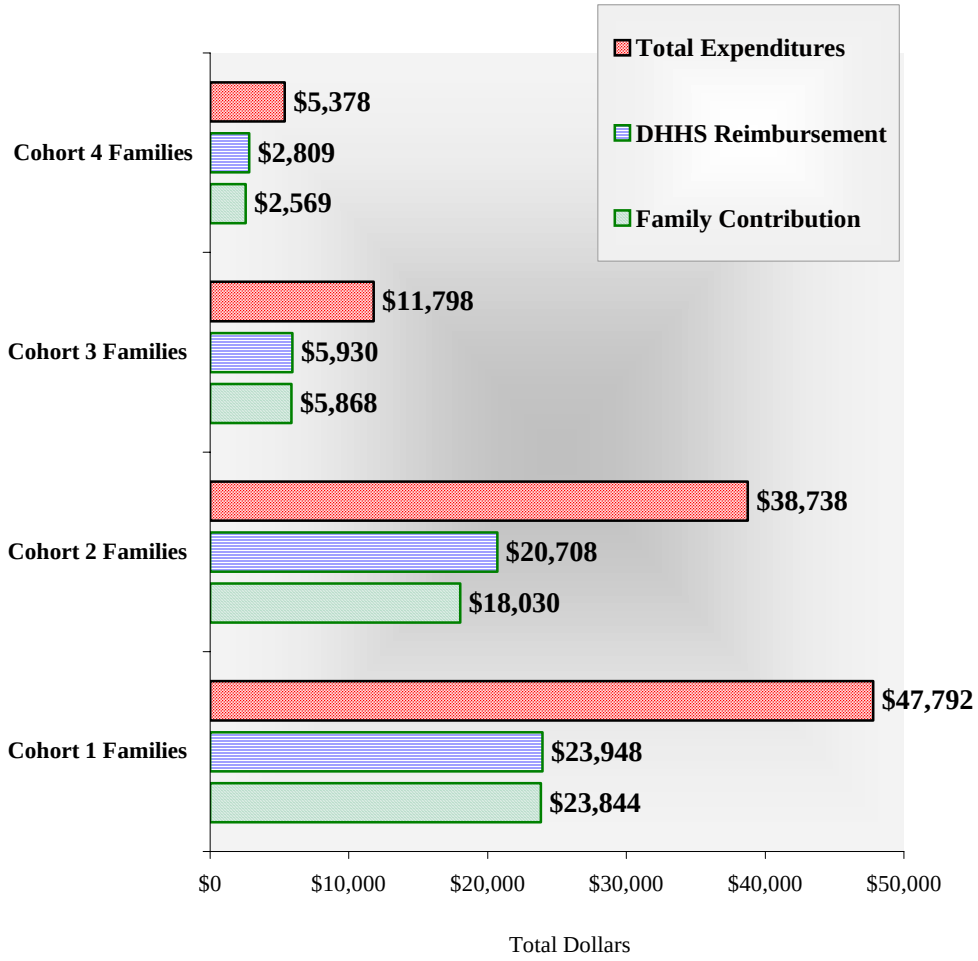
The figure below shows the cumulative savings realized over the period of this project; approximately $640,344. This project demonstrated a savings in that amount to the Federal/State Title IVE Program and thus was cost-neutral.



TITLE IV-E COSTS

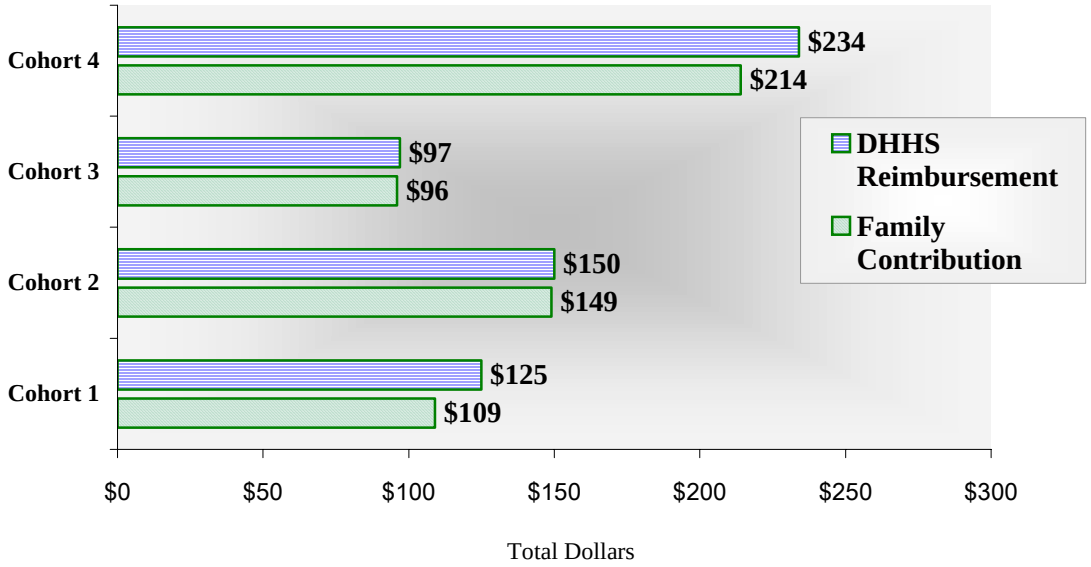
The two following charts tracked costs that were Title IV-E dollars provided only to Guided Services (E) families. These funds were for services of various types that were not paid for from current options such as MaineCare and/or private insurance carriers. These services included such activities as respite, educational activities and/or special therapeutic activities. The intent was for the family to share equally in the costs of these services. Requests were made by the family to MAGS/Casey Family Services social workers and then approved by the state DHHS adoption program manager on a case-by-case basis.

Guided Services Families: IVE Expenditures
December 2004



Average per Family IV E Expenditures

December 2004



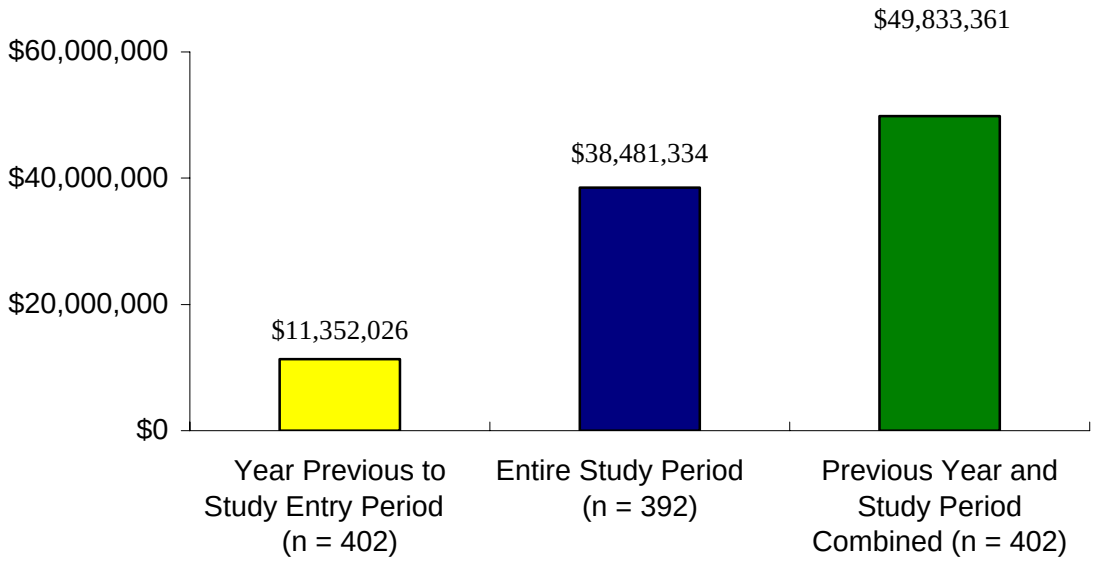
The chart above depicts average overall expenses per family. This data indicated that the intent of co-equal contributions from families and the Title IV-E dollars appeared to be evident; there were no statistical differences to report.

MAINECARE (MEDICAID) COSTS

The evaluation staff at the University established a process with the state DHHS, Bureau of Medical Services to track MaineCare costs per child. Children were tracked by matching DHHS foster/adoptive program identification numbers to DHHS MaineCare identifiers. In this analysis, each service provided to a child was coded in the following manner: (1) Category of Service – a broad definition of service type, (2) Procedure – a more specific coding related to MaineCare regulations, (3) Diagnosis – physical or mental health, and (4) Provider – who or what agency provided that service. The MaineCare cost analysis focused primarily on exploration of between group differences overall and at the level of Category of Service. The general hypothesis for this analysis was that MaineCare costs for those children receiving the intervention, the Guided Services model, would be equal or less than MaineCare costs for those children in the Standard Services comparison group. The belief being that through the intervention, children and their families received effective services and support resulting in less need for services over time.

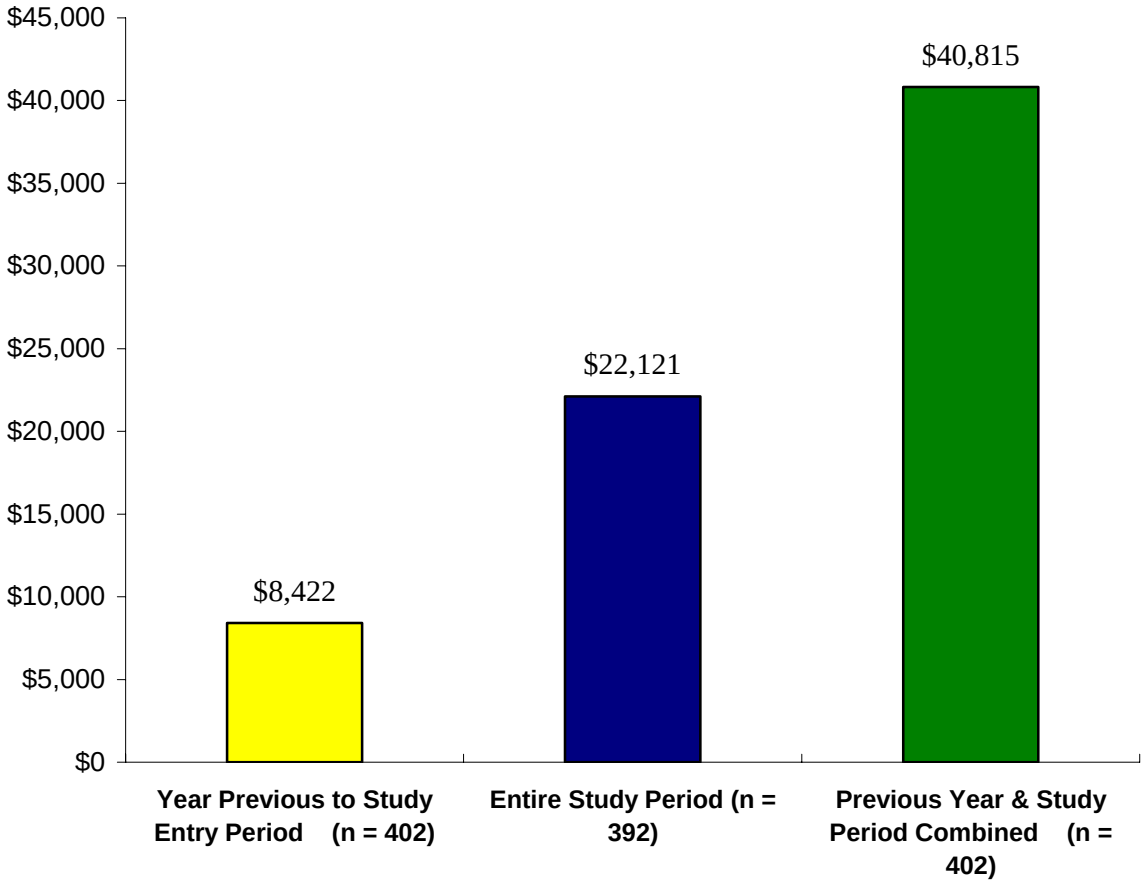
The data set for this MaineCare cost analysis has a total of 402 cases, children who were in the study at baseline; over time this number changed due to attrition. The average age of the children in this MaineCare data set was 8.8 or 9 years old; 52% were female and 48% male. Approximately 12% of these children were adopted by parents who were not Foster Parents at the time of adoption. What is important to note is that for the time period previous to study entry, *there were no statistically significant group differences* on the variables of: Gender, Age, Length of Time in Home, Type of Adoption and Time in Study. At least as measured on these variables, the process of random assignment appears to have created two similar groups.

TOTAL Amount MaineCare Costs
December 2004

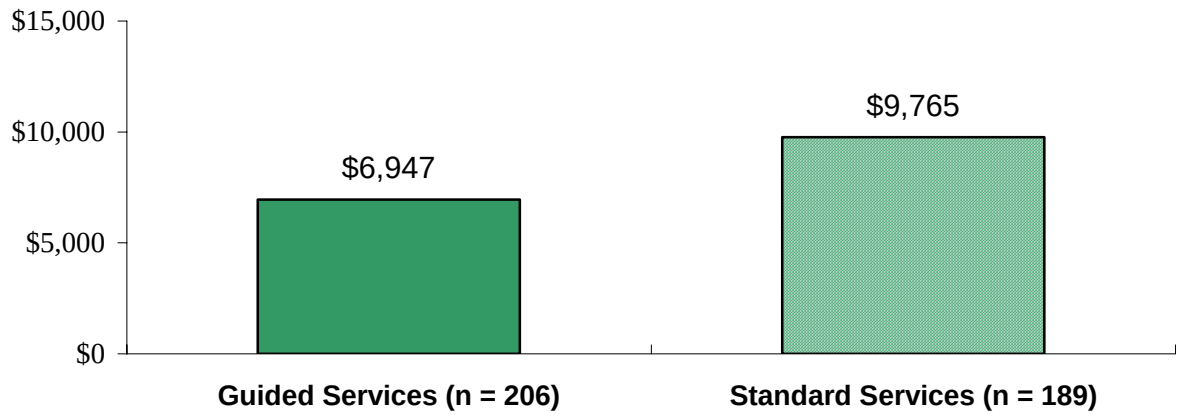


The chart above presents the total amounts for all children, the chart that follows presents the median per child costs for the same time periods. The total amount spent on the study population, n = 392 children, for the study period 1999-2003 (four years), was $38, 481, 334. Due to the nature of these costs, with instances of just a few children having extremely high costs in one or two periods that skew the distribution of the data – most often due to physical medical care - the median amounts were a more accurate average to use in describing these costs. As this data was not normally distributed, in order to calculate between group differences the data was analyzed with non-parametric statistics and/or transformed using a logarithmic procedure. For the study period, the median amount per child costs to MaineCare was $22, 121 for four years.

Median Amount of All MaineCare Costs
MaineCare Costs
December 2004

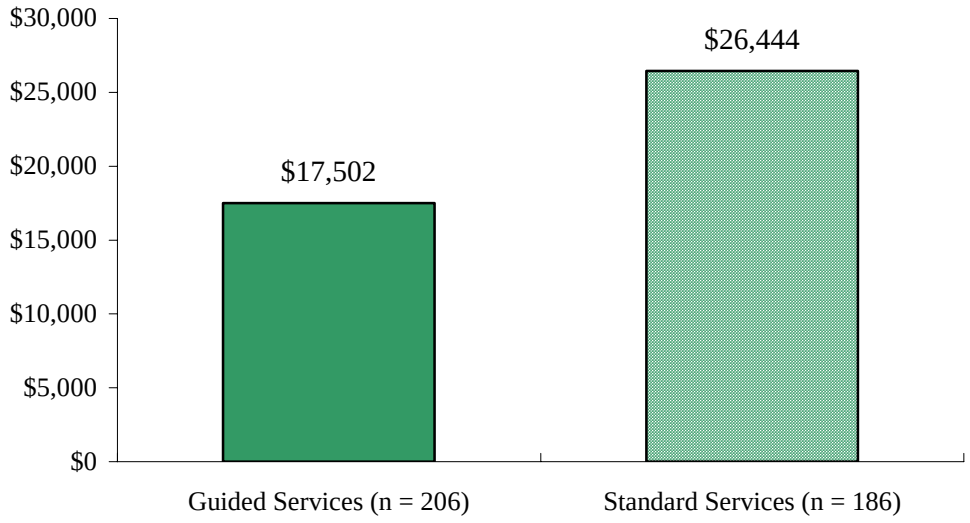


Median Per Child TOTAL MaineCare Costs
Year Previous to Study Entry
December 2004



For the year previous to study entry, using both a parametric statistical test (t-test) and nonparametric statistical test (Mann-Whitney) there were no statistical group differences between those children in the Guided Services group and those in the Standard Services group (t-test p= .681 and Mann-Whitney p=.317). This result indicates that costs for both groups were similar before entering the study.

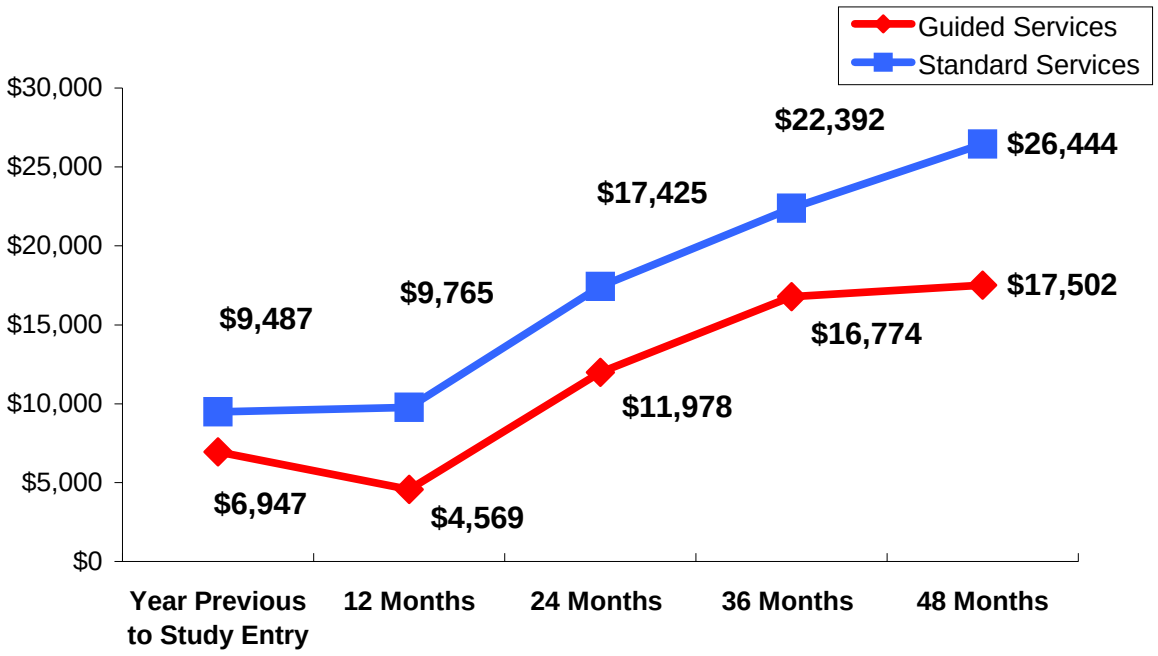
Median Per Child TOTAL MaineCare Costs - Entire Study Period
November 2004



The chart above indicates differences between the groups during the four-year study period. As mentioned earlier, as this data is not normally distributed applying a nonparametric test, Mann-Whitney, does find a statistically significant difference between groups at p = .011. With the use of a transformation, the subsequent parametric test for group differences, Independent Samples t-test, results in a statistically significant difference at p=.016. These results indicate a statistically significant difference in MaineCare costs for the study period. Meaning that those children in the Guided Services group had lower costs overall than those children in the Standard Services group.

The average (median) difference in cost per child for the entire study period was approximately $8, 942.

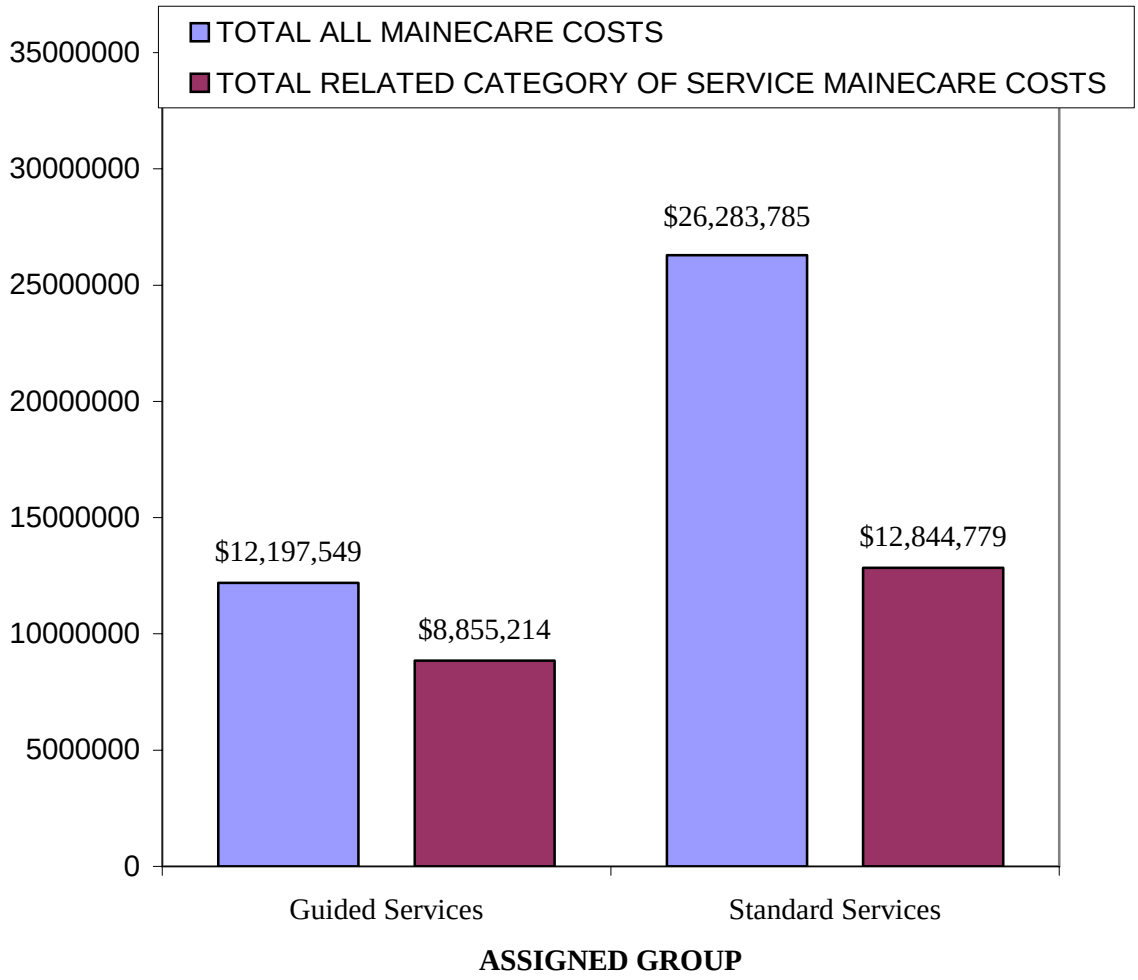
Median Per Child TOTAL MaineCare Costs
December 2004



The analysis was further refined to include just those Category of Service codes thought to be most associated with needs that these children may experience and that may be influenced by this type of clinical case management intervention. These following codes account for over 85% of all the types of services provided to this population. The primary Category of Service codes selected are listed below and provided in the next chart:

- General Outpatient: Covered costs associated with outpatient services, including behavioral health.
- Physician: Recognized that for many families, physicians were involved with both physical and behavioral health treatments.
- Case Management: The specific type of service model.
- Mental Health Services: Therapeutic Services
- Non-Traditional PHP: Services for youth with significant behavioral health needs.
- Prescription Claims: Consistently at least a third of this population were using psychotropic medications; according to parent reports.

MAGS MAINECARE COSTS
December 2004



COST FINDINGS:

- Total amount of MaineCare dollars spent on study population, n=392 children, for the study period 1999-2003 (four-years), was $38, 481, 334.
- Total amount of MaineCare dollars spent on Related Services for the same period, those cost categories most related to what the intervention was thought to effect, was $21, 699, 993. These related cost categories accounted for over 85% of all cost categories for the study population.
- The Guided Services group, the group that received the intervention, had a total savings to MaineCare of $14, 086, 236 over a four-year period in comparison to the Standard Services group that did not get the intervention.
- The Guided Services group costs was 32% of all MaineCare costs and the Standard Services group costs was 68% of all MaineCare costs; for a difference of 36%.
- Analyzing just the most related cost categories; the Guided Services group had a savings to MaineCare of $3, 989, 565 for a four-year period.
- The Guided Services group costs was 41% of the total Related Service Category MaineCare costs and the Standard Services group costs was 59% of those costs; for a difference of 18%.
- The difference in cost between groups was statistically significant for both the total costs analysis and the related services only analysis.

CONCLUSION

In conclusion, the finding is – the Maine Adoption Guides post-adoption services model provided to children and families ***the same or better services and supports, families got what they asked for the way they wanted it, and all for less cost to the taxpayer.*** This intervention model appears to have been designed and implemented to meet needs expressed by these adoptive families, this is an important and positive finding. Statistical group differences are few and are in favor of the Guided Services model. The philosophical intent of providing services in a family-driven framework is evident. The partnership between the Casey Family Services agency and the state DHHS adoption program functioned in support of this project. Both agencies demonstrated willingness to collaborate and work through a uniquely difficult process with families at various stages of engagement.

Despite lack of statistical evidence in favor of the intervention on the majority of the outcomes measured, a focus needs to remain on the fact that there is a substantial need for behavioral health services and supports for the majority of children who are adopted from the state child welfare system. In fact, in 2004 the state DHHS office conducted a survey of all parents receiving adoption subsidy across the state and ***over 400 families*** indicated an interest in receiving post-adoption services. The services and supports that were provided to these families were comprehensive, family-centered and provided at less cost to the taxpayer

In the midst of caring for children with substantial needs, caregivers reported overall positive satisfaction with the adoption process, their services received from state DHHS staff, and with the supports they received from the Guided Services social workers. These findings are a testament to the grace exhibited by these parents. Their lives create families that result in better communities for all of us…they are the ties that bind.

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APPENDICES

Appendices are not attached to this document. Please contact authors for copies or questions regarding data in the Appendices.

Appendix I Survey Measures & Forms

Data Collection Schedule & Description

Non-Standardized measures included the following surveys

Study Participant Information Form
Maine Adoption Guides: Non-Participation
Written Questionnaire IA: Family/Child Information
Questionnaire IIA – Telephone Interview: Parent/Family Interview
Written Questionnaire IB: Family/Child Information
Questionnaire IIB – Telephone Interview: Parent/Family Interview
Casey Family Services Tracking Form & Codes

Consent/Assent Forms

Informed Consent for Participation in the Adoption Services Study
Youth Study Assent
Young Adult Informed Consent for Participation

Appendix II Additional Tables of MAGS Results

Appendix III

- **Univariate analysis of all items (frequencies)**
- **Bivariate analysis on all items (cross-tabulations)**

CHAPTER I – INTRODUCTION

A. OVERVIEW OF THE DEMONSTRATION

1. PURPOSE

The evaluation of the MAINE ADOPTION GUIDES PROJECT, Title IV-E Child Welfare Waiver was conducted for the Department of Health & Human Services (DHHS), Bureau of Child and Family Services (BCFS). It was comprised of two parts: 1.) a process and an impact evaluation of the adoption competency-training program for public and private providers of adoption related services; and 2.) a process and outcome evaluation, and a cost effectiveness/benefit analysis, of the purchase and delivery of guided post legalization adoption support services to children and families. The design of the training evaluation was a nonrandomized pre-post design with follow up interviews to map the impacts of the training on knowledge and application of skills. The design of the post-legalization Adoption Guide support services evaluation was randomized. This final report focuses on this model of supports to families adopting children with special needs.

The training evaluation component began on April 1, 1999 and continued through the end of November 2000. The final training evaluation report is available upon request. Statewide implementation of the Guided Services model began on April 1, 2000 and terminated on March 31, 2004. The entire evaluation ended 9 months after the end date of the Waiver Demonstration Project, on December 31, 2004.

The Maine Adoption Guides Project had both system level and program level intended outcomes.

System Level - Permanency Related Outcomes:

- **Reduce Time in Foster Care to Adoption Legalization without Increasing the Number of Adopted Children whom Re-Enter Foster Care.**
- **Increase Permanency for Special Needs Children**

These outcomes were considered system level outcomes and were tracked through state Department of Health & Human Services administrative data systems.

Program Intervention Level Outcomes:

- **DECREASED RATE OF ADOPTION DISSOLUTIONS**
- **SUPPORTED AND STRENGTHENED ADOPTIVE FAMILIES**
- **MAINTAINED OR ENHANCED THE WELL-BEING OF THE CHILD IN THE ADOPTIVE FAMILY**
- **INCREASED ADOPTION RELATED AWARENESS, KNOWLEDGE, SKILLS AND THE APPLICATION OF THOSE SKILLS AMONG PROVIDERS AND RELATED PROFESSSIONALS WHO SERVE ADOPTIVE FAMILIES.**

The outcomes listed above are conceptualized in relationship to the proposed interventions by the following logic model.

INTERVENTIONS

Adoption Competency Training / Enhanced Supportive Services

SHORT TERM OUTCOMES

- **Increased adoption related awareness, knowledge, skills and the application of those skills by providers and related professionals who serve adoptive families**
- **Decreased Rate of Adoption Dissolutions**
- **Supported and Strengthened Families**
- **Maintained or Enhanced the Well-being of the Child in the Adoptive Family**

LONGER TERM OUTCOMES

- **Reduce Time in Foster Care to Adoption Legalization without Increasing the Number of Adopted Children whom Re-Enter Foster Care**
- **Increase Permanency for Special Needs Children**

2. BACKGROUND

This federal Title IVE Child Welfare Demonstration Project was the result of planning on the part of the state DHHS agency since the mid 1990s. As a result of a series of interactions with parents, adoption agencies and other stakeholders the state DHHS developed a specific focus on post-legalization services. This policy and program development was driven by two pressures on the adoption system: (1) increasing numbers of children requiring adoption services; and (2) pending implementation of the Adoption and Safe Families Act. In response to those pressures, state agency managers, parents and non-governmental adoption agencies undertook a process that resulted in this Child Welfare Demonstration Project - Maine Adoption Guides Project.

The guiding principles that drove this initiative included:

- Adoption is a life-long process.
- Most adoptive families experience normal crisis in their development.
- Families need more support services post-legalization.

In addition to realizing the need for a more concentrated effort to provide post-legalization services, the initiative also intended to impact the adoption competencies of social workers providing services to adoptive families. Parents involved in the planning process were forceful in their concerns about an apparent lack of understanding of the dynamics of adoption on families on the part of mental health social workers.

3. ADOPTION GUIDED SERVICES DESCRIPTION

The core principle of this program is that adoption is different. The dynamics of a family created by adoption are different from the dynamics of a family created by birth. Adoption is lifelong and its impact creates unique opportunities and challenges for families and communities. Adoption is mutually beneficial to parent, child and society. Society is responsible for supporting and aiding integration and preservation of adoptive families.

The program description focused on the services to the Guided supportive Services (experimental) group. The Standard Services (control) group received the same level of post legalization adoption assistance services that were in place, either through DHHS or generally available in the community. The guided service model differed from the standard practice in several ways, see Figure 1 below for a comparison. In addition, see Figure 2 following for a program logic model of the Guided Services intervention.

We recruited the participants from the overall population of families adopting children with special needs, out of the Foster Care System of DHHS. The families were selected at the time they were approved for adoption assistance. We covered the entire state of Maine, which included all eight districts of the DHHS. This service delivery was provided by a partnership of DHHS/BCFS and Casey Family Services. It also included Casey Family Services subcontracting with another service provider to meet statewide needs. Families assigned to the standard services, adoption assistance group were not eligible for the Guided post legalization adoption services. The long-term plan, based on the positive outcomes of this study, was that these same guided services were expanded to the general population of adopting families.

This was a community-based delivery of service program designed to be child-centered and family focused. The adoptive parent(s) was viewed as the expert on their child. The adoption staff are guides who consult with the family through the expected and normal crisis in the life of an adoptive family.

Therefore, the major hypothesis of the study was:
Families and children who receive guided supportive services will be strengthened, have fewer dissolutions, and report higher levels of child and family well being than families and children that receive standard services.

Figure 1
Post Legalization Program Model Differences

Program Attribute	Standard Services	Guided Supportive Services
Target Population	Children w/Special Needs, and their Families	Children w/Special Needs, and their Families
Program Goals	- Provision of Adoption Assistance Funds Funds - Assistance with process to Legalization	- Decrease Dissolutions - Increase Family Strengths - Maintain/Increase Child and Family Functioning - Provision of Adoption Assistance Funds
Staffing	D.H.S. Adoption Worker	D.H.S. Adoption Worker and Casey Adoption Staff
Services Provided	- One time Assessment/ Planning Session - Financial Support for Post Adoptive Services as per Entitlements - Annual Financial Planning for Continuance of Adoption Assistance	- Initial and ongoing support based on family needs identified in "Family Permanency Assessment". - Scheduled check-ins with family and Casey staff at least once every six months. - Permanent assignment of Casey staff to family in an empowerment role. - Financial Support for Post Adoptive Services, not limited to services pre-defined in subsidy agreement. - Annual Financial Planning for Continuance of Adoption Assistance
Access to Trained Providers	- Provided with List of Trained Providers	- Provided with List of Trained Providers

Figure 2
Maine Adoption Guides - Guided Services Intervention Program Logic Model

INPUTS	ACTIVITIES	OUTPUTS	IMMEDIATE OUTCOMES 0 - 6 MONTHS	INTERMEDIATE OUTCOMES 7 - 18 MONTHS	LONG TERM OUTCOMES 19-48 MONTHS
• Social Worker Staff • Financial Supports for Families • Formal and Informal Supports for Families	• Initial Assessment with Family - Strength Based, Family Centered planning • Case Management Activities • Therapy Sessions • Resource Brokerage • Regular Check-ins with Family, at least once every 6 months	• Social Worker meets with family for initial strengths based, family centered assessment, with DHHS/IASC Adoption worker; before legalization. • Regular Check-Ins Occur; at least 2x per year. • Social Worker available to family for case management - supportive services, therapy; ongoing.	• Family is supported and empowered as they respond to their child's needs. • Selected Child(ren) *maintains or improves functioning;* family, school, social and emotional domains. • Families access needed resources, formal and informal supports. • Family & Social Worker staff expresses satisfaction with Guided Services model. • Adoption is maintained • Few to No Displacements - Child Lives at Home	• Family is supported and empowered as they respond to their child's needs. • Selected Child(ren) *maintains or improves functioning*; family, school, social and emotional domains. • Adoption is maintained • Few to No Displacements - Child Lives at Home • Families access needed resources, formal and informal supports. • Family & Social Worker staff satisfied with Guided Services model given normal developmental crises.	• Family is supported and empowered as they respond to their child's needs. • Selected Child(ren) *maintains or improves functioning;* school, social and emotional domains. • Adoption is maintained • Few to No Displacements- Child Lives at Home • Families access needed resources, formal and informal supports. • Family & Social Worker staff satisfied with Guided Services model given normal developmental crises.

Program Logic Model: Outcome Definitions

Family is supported and empowered as they respond to their child's needs.

- Parent - Child Communication
- Parent - Child Relationship
- Feelings about Adoption
- Attachment
- Satisfaction with Adoption
- Caregiver Health (Stress)
- Quality of Home Life
- Family Cohesion/Adaptability/Satisfaction (FACES II)

Selected Child(ren) maintains or improves functioning; family, school, social and emotional domains.

- Juvenile Justice Involvement
- Physical Status
- Emotional/Intellectual Status
- Relations with Peers
- Personality Traits
- Competencies and Problems - Functioning (CBCL)
- Academics/School (CBCL)

Families access needed resources, formal and informal supports.

- Formal Supports include: Case Management; Respite; Advocacy Support by Case Manager; Counseling/Therapy; Family Therapy; Marriage Counseling; Adoption Support Group; Special Education services; Residential Treatment; and other Institutional Placement.
- Informal Supports: identified by the family - documented.

Family & Social Worker staff expresses satisfaction with Guided Services model given expected normal developmental crises.

- Family: Satisfaction with support and services as provided through their Adoption Guide social worker.
- Adoption Guide Social Worker: Satisfaction with their role and performance in the Maine Adoption Guides Program and how they are supported in their work with families.

Adoption is Maintained

- The legalized adoption does not dissolve with the child returning to the state's custody and foster care system.

Few to No Displacements - Child Lives at Home

- The child/adolescent lives in her/his home on a permanent basis - number of days child is at home. A displacement is when a child/adolescent is hospitalized or otherwise removed from the home in order to receive treatment so that the child may return home. Child is considered not at home when she runs away, is incarcerated, lives somewhere else against parents will or is hospitalized for other than a medical necessity.

B. RESEARCH DESIGN AND METHODOLOGY

1. POPULATION CHARACTERISTICS

The intervention component served children who were in the state child welfare system and classified as having special needs. The criteria for special needs in Maine results in nearly all children falling into this category. In April 1999, at the beginning of the Project, Maine had approximately 3,100 children in foster care. In January of 1999 there were 641 children requiring adoption services. As of January 2000, there were 806 children requiring adoption services. For the year 2000, 423 adoptions were legalized in Maine; for the year 2001, 304 adoptions were legalized in Maine; for the year 2002, 319 adoptions were legalized in Maine and, for 2003 , 287 adoptions were legalized. All four years show an increase from 1999 when 240 children legalized. These figures represent the continuation of an upswing in adoptions in Maine, experienced after a four-year decrease from 1990 to 1994.

2. RESEARCH DESIGN AND METHODOLOGY

a. Guided Services Evaluation

As mentioned earlier, the Guided Services component of this initiative commenced in November 1999 through March 2000 with pilot implementation of the intervention. This pilot period was crucial for the evaluation as it provided an opportunity to design, test and implement the necessary procedures for random assignment, data collection, data entry and reporting. The pilot period resulted in the implementation of an evaluation process that was fairly well integrated with the two organizations that were part of this Demonstration project. The following was the basic evaluation plan developed for the Guided Services component of the project.

b. Guided Services Model - Process Evaluation

A process evaluation is critical in describing the program strengths and weaknesses to guide implementation, and to understand the outcome data. For this project, the process evaluation included the monitoring of:

- DHHS and Casey Family Program Organizational Aspects
- Staffing Structures and Profiles
- Financial Commitments
- Level of Acceptance by Field Staff
- Methods of Project Implementation - Fidelity of Guided Services Model
- Contextual Factors
- Demographic Profiles of Families and Children Served
- Utilization of Services and Unmet Needs
- Satisfaction with Services
- Differences in Experimental and Standard Groups
- Family Assessment of Long Term Permanency Needs
- Results of Individual, Family Focused, Series of Regularly Scheduled "Maintenance" Checkups

c. Outcome Evaluation - Guided Services Model

The outcome evaluation began in Year 2 of the Demonstration Project on 4/1/2000 and ended in March 2004. The selection or development of measures and data collection strategies, including a piloting process, was conducted during the Year One, 4/1/1999 - 3/31/2000. The outcome evaluation assessed to what extent the children/families who received the Guided Services Model (experimental group) and the children/families who received Standard Services (control group) differ in regard to a number of outcome measures. The outcome measures included:

- Rates of Adoption Dissolutions
- Number of Days Child in the Home / Displacement Rates
- Assessment of Family Functioning
- Assessment of Child Functioning/Well Being
- Assessment of Access to and Utilization of Services
- Levels of Satisfaction with Services

d. Outcome Evaluation - Research Design

The Figure 3 below outlines the proposed design which was a two-group randomized experimental design such that any family/child meeting the participation criteria would have an equal chance of being assigned to either of the two groups.

Figure 3: Outcomes Study Design

Guided Services:	
Group A	**Randomization --- (Baseline) O --- X --- O (Every 6 mos.) -- O**
Standard Services:	
Group B	**Randomization --- (Baseline) O ---------- O (Every 6 mos.) -- O**

This design intended for at least 60 children assigned to the Guided Services - experimental group and 60 children assigned to the Standard Services - control group each year. Actual recruitment was for 70 children in each group to work against possible attrition. Sample size estimates were as follows:

- Year 2, 2000-2001: 120 children (60E, 60C)
- Year 3, 2001-2002: 240 children (120E, 120C)
- Year 4, 2003-2004: 360 children (180E, 180C)
- Year 5, 2004-2005: 480 children (240E, 240C)

This design resulted in the following sample sizes for longitudinal study:

- Four years in Project: 120 children
- Three years in Project: 240 children
- Two years in Project: 360 children
- One year in Project: 480 children

C. DATA COLLECTION & ANALYSIS

1. DATA COLLECTION

Data was collected from:

a. Self-selected primary caregivers reported on child level and family level variables;
b. Casey Family Services social workers reported on implementation of model and theory of change;
c. DHHS state agency staff and administrators reported on implementation of overall program; and
d. Casey and DHHS administrative records.

Data was collected by telephone interviews with parents, individual and group interviews with clinical staff and DHHS staff, and data extraction forms with secondary data. Data was collected from primary caregivers at baseline upon entry to the study and every six months thereafter through the completion of the project. Both a written survey and a telephone survey are completed at baseline and at every six months. In general, telephone surveys were scheduled upon receipt of the written survey. The average time between the written survey and the telephone interview over all points of data collection was 0.7 months. The measures developed for this component of the evaluation are in Appendix 1.

2. DATA ANALYSIS PLAN

The final sample size for those in the study for at least 24 months is sufficient for both descriptive and inferential statistical analyses. Descriptive statistics, such as percentages, rates, frequency distributions and means, were used to describe the two groups. Inferential statistics were used to test the statistical significance of any differences within and or between groups as established in the research questions. Open-ended questions and results of focus group interviews were analyzed through coding for common themes emerging from the narrative data. Information summarized in this report is presented in two ways: at baseline (from surveys received upon a family's entry into the study) and by six-month waves (corresponding to each wave of data collection from families). In addition, the data was analyzed by assigned group: Guided (experimental group) and Standard (control group). For a complete data analysis plan, please contact the evaluator.

CHAPTER II
DESCRIPTION OF *MAINE ADOPTION GUIDES* MODEL

One goal of the Maine Adoption Guides evaluation was to accurately describe the model—what was it specifically that social workers were providing to families that makes a difference? We collected data over time to keep apprised of how the model evolved, and any changes that occurred. We also incorporated different methods of data collection in order to gain a stronger description. One way that we gathered information about the model was through focus groups. Below is a discussion of the focus group results, including in-depth descriptions of the model from the field.

A. MAINE ADOPTION GUIDES FOCUS GROUPS

Focus groups with social workers provided valuable information on the project model and its process. Focus groups were held with Adoption Guides social workers and supervisors approximately every six months. Staff members were asked to define their roles in the project and provide general feedback on the project's implementation—how the project model compares to their day-to-day work. Following is a summary of all focus groups held between December 2000 and January 2004.

1. DEFINING THE MODEL

In describing the Adoption Guides model, respondents felt strongly that the model is *family-driven*. The model empowers families to identify their own needs, which could be anything from "just checking in" to crisis intervention. Families play an active role in defining what they want. The model supports families and is built on relationships.

Participants mentioned that the model is unique because it is flexible; a moveable structure. Caseworkers are not required to make a certain number of contacts or visits—they fill in gaps depending on what the family wants. The flexibility also allows caseworkers to suspend judgment and have families teach them about their wants and needs. Comments included:

> "You join with families to be co-creators about what suits their needs—there's an element of creativity."
> "It can be more informal contact than formalized meetings; stepping out of the traditional, professional role to just call to say, "How are you doing?"

Adoption Guides is a preventative model—like a safety net for families. Families have someone to turn to before things are at the point of beyond repair, and that helps families develop resiliency.

Other ideas on the model's definition included:

- Helping families get and locate services, resources and tools
- A project to understand what adoptive families need
- Being there in times of crisis
- Families working with master-level social worker case-managers who have an understanding of intrapsychic development needs

- Offering support groups that have childcare components –"That's critical for families with special needs children."

Participants felt that as a result of their experience working on the MAGS project, they have gained knowledge about adoption issues and expertise in attachment work that isn't available in many communities. Workers are also not limited to just working with the child in this model—there's a lot of work done with parents in their connection with the child, or with couples. Families who may not feel comfortable with having therapy, start to open up due to the relationship that has been built with the worker. And during the time the relationship is developing, some clinical work can be done.

One focus group discussion centered on defining some of the MAGS worker competencies. The first competency discussed was "Relational focus rather than a behavioral focus." Workers defined this as asking questions that poll for the relationship between the parent and the child rather than focusing on "OK, how can we change your child?"

> "I do not try to fix kid's behaviors, I try to think about how to support parents who have healing relationships with their kids, with the assumption that the behaviors will improve if the relationship between the parent and child improves."
>
> "It's the relationship that's long-lasting, not the behavior."

The next competency was the "Ability to fit with the parent during the joining phase, as well as through the stuck phase." This was explained as "Putting the suggestion of what I think would be helpful out there, but not harping on it. But also not letting it go."

> "The skill is in "attuning to the parent." It's about timing, knowing when to approach the subject. It is not always easy to sit with a suggestion while waiting."
>
> "Another part of this is having the willingness to bring up tough subjects."

The last competency discussed was the "Willingness to develop a comfort level with challenging children." Self-reflection is important in doing this—seeing the way parents react to the different behaviors. One person will have a different reaction than another. Self-reflection leads to a greater capacity for empathy.

> "The folks on the team respect challenging behavior. Kids are appreciated more than in other settings."
> "A sense of humor really seems to be a competency. And a sense of humility is really important."

Another focus group discussion centered on gathering in-depth descriptions of a few of the service codes social workers use to describe and record their work with families. The first type of service discussed was "General Parent Education and Support." This service code is distinguished from "Building/Maintaining Relationships," and from "Clinical Conversations," and serves as a type of miscellaneous category for the kind of education and support social workers provide to families. Workers mentioned that this code includes such things as educating families (and themselves) on a diagnosis; working with a child's developmental stages; educating a family about the therapy process and helping families decide what they may need for support. Workers also may help a parent think

about a child's behavior in a different way. Participants mentioned seeing themselves as a "safety net" or as a "coach" for families and feel that "General Parent Education/Support" is a major element of the model because it allows a more meaningful connection with the family. Through the home-based work done with families, workers see the family in the context of the family's home and have a depth of understanding of the child and the whole situation. This enables the social workers to have more accurate hypotheses about what is happening with a child or family than another therapist who may only be seeing the child alone.

The next service code discussed was "Collateral Contacts." Social workers described this as identifying needs and building resources. It can be case management or it can be clinical. Workers also help to educate the collateral contacts. MAGS workers are trained specifically on adoption issues and attachment whereas others involved with a family may not be.

"Non-therapeutic" services include recreational and informal activities with families, such as having lunch or dinner, going to picnics, attending parties, going to the movies, or playing with children. These types of services are seen as very important to the model because they break down artificial boundaries—making families feel more comfortable and able to trust workers. Often times, non-therapeutic services pave the way to doing clinical work with a family that may not have wanted therapy initially. The informal activities allow for families' progression. Therefore, this is not a short-term service. Non-therapeutic activities allow parents the opportunity to network with other parents and allow kids with similar issues to come together. Kids and families can connect through these gatherings and can get support in a non-threatening way. These activities also are a great way for families to relieve stress without worrying about the stigma of needing therapy. Workers view these informal connections as a major component of the model.

The focus groups also discussed the process of social workers teaming up to work together. The decision to team up is driven by the needs of the child and the family. If a particular worker doesn't feel that he or she has the needed skills for working with a family, he or she can team up with someone who can help with the family and/or teach the necessary skills. Sometimes a family may have more needs than one worker can assist with and another worker can help provide services. Working in teams helps social workers reflect on their cases and provides opportunities for them to bounce ideas off of each other. Supervision was noted as a key piece of the model. Workers have regular meetings but also have frequent informal supervision where they exchange ideas and ask for advice. That sort of informal supervision doesn't occur in many other agencies because workers need to bill for every hour of work. The social workers in Houlton are not able to team together due to the great distance between where families live.

2. INITIAL WORK WITH FAMILIES

Participants were asked what the model looks like during the first three months of working with a family. These months were described as a time to build trust with the family, and a time for the family to feel comfortable working with them. It is a period of information gathering, when material for the intake summary is gathered slowly through informal conversations. Some families feel comfortable getting services right away, others need their space initially and want to wait. Workers felt that that flexibility is part of the beauty of the model—workers can do what the families want and follow their lead.

If the child is old enough, the worker may also talk with the child about his/her needs. Workers use this time to do such things as:

"Be a sounding board for parents."
"Develop a warm rapport."
"Hear their story in their own words."
"Help families explore their options and choices."

A common theme among participants was the difficult task of getting to know families and letting them know you're available without being intrusive. This is hard because often a family doesn't come into the program with an identified problem to discuss. Also, many families have had negative experiences with other social workers. Due to this, many families want to be left alone. Comments included:

- "A family's past experience is a stumbling block."
- "You work together to get past the adversarial relationship."
- "That's a struggle you're always working with—there's a fine balance in not being too intrusive but letting them know you're available."
- "A big part of what we do is helping the family to understand what our role is—allowing a family to get to know me and see me in a different role."
- What I've learned is that it's different with every case.

At Community Health Counseling Services (CHCS), workers said they have a different situation compared to the Casey Family Services workers because CHCS workers have another caseload. At Casey, workers can do more checking in, finding ways to connect informally with families.

3. WORK WITH FAMILIES OVER TIME

After the first three months, the work with families is individualized, and can vary from providing any number of services to just visiting the family once every 6 months. The model allows for workers to plug in different services for different people. Some families use IV-E funds and others don't. Some families find education around the child's behavior resonates for them. For some parents, the social activities are relaxing, and a safe place where they can come and develop relationships—this helps get them in the door. The support groups also help some parents get to know and trust the worker. One worker noted, "They trust me because they can see I can listen to them."

Although some families are still hesitant to become involved with one more caseworker, families who have been in the project for more than a year have become more receptive and are more comfortable with asking for help. Caseworkers felt they have earned credibility with families because workers don't approach families as an "expert" on every family's issues.

As caseworkers' relationships with families progress, they do more consultation work, working to prevent crises, and advocating for families. Some felt they were able to identify a family's problems more quickly. A lot of time is spent listening to parents talk about their kids. Workers need time to feel around where a family is, how and when they should push. They can take a look at the children's complex problems and how the problems affect their social relationships.

Many workers encouraged families to call at least once a month. The families might not be interested in getting services right off the bat but when they need services, the relationship will be there. One worker commented, "They're a little bit more open in calling me and asking me questions that they wouldn't have initially."

Some families who don't want help may feel that a troubled, chaotic state is their norm. Other families may be afraid to ask for help because they fear seeming incompetent. Other families may not realize they are in distress, so may not feel in distress. The MAGS project works with such families by developing a relationship in the meantime, and planting seeds—so that when families are ready, they have a place to turn. After time, most families become comfortable enough to ask for help when they need it.

Other ideas about activities after three months were:

- Advocacy in the school system—education around adoption
- Helping families connect to other families who have adopted
- Simplifying tasks (e.g. dropping a duplicate name on a mailing list so they don't receive two copies of everything)
- Helping with communication with other providers/agencies
- Cost-share for recreational activities
- Therapeutic work with one family member or parents as a couple

Often times a child will reach a new developmental stage and the family might be seeing it for the first time. A worker commented that at those times, she concentrates on ,"Just letting them know that I can help be a sounding board to sort that out." Workers also work with families on attachment-related issues and other challenging needs.

Also mentioned was, "Once a family leaves the DHHS case management system, no other provider is usually looking at the whole family member in such an ecological way as Maine Guides. I think it's really helpful for families to know that somebody else carries all the other information."

4. STRESSORS FOR ADOPTIVE FAMILIES

Focus group participants were asked to discuss the difficulties adoptive families face, and their thoughts on why some families struggle while others prevail. Participants talked about the expectations of the parent—parents are generally better able to accept a child's behavior if they expect that behavior. Often as a child grows older, parents' expectations change and their tolerance for certain behaviors lessens. In addition, some families talk about how they didn't expect the child's behavior to affect their family life. The flexibility/rigidity of the parents affects how they deal with new behaviors.

Parents who are able to not take behaviors personally also are better able to accept challenging behaviors. One worker commented: "I think it really makes a difference—It's the parents who can see that a lot of their child's behaviors are because of the trauma of their past and not because of them."

Families who accept support also seem to fare better than those who try to go it alone.

Other factors that participants mentioned affecting families' stress are: financial situation, first-time parenting, medical issues, kinship adoption issues (i.e. working with birth family), social acceptance of challenging behaviors, and whether one parent is able to stay home full-time.

5. MAKING A DIFFERENCE

When discussing what it is about the model that makes a difference for families, participants said it's the relationship between worker and family. One worker stated:

> "The ongoing presence. Just knowing we're out there and that they have connected with us in the past, and may connect with us in the future. I think they find security in that."

Participants mentioned that the longer you are with a family, the more they respect your opinions, and the more willing they might be to take recommendations. It was noted that families do not often work with the same person from DHHS over a period of time. Work with parents is delicate, helping them to up open and trust.

Participants discussed how the model has increasingly become focused on the parent compared to other kid-focused programs. The model is family-focused—MAGS allows for the context of the bigger picture beyond the one child. The project is, "Family focused with respect of the parent as the gatekeeper. The person who sets the tone in the family." Workers focus on the relational piece within the context of the families and work hard to support that.

> "We are not just looking at the mental illness or the trauma history of the child but how parents are reacting to it. It is so vital because every parent responds differently to different sets of behavior."

The longevity of the relationship with families enables workers to witness the ebb and flow of the parent-child relationship. Workers can remind parents that they have been through bad times before and that they will pass, it gets easier. The anxiety of parents lowers through the relationship with MAGS and that lowered anxiety filters through.

The work is more solutions-focused—normalizing. Saying it is not OK that the child has this behavior, but that the behavior makes sense with the trauma history and the baggage the child is bringing.

> "You take the blame away from the parent and commit at the same time to support them and what they need."
> "The freedom from neither a parent, nor a child carrying the burden of a label that there is something really horribly wrong with me that I am never going to get over."

The maturity of the MAGS team enables them to normalize and reframe situations, as opposed to joining in the hysteria over a child's behavior.

The flexibility of the model is essential. In some cases, the only convenient time to have a conversation with a parent is at night, and the model allows this.

"Our availability reduces their sense of isolation. Being able to go to their homes and bring the knowledge of what other families are going through, the different crises that can happen and show them it's not just them, they're not crazy. I think that's a big part of what we do."

The teamwork between MAGS workers is another integral part of the model. Workers don't feel as if they have to do all the work—and as a result, are not as frustrated. Part of the teamwork is a willingness to self-reflect. Workers help each other, and point out things in a way that can be heard.

"We really support each other as a team—being able to collaborate and work together or even just consult with each other on the work that is done. I think that really helps us to stay regulated."
"This is a place for discussion not for judgment."

Workers agreed one major benefit of the Adoption Guides program is that it offers a family access to a variety of resources:

"One-stop shopping—a multitude of clinical, therapeutic services. I think a lot of our families feel scattered, they go in so many different directions, everyone has a different therapist and so many different needs. For some of them, working with us, they can consolidate the number of providers they see . . . they don't have to start from the beginning and they certainly don't have to educate us about the dynamics of adoption and we already know their history."
"Having clinical level social workers show up and be able to work with whatever is happening in the moment really is less stressful."

Continued support for families is important. In addition, the fact that Adoption Guides workers are non-judging helps families work through trying situations. Families are used to being evaluated and judged and working with Adoption Guides workers is different.

"There's a tolerance you're practicing so that the family can play out what they feel they need to play out . . . Most traditional agencies would have found a reason to say you know, forget it. I think there's a willingness, a tolerance, a flexibility."
"We honor their view and their perspective. . . Empowering them to be in charge facilitates their sense of ownership."

Participants were asked to describe what is necessary in order for the model to work. The most crucial things are flexibility, creativity, and time.

"[Workers] need to have enough give on their work load so they can do that whole engagement thing, and if you are backed up with 20 cases you can't do that or you're doing 500 other things. That's critical that there's enough time to be able to spend—sending a little note, making a quick phone call, or that little stop you do in between, going out and having coffee."

Other important factors are ample supervision, financial resources, support groups, technology and user-friendly paperwork.

Everyone agreed that the parents really enjoy and benefit from support groups. The name of the groups, "Parents of Challenging Children," invites the possibility that other parents are struggling too, which is reassuring to members. Families receive emotional support, community resources, and advice on clinical issues.

However, support groups can be challenging to organize and run due to families' busy schedules and geographical distances in rural areas. Flexibility is key—some groups survived dips in attendance and some took time off and then regrouped. In the rural areas, informal get-togethers were used in lieu of groups. Although some families could not make a weekly commitment, they were able to attend recreational activities, which still offer the opportunity to connect with other adoptive families. In addition, workers in rural areas encourage informal contact between families, who can get together on their own to share experiences.

6. MEASURING EFFECTIVENESS WITH A FAMILY

Participants were asked how they know when they are being effective with a family. A common thought was that success means a family opening up and feeling comfortable enough to be honest or ask questions. Comments included:

- "When people feel they can be open—that's when I feel I've really done my job. They can share their joys and sorrows and their struggles."
- "They slowly become more honest."
- "When a family starts asking more questions of me."
- "They felt comfortable enough to call me in a crisis—to really start to open up and be vulnerable to me."
- "Support group members wanting to stay in the groups past the initial 6-8 weeks."
- "Seeing connections made between families."
- "When families can tell you what's been helpful and they thank you."
- "Feedback from DHHS workers."

7. SUPPORTS FOR MAGS WORK

A major support that helps workers is the flexibility of the model. Workers don't have demands in terms of billable hours—this enables them to be more flexible and creative with their time. There is the opportunity to do prep-work before visiting with a family and time to reflect afterwards. One worker commented, "We don't get burned out and there is time to learn." In addition, the work is not all clinical. The model allows for time to do community outreach.

Another main support behind Adoption Guides work is the group of people involved. Colleagues, supervisors, and the administration are all dedicated and supportive and share a common philosophy. The various backgrounds of everyone on the team are a support. Different people bring different kinds of expertise to the group. Also, the non-cynical attitude of the team is a support. Other supports mentioned were:

"Consultation/access to a psychiatrist."
"The ability to go to conferences."
"Having meetings is a real good support. That they're flexible enough to come up and meet in Bangor—meeting our needs."
"Feeling inspired by the project. I think that we're doing something neat and we're getting recognition from that—national recognition."
"I think we have families that are wonderful and gracious, hard-working and persevering."

8. BARRIERS TO THE MAGS WORK

Overall, barriers to the project are the difficulties of coordinating a project statewide. Resources differ in each region and certain DHHS practices differ between district offices. However, caseworkers reported seeing improvements in the coordination of the referral process.

One major difficulty for workers is the lack of clarity on what Medicaid or other insurance covers and reimburses. Another problem mentioned is the lack of support groups—parents often ask about openings in groups. Sometimes, families have trouble finding services from people who are "knowledgeable about adoption." Workers can assist families in finding resources or can refer them to a service within Casey.

Participants again discussed the barrier of many families' prior negative experiences with social workers, which makes them hesitant to trust another social worker.

The CHCS social workers in Houlton discussed barriers specific to their work. Working with computers had been a struggle, but with time, the workers are coming to understand the computer system. Another barrier mentioned was the unavailability of state DHHS workers when first meeting with a family. DHHS workers are overburdened with work but since they already have a relationship with the families, it is easier to be introduced to a family with the DHHS worker instead of going alone. Houlton workers also are separated from the rest of the MAGS workers and do feel some isolation. Being able to share ideas would benefit them in their work.

Other barriers included:

- Lack of knowledge about the program
- Higher needs of children today "I think part of the reality is that for some kids there aren't any easy solutions. So it's an ongoing struggle that doesn't find finality."
- Families' misperceptions about Casey: (e.g. feeling entitled to certain things)
- Some families ill-prepared—mismatched with children
- Universal deficit in understanding/awareness of attachment issues
- Attracting and retaining childcare providers

9. LESSONS LEARNED

One issue mentioned was that the social workers over time are doing a lot more work with couples and parents than before. Sometimes things crop up for families (i.e. losses in terms of infertility, dreams of what the adoption would have been like, struggles with birth family) and those issues continue through life.

> "That's just such a necessary piece now… We've all learned that a lot of the work ends up being helping the parents look at their own past issues, so it's the couples and also the individual. I think we find ourselves doing a lot more work with parents than we maybe expected because of the triggers of the challenging behaviors."

Workers have learned that parents' expectations are big—adoptions are not always what people think they'll be. Many families say that they heard about such problems during the training but didn't think that it would happen to them. Participants mentioned that kinship adoptions are different and that

maintaining boundaries for the adoptive family is very important. The extended family may be a big support but the biological family is still in the picture.

An individual family's needs change over time. The challenges that adoptive families face are huge and ongoing. However, how the challenges affect families differs. It was discussed that it seems to be less about the specific child and presentation of challenges than about the parents and the amount of support they have.

In talking about how their work has changed since the project's inception, participants described feeling more knowledgeable about the clinical work with families and as a result, clinical work is done sooner with families. Conversations with families are more targeted. Workers have become familiar with the struggles families face and are able to reassure families, letting them know that other families have similar problems.

Workers have become used to families being a bit wary of them in the beginning and realize that the relationship building takes time. There is an awareness that families will go through cycles of strength, hope, and despair. One worker commented:

> "I have a family that I have been working with probably for two years and they just called the other day asking me to go to a PET meeting. And I call every other month and say, "Hey, how are things going?" They say, "Great!" or we just talk about her kids. Then the other day she said, "Would you come here to the PET?" I think it's just the underlying sense that somebody is out there, waiting for a call."

Over time, much has been learned about resources—i.e. mental health providers, agencies, psychiatrists, and therapeutic day care. Participants also feel that the model is better understood by outside providers.

B. SERVICE DATA FROM MAGS SOCIAL WORKERS

An additional method used to gather information describing the model is data collection from the Adoption Guides social workers. Social workers enter data into a database on every service they provide to a child/family. This data allows for an overall look into the types and amounts of services provided to families.

Service codes were developed with Casey Family Services in order to categorize the work they do with children and families. When a Casey social worker provides any of the following services to a child or family, the worker enters the corresponding code into the database.

Figure 4
Casey Family Services: Maine Adoption Guides Service Codes & Definitions

01 Initial Assessment

The Collection and assessment of information regarding the child, family and other relevant persons, to determine the nature of individual and family issues and the services needed to foster strengths and provide supportive services to a family. Activities consist of interviewing, making an assessment of need, assessing the availability and accessibility of services, making case recommendations and setting objectives. This activity includes conducting family assessment at time of referral to MAGS. Services Rendered to: Family

02 Case Plan (Initial and Subsequent Reviews)

Case plans are developed in accordance with overall MAGS program philosophy of family strengthening and empowerment. A case plan is developed in conjunction with the family and in consultation with a supervisor and other professionals as needed. The case plan identifies the client's needs, and delineates the objectives designed to meet those needs. The case plan is developed at completion of the intake process and is reviewed every six months or as needed. Services rendered to: Family

03a1 Building Relationship/Maintenance

Contacts with the primary purpose to engage the client, build trust, or to maintain an existing relationship. Services rendered to: Parent

03a2 Clinical Conversation

Conversations focused on identifying, clarifying and addressing client's multiple needs. Social workers address interpersonal and intrapsychic issues that might be affecting the individual or family. These conversations are therapeutic in nature but are more global than traditional counseling. Services rendered to: Parent

03a3 General Parent Education and Support

Providing information to parent to educate and support including preparation for PETs, assistance with parenting skills, information regarding such topics as birth family, normative developmental stages, attachment. Services rendered to: Parent

03b Crisis Stabilization/Follow-up

Activities in response to a situation when a specific and urgent issue requires immediate attention from MAGS social worker or on-call staff member. Subsequent contacts may also be included to assess any additional services needed to insure ongoing stability. This requires that some action be done other than just supporting the parent by phone. Any situation requiring a critical incident report will be coded under this category.

03c Referral to Mental Health/Substance Abuse Services

Coordinating information that results in a referral to an outpatient community based mental health and or substance abuse service agency. Referral can be for the child and or any member of the family who is recipient of services.

03d Referral to Community Resources (other than Mental Health, include

Coordinating information that results in a referral to a community based resource and or support. Referral can be for the child and or any member of the family.

03e Provision of concrete services (include type in DOC)

Activities that result in the purchase of concrete goods or services for the child and or family. Financial Assistance that is provided in addition to the Adoption Subsidy paid to the family through D.H.S. IV-E funding.

03f Collateral Contacts

Sharing with and gathering information from other parties associated with the child and or family.

03g Non-Therapeutic Services

Informal social/recreational activities such as agency-sponsored picnics or attendance at legalization celebrations. These also may include recreational activities completed alone with children or with groups of children. Effective May 1, 2002, this code includes child care provided during parent support groups.

04a General Advocacy

Contacts with others who have influence/power in the client's life with the goal of insuring that their needs are met. Negotiating and coordinating services on behalf of children and families to assist them to obtain otherwise inaccessible or unavailable services. Negotiating the development of new resources or services.

04b Educational Advocacy

Similar to the general advocacy defined above but specifically related to the educational needs of the child. Includes attendance at PETS. Services rendered to: Child

05 Preparation and Placement

Providing support to family/child when the child requires placement out of the home. Services Provided To: Child

06a Therapeutic Services: Child

Goal directed, therapy sessions for Individual child; may include therapeutic Life Book work.

06b Therapeutic Services: Parent

Goal directed, therapy sessions for Individual parent.

06c Therapeutic Services: Family

Goal directed, therapy sessions for the family; may include therapeutic Life Book work; Dan Hughes.

06d Therapeutic Services: Group Children

Goal directed, therapy sessions for children group.

06e Therapeutic Services: Group Adult

Goal directed, therapy sessions for adult group.

06f Therapeutic Services: Multiple Social Workers

Therapeutic services delivered to parent, family, group children or group adult by more than one social worker. (Effective 9-1-02)

07 Case Related Documentation

Reviewing of written materials and any written work including assessment reports, case plan, contact logs, critical incident reports, reading records, letters, reports, etc. Anything that requires 15 minutes or more is documented.

08 Psychiatric Services

Psychiatric Consultation and/or medication monitoring provided by the Casey Family Services psychiatric consultant. (Effective 9-1-02)

88 No Contact This Month Per Family Request

Table 1
Amounts of Each Type of MAGS Service Provided As Reported by MAGS Social Workers by Project Year
December 2004

Service	Year 1 Count N=28	Year 1 Percent N=28	Year 2 Count N=72	Year 2 Percent N=72	Year 3 Count N=102	Year 3 Percent N=102	Year 4 Count N=137	Year 4 Percent N=137
General Parent Education Support	540	47.0	2316	46.3	1506	16.1	1620	12.6
Collateral Contacts	160	13.9	822	16.4	1314	14.0	1406	10.9
Building/Maintaining Relationship*	0	0.0	7	0.1	2433	25.9	3896	30.2
Therapeutic: Adult Group	115	10.0	188	3.8	290	3.1	473	3.7
Therapeutic: Family	46	4.0	215	4.3	302	3.2	497	3.9
Non-Therapeutic Services	0	0.0	151	3.0	519	5.5	680	5.3
Therapeutic: Indiv. Child	14	1.2	229	4.6	601	6.4	932	7.2
Clinical Conversation*	0	0.0	7	0.1	620	6.6	847	6.6
Initial Assessment	138	12.0	523	10.5	312	3.3	272	2.1
Case Plan	43	3.7	155	3.1	251	2.7	292	2.3
Community Resources Referral	5	0.4	97	1.9	222	2.4	166	1.3
Therapeutic: Multiple Social Workers	0	0.0	0	0.0	313	3.3	289	2.2
General Advocacy	30	2.6	114	2.3	140	1.5	130	1.0
Concrete Services	12	1.0	62	1.2	116	1.2	172	1.3
Crisis Stabilization/Follow-up	1	0.1	48	1.0	88	0.9	368	2.9
Educational Advocacy*	0	0.0	0	0.0	131	1.4	124	1.0
Therapeutic: Indiv. Parent	7	0.6	9	0.2	32	0.3	266	2.1
Psychiatric Services	0	0.0	0	0.0	62	0.7	134	1.0
Therapeutic: Children Group	33	2.9	1	0.0	0	0.0	230	1.8
Mental Health Referral	5	0.4	56	1.1	109	1.2	95	0.7
Preparation/Placement	0	0.0	0	0.0	15	0.2	3	0.0

*These service codes have been in place since May 2002. Building/Maintaining Relationship and Clinical Conversation were added to the list of service codes in an attempt to further refine the Parent Education and Support category. Educational Advocacy was added to clarify the Advocacy category. Non-Therapeutic services was added to quantify recreational activities.

This table includes only results from actual services to families. In addition, social workers coded "Case-Related Documentation," and "No Contact This Month" -- discussed below.

The most common service provided was General Parent Education/Support. Other services provided frequently were Building/Maintaining Relationships, Collateral Contacts, Individual Child Therapy, and Adult Group Therapy.

Types of services were also analyzed by the amount of time families were in the study.

Table 2
Types of MAGS Services Provided To Families By Time in Study
December 2004

Time in Study	First Most Common Service	Second Most Common Service	Third Most Common Service	Fourth Most Common Service
0 – 6 months	Parent Education/Support	Initial Assessments	Collateral Contacts	Building/Maintaining Relationship
7-12 Months	Parent Education/Support	Building/Maintaining Relationship	Collateral Contacts	Non-therapeutic Services
13 – 18 months	Building/Maintaining Relationship	Parent Education/Support	Collateral Contacts	Individual Child Therapy
19 – 24 months	Parent Education/Support	Building/Maintaining Relationship	Collateral Contacts	Clinical Conversations
25 – 30 months	Building/Maintaining Relationship	Parent Education/Support	Collateral Contacts	Non-therapeutic Services
31 – 36 months	Building/Maintaining Relationship	Parent Education/Support	Collateral Contacts	Individual Child Therapy
37 or more months	Building/Maintaining Relationship	Parent Education/Support	Individual Child Therapy	Collateral Contacts

The average number of services provided to each family in Cohort I was 170 (n=26); in Cohort II was 102 (n=43); in Cohort III was 80 (n=32) and in Cohort IV was 36 (n=47). The total average for all Cohorts was the provision of 97 types of services per family.

In addition to providing services to Guided children, caseworkers also spent time documenting their casework. Case-related documentation was recorded in the database, and represented six percent of Cohort I total services, 11 percent of Cohort II total services, 8 percent of Cohort III services and 5 percent of Cohort IV total services. Caseworkers also recorded when families requested "No Contact this Month." This accounted for two percent of entries for Cohort I, two percent of entries for Cohort II, two percent of Cohort III entries, and one percent of Cohort IV entries.

The number of services provided, however, does not reflect the amount of time spent on each service. The mean number of minutes spent on each service for all years of the project is shown in the table below.

Table 3
Mean Number of Minutes Provided for Each MAGS Service Type
December 2004

Service	N	Mean Minutes	Standard Deviation
Therapy to Children's Group	100	137.70	33.74
Non-Therapeutic Services	556	119.84	78.44
Therapeutic: Adult Group	434	90.83	12.08
Therapeutic: Multiple Social Workers	244	88.89	31.34
Therapeutic: Individual Parent	199	88.12	29.73
Educational Advocacy	94	81.06	41.35
Therapeutic: Family	481	78.49	28.89
Therapeutic: Individual Child	686	72.14	27.44
Initial Assessment	534	70.42	60.19
Case Plan	355	64.44	36.45
Clinical Conversations	614	58.49	34.94
Advocacy	142	53.56	45.63
Crisis Stabilization/Follow-Up	142	53.03	53.94
Psychiatric Services	80	51.94	49.89
Parent Education/Support	2440	37.32	44.87
Collateral Contacts	1379	27.60	23.63
Preparation/Placement	5	27.00	12.55
Community Resources Referral	183	25.82	16.22
Building/Maintaining Relationship	2826	24.75	25.56
Mental Health Referral	92	23.15	17.57
Concrete Services	156	17.21	8.14

The most minutes per service were spent doing therapeutic work—for children's groups, adult groups, with individual parents, and when social workers teamed to work together with a family—and Non-therapeutic services, such as recreational activities and informal get-togethers including picnics and pool parties.

Workers spent a total of 3896 hours working with Cohort I families, a total of 3035 hours working with Cohort II families, a total of 2206 hours working with Cohort III families, and a total of 1331 hours working with Cohort IV families. The amount of time (minutes) spent working with each family differed—ranging from 15 minutes to 486 hours. The table below provides average service time by minutes for each type of service dependent upon length of time in the study.

Table 4
Mean MAGS Service Time Minutes Per Service by Length of Time in Study
December 2004

Report

Service Time in Minutes

Time in Study by Year	Mean	N	Std. Deviation	Minimum	Maximum	Median	Sum
One Year or Less	49.92	686	49.399	0	405	30.00	34245
One to Two Years	51.28	2513	52.477	0	570	30.00	128865
More than Two Years	47.20	9852	44.927	0	1200	30.00	464985
Total	48.13	13051	46.739	0	1200	30.00	628095

Until November 2000, there were four caseworkers providing services for Adoption Guides families and entering them into the database at Casey. A fifth worker began entering cases in November 2000, and then in March 2001, more workers were added month by month—until the final number of 13 workers and two team leaders entering services.

Social workers recorded every service they provided including visits with clients, telephone calls or documenting notes in a file. The breakdown of recorded services was as follows:

Chart 1
Contact Type For Services Provided Reported by MAGS Social Worker
December 2004

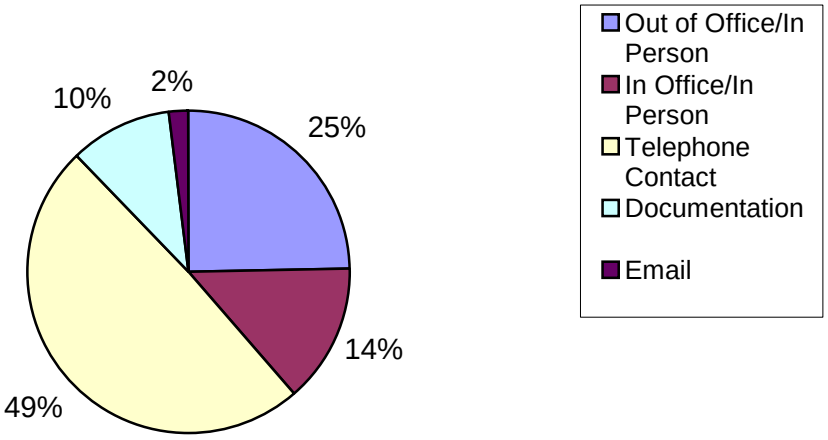
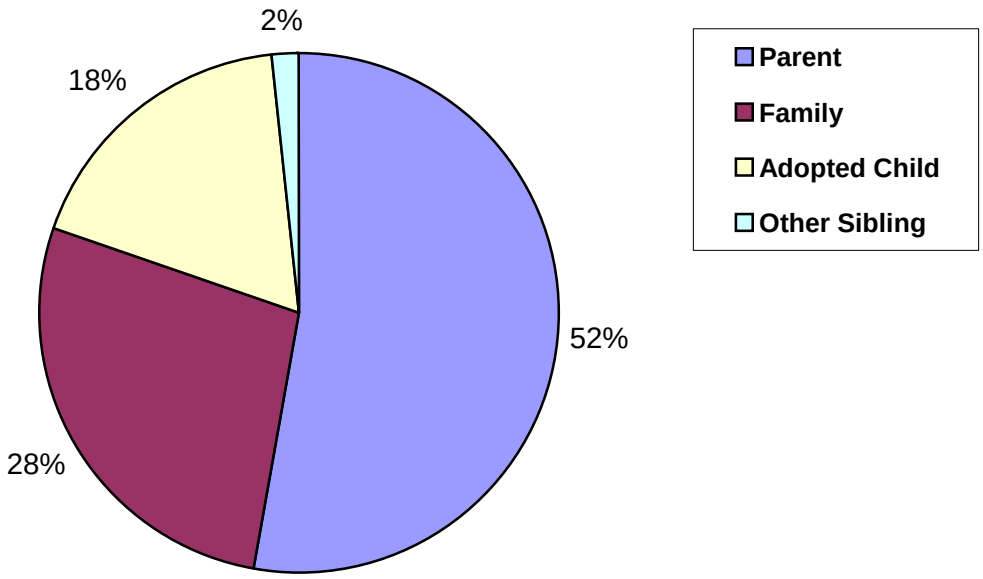


Chart 2
Service Recipients as Reported by MAGS Social Worker
December 2004



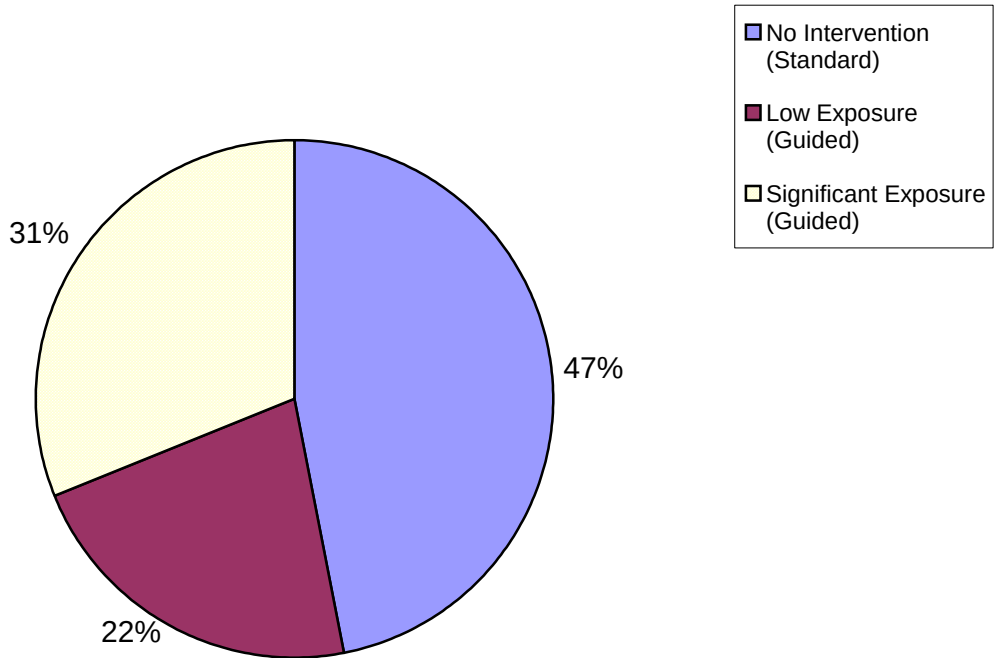
On average, more than half of all services provided were provided to the parent, and more than a quarter of all services were provided to the whole family. One reason for the large number of services provided to parents was the high number of telephone contacts recorded. In addition, MAGS social workers reported that over time in the project, in gaining knowledge about how to best support families, more work was done directly with parents. High numbers of services provided to the family reflect the fact that social workers did family-centered work, most often meeting with the adopted child and his/her parents together, rather than meeting with the child alone.

The amount of time spent on providing a service and on travel was recorded into the database. Fifty-eight percent of all services took a half-hour or less to provide, while 24 percent took between one and two hours. Four percent of services took more than two hours.

Seventy-six percent of services did not require any travel time. Seven percent involved between 15 – 60 minutes of travel and 12% required between one and two hours of travel. Five percent required more than two hours of travel. The large number of entries with no travel time reflects the fact that the majority of services recorded were telephone contacts. In addition, no travel time was required for in-office visits or documentation. However, social workers often needed to travel long distances across the state to meet with families.

One of the components of the Adoption Guides model was that families decided how much assistance they needed from the Guided social worker. The amount of service time provided was dictated by families. Overall, the amount of service hours varied—from families who only wanted contact once every six months, to families who needed contact almost daily. Analysis was conducted using 3 levels of the intervention—No Intervention [those in the Standard group], Low Exposure [those in Guided who received less than the 50 percentile mark of service hours (based on averages by cohort) provided to families], and Significant Exposure [those in Guided who received the 50 percentile mark or more of service hours provided to families].

Chart 3
Amount of MAGS Intervention Received by Children
December 2004



After examining the amount of MAGS intervention children and families received, we conducted further analysis in March 2003 to see if the families who most needed services were the families who received the most service hours. In order to assess which families most "needed" services, we did some exploratory, descriptive work on the topic of stress in adoptive families. This was not part of our research questions but it was something that arose through our conversations with MAGS social workers. We held a meeting with the MAGS social workers and supervisors, and with the MAGS Parent Advisory Group in order to discuss the factors that most contribute to stress in an adoptive family. We wanted to know which of the research variables would be important to consider in figuring whether a family was "distressed" or not. The group decided on the following:

Table 5
Variables Defining "Distressed" Families
December 2004

Child variables	Family/caregiver variables
CBCL scores in clinical range	Stability and accessibility of resources
Child reaching puberty (Age 13+)	Financial situation
Level of caregiver trust in child	Caregiver health
# of child's previous foster care placements	Multiple children close in age
Length of time in foster care	Foster parenting experience
	FACES Adaptability
	Family attachment to child
	Satisfaction with adoption

We analyzed the data according to these variables at Baseline and again at 12 months. We found that at Baseline, just less than half of all families in both groups were "distressed," (scored as distressed in more than 7 of the above variables). At 12 months into the study, that number had decreased, to less than a third. There were no significant differences between groups. We also found that families who were "Distressed" at both baseline and 12 months reported receiving more service hours than "Non-distressed" families.

Table 6
Percent of "Distressed" Families
December 2004

	Guided	Standard
Distressed at Baseline	48%	46%
Distressed at 12 Months	30%	23%

We found that in comparing this "distressed" population with the rest of the project participants, the "distressed" families reported receiving more service hours than the "non-distressed" group. However, after conducting some statistical analysis, we found no correlation between any of the above Table 5 variables and Overall Satisfaction with the Adoption, or Overall Quality of Home Life, and concluded the analysis. Should anyone be interested in obtaining results from analysis conducted with the entire study data set, he/she can contact the evaluator.

CHAPTER III – PROCESS ANALYSIS

A. IMPLEMENTATION

1. WHAT IS THE MAINE ADOPTION GUIDES (MAGS) MODEL OF INTERVENTION?

A description of the Guided Services program is provided in Chapter I. Essentially this intervention is a case management type of model. Casey Family Services social workers liaisoned with DHHS Adoption Caseworkers and met with the selected family approximately 3 months before legalization. This was the target point in time, however, this time period was somewhat arbitrary as the actual timeframe for legalization depends solely on the courts' capacity to litigate these cases. During this initial meeting with the family, or sometimes over the course of two or three meetings, an assessment was conducted. Based on this assessment, driven by the needs of the family, services and supports were provided. Families were required to meet with the Casey Family Services social worker at least once every 6 months.

It was assumed that the intervention would evolve as the project developed. The evaluator met with the clinical staff as they refined this approach to post-legalization supports and services. The clinical staff, in consultation with the DHHS program manager, developed the following mission and standards statements (Casey Family Services, March 2000) that helped to define this intervention model.

Maine Adoption Guides
Mission Statement and Case Practice Standards

Mission Statement:

Adoption is a common and acceptable way to create a family. Still, a family formed by adoption has unique dynamics and issues. Bonding and attachment between an adoptive parent and child is not automatic, rather it is a process. And in this process of building a cohesive family, crises are predictable and normal.

A child who is adopted brings to the family a unique history that includes the trauma of separating from his or her birth parents and often includes other life trauma. Adoptive parents also bring unique histories to the relationship. In addition, they have expectations about parenting that are sometimes not met by their adopted child. Siblings, by adoption, birth, or by fostering significantly contribute to the family dynamics.

Communities are responsible for supporting and aiding integration and preservation of adoptive families. The process of building a cohesive family can be supported by community services and extended family, or it may be hindered if the community and/or extended family is not informed about adoption related issues, or is not supportive. Communities may need support in developing adoption competent resources.

Consideration and respect is given to all triad members. The child's birth family as well as adoptive family is vital to the child's development and overall sense of well-being. The type of

contact or the amount of information the child has regarding his or her birth family should be based on the child's developmental and therapeutic needs. Adoptive families may need encouragement to increase their comfort with birth family issues so that they can support their child's integration of his or her history.

A child's family of origin may differ culturally from his or her adoptive families'. It is important for a child who is adopted to develop a positive understanding of his or her cultural heritage in order to form a healthy identity. Adoptive parents may need assistance finding ways to facilitate their child's positive identity formation.

Services delivered will be client-centered reflecting families' interest, ability and desires. Parents will be supported in creating a safe and nurturing environment for their children. The Maine Adoption Guides will have the goal of empowering parents to claim their children and maintain hope.

Case Practice Standards:

Assessment

The assessment of an adoptive family will take into account the normal struggles adoptive families are bound to have. Within this "normative crisis" framework, the interplay of the parent/child dynamics and the influence of the community will be assessed.

Child factors will include:

- ability to attach;
- history of trauma;
- stages of normal child development;
- educational, medical, social recreational and psychological needs;
- birth family relationships.

Parent factors will include:

- parenting style;
- the parent's perspective and ability to respond to normative crises;
- parent's history;
- parent's personal strengths;
- parent's ability to seek and use support;
- parent's knowledge and understanding of their child's cultural heritage;
- parent's previous experience with service providers.

Parent-Child Relationship will include:

- degree of family integration;
- parent-child fit;
- assessment of preparedness.

Resources:

- the availability of adoption competent providers;
- the ability to meet the special needs of the child and family;
- extended family support.

Service Plan

- service plans will be individualized and will reflect the assessment of the parent's and child's needs;
- service plans will be re-evaluated regularly to adapt to changing needs and abilities in a family;
- service plans will identify the current community supports;
- service plans will support family connections regardless of whether a child is able to live in the home at any given time;
- service plans will recognize the importance of the adopted child's birth and cultural heritage;
- time frames identified in service plans will be realistic and reflect the family's stage of development;
- barriers to achieving goals and services needed will be identified and documented.
- service plans will be realistic in terms of balancing and prioritizing all family members needs.

Contact with Family:

- will occur minimally every six months;
- will occur regularly and will coincide with the normative stages of family development;
- will be driven by family needs.

Use of Community Resources:

- referrals will be made to adoption competent providers;
- respite providers will have the knowledge and experience necessary to provide the level of care necessary to meet the child's needs;
- communication between the agencies, providers and families will occur regularly to assure that goals and treatment plans are agreed upon.

The Adoption Guides model was statewide. During the first year of the project, there were no social workers available in Aroostook County, the northern part of the state. Therefore, the program was not available to families in that county. In order to combat this problem, Casey Family Services developed a contract with Community Health Counseling Services, to provide social workers in Aroostook.

a. Staffing

MAGS social workers all have Master's Degrees in Social Work or Counseling and are licensed as LCSWs, LMSWs or LCPCs.

Social workers provided intake and permanency planning services to special needs children, with birth, adoptive and foster families. They performed professional casework, group work and advocacy for children and families, functioned as clinical team members, and participated in individual and peer supervision. Responsibilities included providing ongoing education for families; gathering and presenting clinical information for disposition of referrals; providing ongoing assessment of each child or family's needs; developing and administering case plans; and providing individual, family or group treatment.

Social Workers' territories were as follows:

Table 7
Social Worker Territories
December 2004

Region	Number of Families*	Number of Social Workers
Greater Portland/York County/Kennebec County	73	8
Lewiston/Auburn/Skowhegan/Waterville	25	1
Bangor/Ellsworth/Machias/Kingfield	31	5
Aroostook County	8	2

*A family's appointed district may not reflect where they live. These numbers are approximations.

Two additional social workers were team leaders—one overseeing Augusta and southern Maine and the other covering the northern regions of the state. Team leaders provided clinical supervision to staff delivering services to children and families referred to Casey Family Services. Team Leaders were members of the Divisional Management Team and participated in planning program development and other special projects. Responsibilities included planning, assigning, supervising and evaluating the work of social workers; assessing staff training needs; reviewing and monitoring case progress; and providing direct services to children and families when appropriate.
Following are the Guided Services population served:

Table 8
Guided Services Population Served By Project Year (Cohort)
December 2004

	April 2000 - March 2001	April 2001 - March 2002	April 2002 – March 2003	April 2003 – June 2004	Total
Children Served	**50**	**69**	**50**	**74**	**243**
Families Served	**28**	**33**	**29**	**40**	**130**

Casey Family Services provided a wide variety of services to families as part of the Adoption Guides project. For further discussion of the amounts and types of services used, please see Chapter 3, Section C: Service Characteristics.

b. Support Groups

One important service provided as part of the Adoption Guides project was support groups. Support groups offered adoptive families an opportunity to share parenting strategies and struggles with other parents in similar situations. Called "Parents of Challenging Children," these groups helped parents who were raising children with special needs, which may have included learning disabilities, psychiatric disorders, socialization/behavioral difficulties, or children who were hospitalized, or had received day treatment or residential services. Facilitated by therapists, the groups met weekly to offer adoptive parents a safe environment to discuss their problems, as well as the opportunity to meet and connect with other adoptive parents.

Intended Outcomes:

Goals of the parent support groups included:

- Parents felt more capable to meet the special needs of their child(ren)
- Parents felt more supported
- Parents felt more satisfied with their adoption(s)
- Fewer dissolutions

Target Population:

Parent support groups were open to any adoptive parent of children with special needs (support groups are available to adoptive parents in all agencies, private or DHHS). For the purposes of these support groups, "special needs" are defined mostly as behavioral or psychiatric conditions—not special physical needs.

Adoptive parents contacted Casey if they were interested in joining a group and were then invited into Casey for an interview.

At the end of the project period, Casey Family Services "Parents of Challenging Children" support groups were underway in Lewiston, Augusta, Ellsworth and two groups met in Portland. The parent support group meetings were potluck dinners and included child-care and dinner for children. A Casey Family Services therapist led each group. Many of the current groups continued past their timeframe and members met informally on their own.

In addition to the parent groups, two movie groups met regularly in Unity and Lincoln, and there was a monthly movie night in Portland. Creative respite days are also hosted for children on school holidays. Groups of children participated in such activities as horseback riding, rock climbing, yoga and cooking.

Some difficulties occurred in organizing support groups in the northern part of the state. Families live further apart from each other and although social workers used central locations for group meetings, families would often have to travel an hour to and from meetings. With the added travel time, meetings required families to set aside four hours or more. Sparing four hours during the day was difficult for parents and four hours in the evening often interfered with children's bedtimes. Therefore, attendance at meetings varied and some groups ended. Families however, expressed their interest in group meetings and social workers began to use a less structured form of groups—meeting at informal, recreational events, rather than weekly meetings. Picnics, outdoor events, or swimming parties offered parents and children the opportunity to gather together and share feelings and experiences in the same way that group meetings did—and families were able to plan for one day/evening at a time without having to commit to driving to meetings every week. In addition, two different 6-week movie groups were established as a recreational outing for parents.

2. HOW MAGS WAS IMPLEMENTED

Every family who was adopting a child from the state DHHS, unless the family was moving out of state, was invited to participate in the project. Based on random assignment, the family then received the intervention.

a. Results of Referral Processes

During the second year of the project, there was a slow down in referrals. DHHS investigated why this was happening and fixed the problem. When DHHS caseworkers invited families to participate in the project, they completed a brief questionnaire with families who declined to participate in the project.

Table 9
Non-Participants by District – Year 4
December 2004

District 1	District 2	District 3	District 4	District 5	District 6	District 7	District 8	Total
12	4	8	10	5	14	13	10	76

The most common reasons for families declining to take part in the project included:

- Have had enough contact with state agencies and want to be left alone.
- Being contacted twice a year would be too time consuming – too much of a bother.
- Concerned that participating in the study may somehow make the adoption process more difficult.
- We have comprehensive services in place.
- I feel it would not be beneficial to my children.
- Child is 17.

b. Implementation Progress Survey Results

Each year of the project, USM research staff conducted an Implementation survey in order to assess the project's implementation. Surveys were administered via email to those involved in the project—56 caseworkers and supervisors from DHHS and 14 from Casey Family Services. In 2003, the return rate was 31% (22 surveys received), in 2002, the return rate was 40% (28 surveys received), in 2001, the return rate was 33% (23 surveys received). The survey was not conducted in 2004 due to the project ending in March 2004. The following table displays the number of surveys received by district each time the survey was administered.

Table 10
Overall Received Surveys by District
December 2003

	Biddeford	Portland	Lewiston	Augusta/ Rockland	Bangor	Ellsworth/ Machias	Houlton	Total
DHHS Staff 2003	**2**	**1**	**2**	**1**	**2**	**4**	**3**	**15**
CFS Staff 2003		**3**			**4**			**7**
DHHS Staff 2002	**3**	**3**	**1**	**4**	**3**	**2**	**3**	**19**
CFS Staff 2002		**4**		**1**	**2**			**7**
DHHS Staff August 2001		**3**				**2**		**5**
CFS Staff August 2001		**4**		**1**	**3**			**8**
DHHS Staff January 2001	**4**	**4**	**4**	**7**	**3**	**3**	**3**	**28**
CFS Staff January 2001		**3**						**3**

In general, the majority of respondents reported being in support of the project each year. In 2003, 77% were supportive of the project—59% answered "very supportive." In 2002, 89% were supportive of the project—79% answered "very supportive." In January 2001, 100% were supportive and 81% were "very supportive;" in August 2001, 100% were supportive and 92% were "very supportive." Related comments included that there was a definite need for post adoption services and that the project was a great idea.

The percentage of respondents who agreed the Guided Services model was implemented as intended ranged from 89% in 2003, to 93% in 2002, to 83% in January 2001 to 92% in August 2001. The few respondents who did not think implementation was as intended mentioned that services offered were not the same statewide—Aroostook County had fewer services available than Portland. Other comments were that families were not always informed about the project or that the respondent had not yet had experience with Guided Services.

Some workers suggested implementation would improve through better coordination between DHHS and Casey caseworkers. Specific comments included:

- **"**During the pre-adoptive period, more education (for parents) about the project and the issues that typically came up in families that have adopted so that they can better utilize the services MAGS offers."
- "Ensure that all families are being referred to the project at the right time."
- "Provide a clearer explanation for workers of the referral process."

The majority of respondents at all times of data collection reported being informed about the project, and that the project materials, the video, written forms and other paperwork were helpful in describing the project to families.

Inviting Families

The amount of time it took workers to introduce the project to families and complete the participation/non-participation paperwork ranged between 20 – 60 minutes. The average amount of time was 42 minutes (equal to the 2002 average and down from 58.5 minutes the year prior.) When asked if allotting this time adversely affected their other work, 100% percent in 2003 said no (up from 85% in 2002 and 58% in 2001). Suggestions to shorten the invitational process included sending written information in advance to the family. Some workers mentioned that they liked to let families take the information home to have time to read it over and "sleep on it." The most common difficulty in introducing families to the project was having to tell certain families that they were not selected for Guided Services.

c. Transition Meetings

Families taking part in the project met with the DHHS Adoption caseworker and the Casey Family Services worker two weeks after agreeing to participate. When asked about this "transition" process, respondents said that this "bridging" was helpful for the families—having both DHHS and Casey invested in a family during legalization. It provided some closure for the worker and for families and was helpful to share the child's background information and history, identify developmental stages and challenges, and made sure "everyone is on the same page."

A common difficulty for workers in the transition process was coordinating schedules between DHHS and Casey caseworkers. Needed paperwork was at times hard to gather, and organizing it can be time-consuming. Some Casey workers reported not receiving the sufficient information. Another difficulty for the transition process was that hold-ups occur in Probate court. When asked how this process could be improved, respondents suggested scheduling meetings during times when the worker already needed to be at the family's home; getting permission from families to give information to the Casey staff prior to the transition meeting; tying referrals in more closely with legalization; and reinforcing to workers and supervisors the importance of the meeting and the meeting goals.

d. Forces For and Against Project Implementation

Overall, respondents felt that the most helpful force for the implementation process was the cooperative and committed families. Other forces were clear paperwork, regular management meetings, the video, team and program flexibility, understanding supervisors, and staff willingness to commit extra time.

Forces against the process were timeframes, difficulty coordinating schedules of various players, and lack of communication. Many felt that heavy workloads prevented

workers from having adequate time to attend or prepare for transitional meetings. Some respondents mentioned that the families that most needed guided services didn't get them. Other comments included that adoption-savvy therapists were not available, that workers don't know exactly when legalizations will occur, and that there have been problems with support groups. One respondent mentioned that the statewide nature of the project was a force against it.

Respondents were asked if the organizational structure of DHHS, Casey Family Services and/or the USM research unit had enhanced or prevented implementation, and the majority said no. Some respondents mentioned that DHHS workers have large caseloads and weren't able to devote time to the transition meeting or gathering information. Communication was noted as an important factor in the project's development, although it was sometimes challenging and not always clear or in a timely manner. Another comment was that buy-in on the project varied from district to district, and that the project didn't seem complete in northern Maine. Others felt cooperation was excellent, and reported positive working relationships and that collaboration had gone well.

e. Overall Comments

Suggestions to improve implementation included offering earlier intervention services pre-adoption, and cutting down on the paperwork families need to complete. Other suggestions included holding quarterly implementation meetings with district offices, inviting adoptive families to an informational meeting where MAGS staff could present the project, and providing information to districts on local customer satisfaction. Another idea was to have adoptive parents already in the program serve as mentors who could answer questions about the project. Also suggested was better clarity on what Medicaid and private insurance covers.

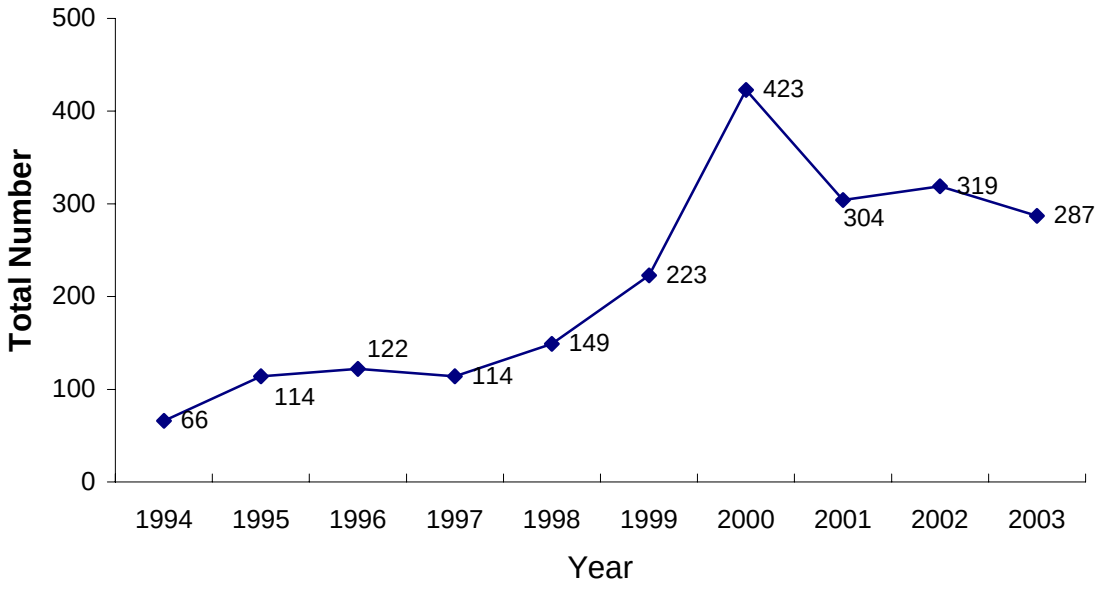
In general, there was widespread support for the project in each year, and at the end of the project's third year, respondents felt positively about its implementation.

B. SAMPLE CHARACTERISTICS

1. WHO ARE THE CHILDREN INVOLVED IN MAGS?

Children entering this study were part of a historical event in terms of adoption legalizations in Maine. The increase in the number of these legalizations in the past few years is part of the rationale for developing approaches such as Maine Guides to assist families.

Chart 4
Adoptions In Maine From The Foster Care System
Adoption Finalizations by Years
June 2004



As mentioned in Chapter I, all children who entered this study came into adoption from the state child welfare system. The following are a set of selected variables that were being investigated for change between groups and over time. Most tables display the data (from all Cohorts combined) by Assigned Group. The figures represent data collected through the end of the project: March 2004. A Pearson Chi-Square statistic was used to test for differences between groups for nominal - categorical data and Independent T-tests were calculated for ordinal -continuous type data. There was a significant difference between assigned groups at Baseline for one variable: Is Child Attending School. However, this was not a key variable in the research. There were no significant differences found between assigned groups for any major outcome variables at Baseline. This result verified the randomization process.

NOTE: Data used for analysis differed slightly from the actual study data (number of children and families currently served) due to attrition from the project. The MAGS research team asked families who dropped out of the study for permission to keep their data. Therefore, the data from participants who agreed remains in the analysis databases. The number of children and families in the following tables reflects that total (actual plus attrition combined) unless the table refers to actual number of children or families served.

Table 11
Total Number of Children by Cohort and Assigned Group
December 2004

		Assigned Group		Total
		Guided (E)	Standard (C)	
Cohort One Baseline	Count	56	61	117
	% within Assigned Group	20.1%	27.6%	23.4%
Cohort Two Baseline	Count	82	46	128
	% within Assigned Group	29.5%	20.8%	25.7%
Cohort Three Baseline	Count	62	58	120
	% within Assigned Group	22.3%	26.2%	24.0%
Cohort Four Baseline	Count	78	56	134
	% within Assigned Group	28.1%	25.3%	26.9%
TOTALS	Count	278	221	499
	% within Assigned Group	100.0%	100.0%	100.0%

Table 12
Total Number of Families by Cohort and Assigned Group
December 2004

			Assigned Group		Total
			Guided (E)	Standard (C)	
	Cohort One Baseline	**Count**	**30**	**34**	**64**
		% within Assigned Group	**20.1%**	**27.4%**	**23.4%**
	Cohort Two Baseline	**Count**	**42**	**28**	**70**
		% within Assigned Group	**28.2%**	**22.6%**	**25.6%**
	Cohort Three Baseline	**Count**	**36**	**34**	**70**
		% within Assigned Group	**24.2%**	**27.4%**	**25.6%**
	Cohort Four Baseline	**Count**	**41**	**28**	**69**
		% within Assigned Group	**27.5%**	**22.6%**	**25.3%**
Total		**Count**	**149**	**124**	**273**
		% within Assigned Group	**30**	**34**	**64**

Table 13
Child Gender by Assigned Group
December 2004

			Assigned Group		Total
			Guided (E)	Standard (C)	
Gender	Male	Count	123	110	233
		% within Assigned Group	44.2%	49.8%	46.7%
	Female	Count	155	111	266
		% within Assigned Group	55.8%	50.2%	53.3%
Total		Count	278	221	499
		% within Assigned Group	100.0%	100.0%	100.0%

Table 14
Child Age by Assigned Group
December 2004

Age Intake Categories * AssignedGroup Crosstabulation

			AssignedGroup		
			Guided (E)	Standard (C)	Total
Age Intake Categories	0 - 5 years old	Count	121	101	222
		% within Age Intake Categories	54.5%	45.5%	100.0%
		% within AssignedGroup	43.5%	45.7%	44.5%
	6 - 10 years old	Count	95	74	169
		% within Age Intake Categories	56.2%	43.8%	100.0%
		% within AssignedGroup	34.2%	33.5%	33.9%
	11 - 17 years old	Count	61	46	107
		% within Age Intake Categories	57.0%	43.0%	100.0%
		% within AssignedGroup	21.9%	20.8%	21.4%
	18 + years old	Count	1	0	1
		% within Age Intake Categories	100.0%	.0%	100.0%
		% within AssignedGroup	.4%	.0%	.2%
Total		Count	278	221	499
		% within Age Intake Categories	55.7%	44.3%	100.0%
		% within AssignedGroup	100.0%	100.0%	100.0%

Table 15
Average Child Age (Mean Scores) at Entry in the Program by Assigned Group
December 2004

Age at Intake by Years

Assigned Group	Mean	N	Std. Deviation	Median
Guided (E)	**7.35**	**278**	**4.134**	**6.38**
Standard (C)	**7.19**	**221**	**4.205**	**6.50**
Total	**7.28**	**499**	**4.162**	**6.42**

An important part of our analysis was to compare the differences between adoptive parents who were originally foster parents and those who were not foster parents. Eighty-nine percent of the parents in the study were identified as foster parents. The actual numbers were as follows:

Table 16
Type of Adoption – Foster Parent and Non-Foster Parent by Assigned Group
December 2004

			Assigned Group		Total
			Guided (E)	Standard (C)	
Type of Adoption	Foster Parent	Count	247	195	442
		% within Assigned Group	88.8%	88.2%	88.6%
		% of Total	49.5%	39.1%	88.6%
	Non-Foster Parent	Count	31	26	57
		% within Assigned Group	11.2%	11.8%	11.4%
		% of Total	6.2%	5.2%	11.4%
Total		Count	278	221	499
		% within Assigned Group	100.0%	100.0%	100.0%
		% of Total	55.7%	44.3%	100.0%

Twenty-six percent of families had a total family annual income of more than $65,000. The next largest group (approximately 20%) earned between $45,000 and $55, 000 per year. Annual income varied fairly evenly over the different categories, with a small percentage earning less than $15, 000.

Table 17
Current Total Annual Income Before Taxes by Assigned Group
December 2004

	GUIDED SERVICES	STANDARD SERVICES	TOTAL
LESS THAN $15,000	2%	2%	2%
$15,000 - $25,000	8%	11%	9%
$25,000 - $35,000	10%	15%	12%
$35,000 - $45,000	19%	15%	17%
$45,000 - $55,000	21%	18%	20%
$55, 000 - $65,000	14%	11%	13%
Over $65, 000	25%	28%	26%
DON'T KNOW	<1%	< 1%	< 1%
TOTAL	**100%**	**100%**	**100%**

The race of adopted children was also predominant in one category—92 percent of all children in the study were White. Roughly four percent were Black, and a small percentage were American Indian/Alaskan Native, Asian & Pacific Islander, and Unable to Determine.

Table 18
Child Race by Assigned Group
December 2004

			Assigned Group		Total
			Guided (E)	Standard (C)	
Race	White	Count	263	195	458
		% within Assigned Group	94.6%	88.2%	91.8%
	Black	Count	6	12	18
		% within Assigned Group	2.2%	5.4%	3.6%
	American Indian / Alaskan Native	Count	2	6	8
		% within Assigned Group	.7%	2.7%	1.6%
	Asian & Pacific Islander	Count	1	4	5
		% within Assigned Group	.4%	1.8%	1.0%
	Unable to Determine	Count	6	4	10
		% within Assigned Group	2.2%	1.8%	2.0%
Total		Count	278	221	499
		% within Assigned Group	57.4%	42.6%	100.0%

When parents were asked if they were the same race as the child, the majority said yes. Of the 12 percent who said no (67 parents), 16 percent (11 parents) said this racial difference made a difference in their relationship with the child. Some parents mentioned that the race difference is a positive, enriching experience. Others mentioned noticing reactions from the community, or that it is difficult for the child to understand that he/she is a different color from his/her adoptive parents.

Adopted children in the study lived with families that largely were married couples. Eighty-seven percent of families were married couples, 2 percent were unmarried couples, ten percent were single mothers, and 1 percent were single fathers.

Table 19
Family Structure by Assigned Group
December 2004

Family Structure * AssignedGroup Crosstabulation

			AssignedGroup		Total
			Guided (E)	Standard (C)	
	Married Couple	Count	239	188	427
		% within AssignedGroup	87.9%	85.5%	86.8%
	Unmarried Couple	Count	6	6	12
		% within AssignedGroup	2.2%	2.7%	2.4%
	Single Female	Count	25	23	48
		% within AssignedGroup	9.2%	10.5%	9.8%
	Single Male	Count	2	3	5
		% within AssignedGroup	.7%	1.4%	1.0%
Total		Count	272	220	492
		% within AssignedGroup	100.0%	100.0%	100.0%

Table 20
Pre-Adoption Relationship to Child by Assigned Group
December 2004

			Assigned Group		Total
			Guided (E)	Standard (C)	
Pre-Adoption Relationship to Child	Foster Parent and Relative	Count	11	4	15
		% within Assigned Group	7.4%	3.2%	5.5%
	Foster Parent Non-relative	Count	98	84	182
		% within Assigned Group	65.8%	67.7%	66.7%
	Relative	Count	8	4	12
		% within Assigned Group	5.4%	3.2%	4.4%
	Friend of Biological Family	Count	1	1	2
		% within Assigned Group	.7%	.8%	.7%
	None of the Above	Count	31	31	62
		% within Assigned Group	20.8%	25.0%	22.7%
Total		Count	149	124	273
		% within Assigned Group	100.0%	100.0%	100.0%

As mentioned earlier, the majority of families were first foster parents to the child. Sixty-eight percent identified themselves as foster parents who were not related to the child—only 12 (less than 5%) parents in the study were foster parents and relatives to the child. Four percent of respondents were relatives of the child or friends of the family. Twenty-three percent were neither foster parents nor relatives to the child.

Sometimes children who were newly adopted joined a family with a child(ren) who had previously been adopted and was receiving federal Title IVE subsidy. This then qualified both the current and previously adopted child(ren) to be in the study sample. However, the fact that some children in the study were part of the same family could potentially have been a limitation to the research. Most inferential statistical techniques assume that members of a population are randomly and independently drawn—that the fact that one child became a member of the sample should not have any relationship to the probability of another child becoming a member of the sample. Lack of independence of observations can compromise the significance and power of certain statistical tests. Therefore, we closely monitored the percentages of the two groups (Current and Previous) as well as any differences between them. Overall, 83 percent of children were current adoptions (85% of Guided; 81% of Standard) and 17 percent (15% of Guided; 19% of Standard) were previous adoptions.

Table 21
Number of Children: Current or Previous Adoption Baseline by Assigned Group
December 2004

			Assigned Group		Total
			Guided (E)	Standard (C)	
Is Child Current or Previous Adoption?	Current Adoption	Count	235	180	415
		% within Assigned Group	84.5%	81.4%	83.2%
	Previous Adoption	Count	43	41	84
		% within Assigned Group	15.5%	18.6%	16.8%
Total		Count	278	221	499
		% within Assigned Group	100.0%	100.0%	100.0%

We received state data on children from the Maine Automated Child Welfare Information System (MACWIS). This data provided us information on the number of a child's previous placements in foster care and how long he/she had been in the foster care system. Data was not available on all children in the study. The tables below represent data available on children in the study as of December 2004.

The overall average number of previous placements was two (2.2 for Guided and 2.1 for Standard). The number of placements ranged from zero to nine. The average number of years a child had been in foster care was 4 (4.12 for Guided and 4.07 for Standard).

Table 22
Average Number of Child's Previous Foster Care Placements by Assigned Group
December 2004

Number of Previous Placements

Assigned Group	Mean	N	Std. Deviation	Median
Guided (E)	2.21	151	1.614	2.00
Standard (C)	2.06	126	1.307	2.00
Total	2.14	277	1.481	2.00

Table 23
Average Number of Years Child Has Been in Foster Care by Assigned Group
December 2004

Total Years in Foster Care

Assigned Group	Mean	N	Std. Deviation	Median
Guided (E)	4.12	153	2.1257	3.75
Standard (C)	4.07	.130	2.2278	3.41
Total	4.10	283	2.1695	3.67

The General Accounting Office issued a report in June 2002, "Foster Care: Recent Legislation Helps States Focus on Finding Permanent Homes for Children but Long-Standing Barriers Remain." Based on national child welfare data sets, statistical reports, and state surveys, the report examined foster care and adoption trends since the 1997 Adoption and Safe Families Act (AFSA). One of the variables analyzed was children's average length of stay in foster care. Specifically, the GAO examined length of stay for children who were adopted from foster care (FY 1998-2000). The graph below displays how length of stay compares between the Adoption Guides study children and the GAO national sample.

Chart 5
National Data Compared to Adoption Guides
December 2004

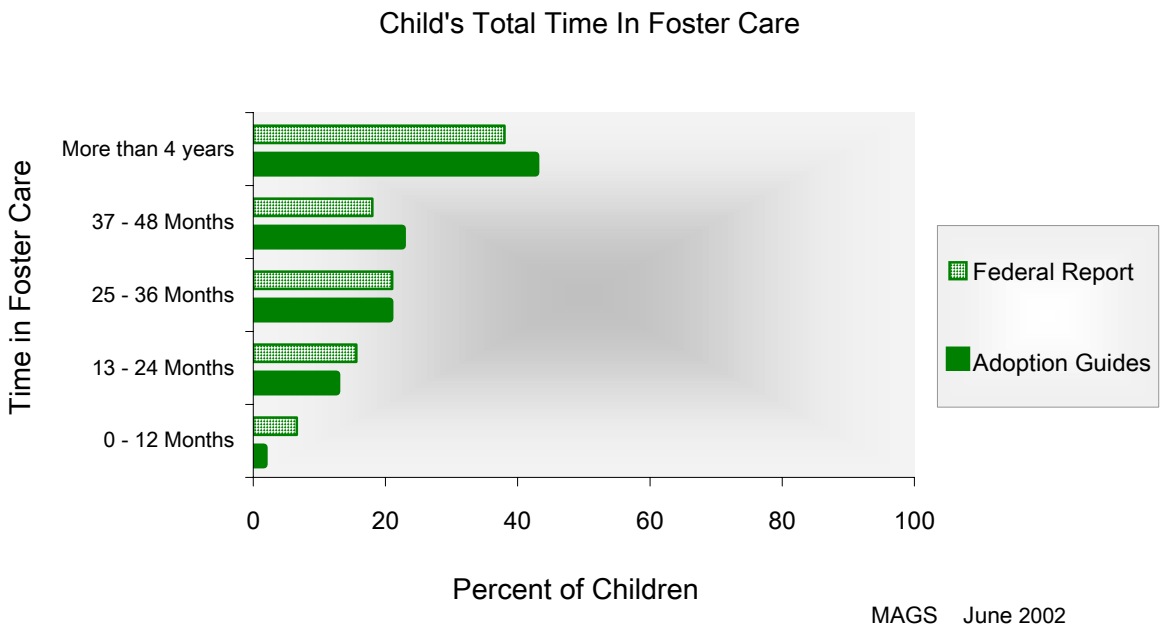


Table 24
Average Time Child Has Lived in the Home (mean amounts - in months) by Assigned Group
December 2004

	Assigned Group	N	Mean	Std. Deviation	Median
Time in Home	Guided (E)	270	35.14	29.150	28.00
	Standard (C)	212	35.13	31.286	25.00
	Total	482	35.13	30.076	27.00

On average, children have lived in their present home for just under four years (35.14 months for Guided children and 35.13 months for Standard children).

Table 25
Median Number of Days Child Has Been Out of the Home in Past Six Months by Assigned Group
December 2004

Median Number of Days Out of Home

	Baseline	6 Months	12 Months	18 Months	24 Months	30 Months	36 Months	42 Months
Guided	53 (n=6)	11 (n=7)	20 (n=5)	14.5 (n=4)	95 (n=4)	30 (n=3)	5 (n=1)	33 (n=1)
Standard	7 (n=7)	5 (n=5)	3 (n=2)	60 (n=1)	45 (n=3)	44.5 (n=2)	9 (n=3)	27 (n=2)
Overall	14 (n=13)	11 (n=12)	11 (n=7)	21 (n=5)	66 (n=7)	30 (n=5)	7 (n=4)	31 (n=4)

Participants were asked to indicate if their child had been out of the home for a day or more for the following reasons: 1) Ran away, 2) Hospitalized because of serious behavioral problems including potentially being a danger to themselves or others, 3) Detained in a jail, juvenile correction facility or 4) Other. At baseline, there were 13 children who were reported to be out of the home due to a problem—the median number of days was 14. At 6 months, there were 12 children out for a median number of 11 days. At twelve months, there were seven children out for a median number of 11 days; at 18 months, five children were out for a median number of 21 days, at 24 months, seven children were out for a median of 7 days. At 30 months, five children were out for a median of 30 days. At 36 and 42 months, four children were out of the home for a median number of 7 and 31 days respectively.

In November 2001, 867 Maine Post-Legalization Adoption Services surveys were mailed to DHHS adoptive parents. This was a statewide sample of adoptive parents who receive a IV-E subsidy and the survey was anonymous. The response rate was 44%: a total of 379 surveys were received. Of these 379 respondents, 34 (9%) people indicated that their child had been out of the home in the past year, and 27 (7%) indicated the number of days the child was out of the home. The median number of days children were out of home for the Maine Post-Legalization Adoption Services surveys was 21. Broken into percentages, the resulting data (N=27) was as follows:

- 30% of children were out of the home for less than 10 days
- 50% of children were out of the home for less than 52 days
- 85% of children were out of the home for 75 days or less

Table 26
Time in Study (mean amounts -- in months) by Cohort and Assigned Group
December 2004

CWave	Assigned Group	N	Mean	Std. Deviation
Cohort One	Guided (E)	56	50.16	3.324
	Standard (C)	61	49.25	5.790
Cohort Two	Guided (E)	82	34.27	3.820
	Standard (C)	46	33.50	4.515
Cohort Three	Guided (E)	62	23.79	3.880
	Standard (C)	58	23.62	3.433
Cohort Four	Guided (E)	78	11.63	3.858
	Standard (C)	56	10.86	3.615

Table 27
Percent of Children in Study Legally Adopted – At 6 – 24 Months In Study by Assigned Group
December 2004

	6 Months	12 Months	18 Months	24 Months
Guided Services	86%	95%	99%	100%
Standard Services	87%	95%	100%	100%

Table 28
Child Behavior Problems Before Legalization – Baseline
December 2004

Respondents answered per child and chose from one or more of 11 problem type behaviors. Means represent the sum of the total behavior problems.

Guided Services	Standard Services
N = 274 **Mean = 3.96** **SD = 2.886**	**N= 214** **Mean = 3.64** **SD = 2.910**

Table 29
Types of Child Behavior Problems Before Legalization – Baseline
December 2004

	Yes		No	
	Count	%	Count	%
Child Defied Rules?	277	58.4%	197	41.6%
Child Had Tantrums?	316	66.4%	160	33.6%
Child-Sibling Fighting?	261	56.1%	204	43.9%
Child Destructed Property?	159	33.4%	317	66.6%
Child Emotionally Withdrew?	146	30.7%	329	69.3%
Child Didn't Participate with Family?	111	23.3%	365	76.7%
Child Eating Problems?	151	31.7%	325	68.3%
Child Refused to Do Chores?	163	34.5%	309	65.5%
Behavioral Problems in School?	183	39.1%	285	60.9%
Child Ran Away?	26	5.5%	449	94.5%
Child Sexually Acted Out?	70	14.7%	405	85.3%

Table 30
Is the Child Currently Attending School by Assigned Group
December 2004

			Assigned Group		Total
			Guided (E)	Standard (C)	
Is Child Attending School?	Yes	Count	224	171	395
		% within Assigned Group	80.6%	77.4%	79.2%
	No	Count	54	50	104
		% within Assigned Group	19.4%	22.6%	20.8%
Total		Count	278	221	499
		% within Assigned Group	100.0%	100.0%	100.0%

Chart 6
Child Has Individualized Education Plan (IEP) Children Age Five and Older by Assigned Group
December 2004

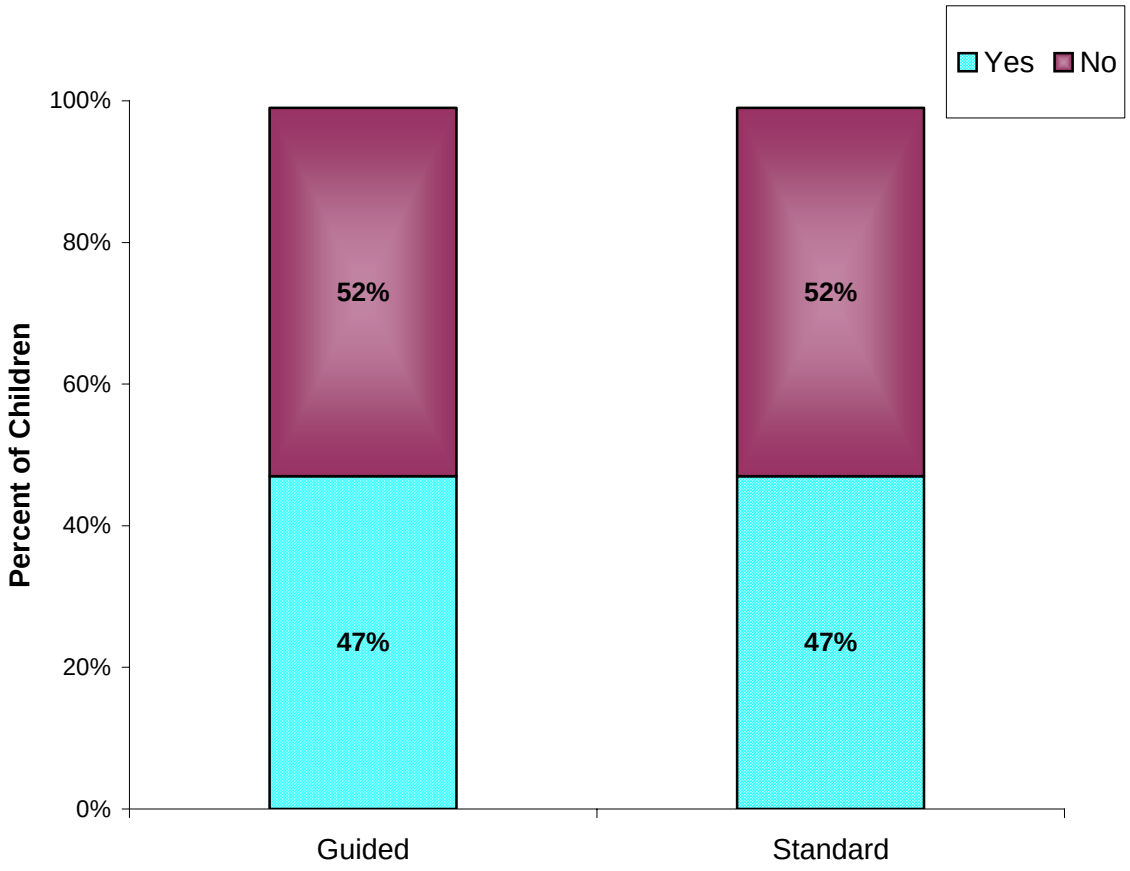
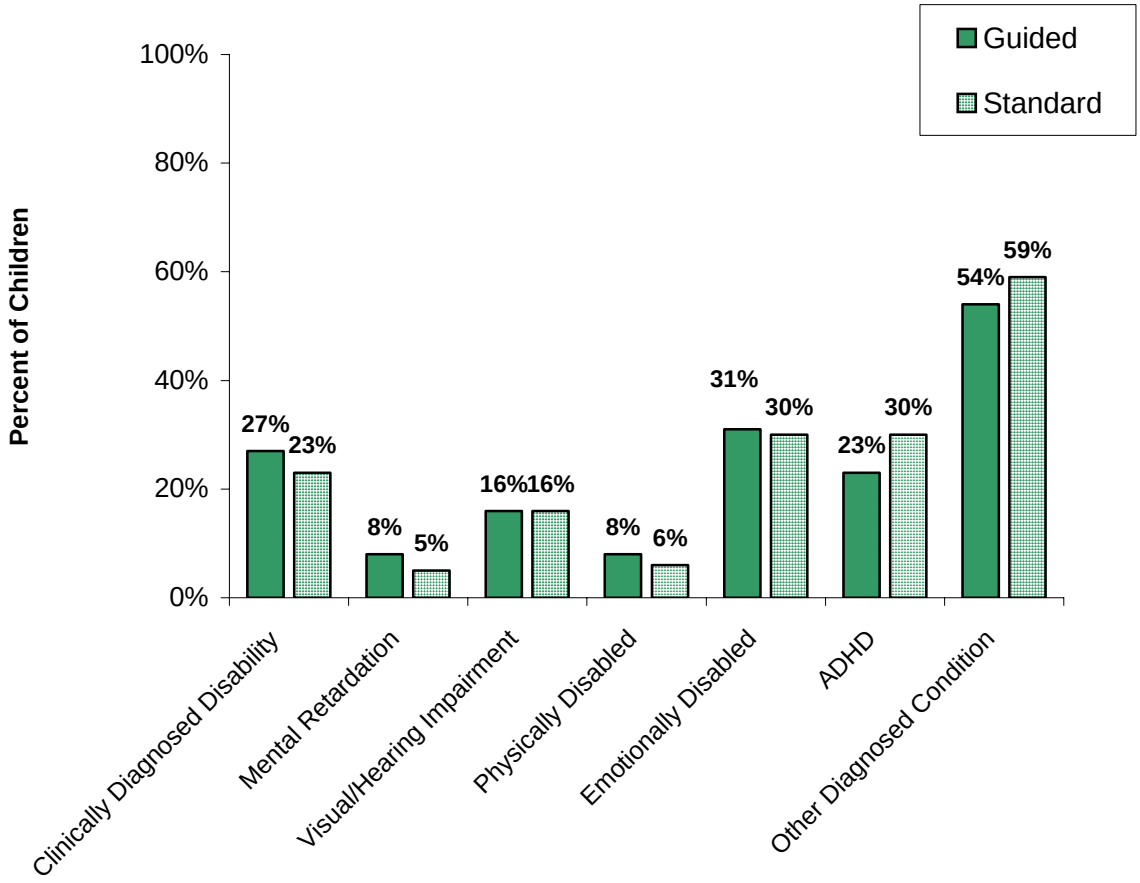


Chart 7
Clinically Diagnosed Disabilities
December 2004



Less than one-third of children in the study had clinically diagnosed disabilities—29 percent of Guided children and 26 percent of Standard children. The most common diagnoses were emotionally disturbed, ADHD, and "other" conditions. Of those who responded "Other," the most common responses were post-traumatic stress disorder (18%), attachment disorder (10%), asthma (10%), fetal alcohol syndrome (6%), and developmental delays (6%).

Chart 8
Percent of Clinically Diagnosed Disabilities as Reported By Parents - Baseline

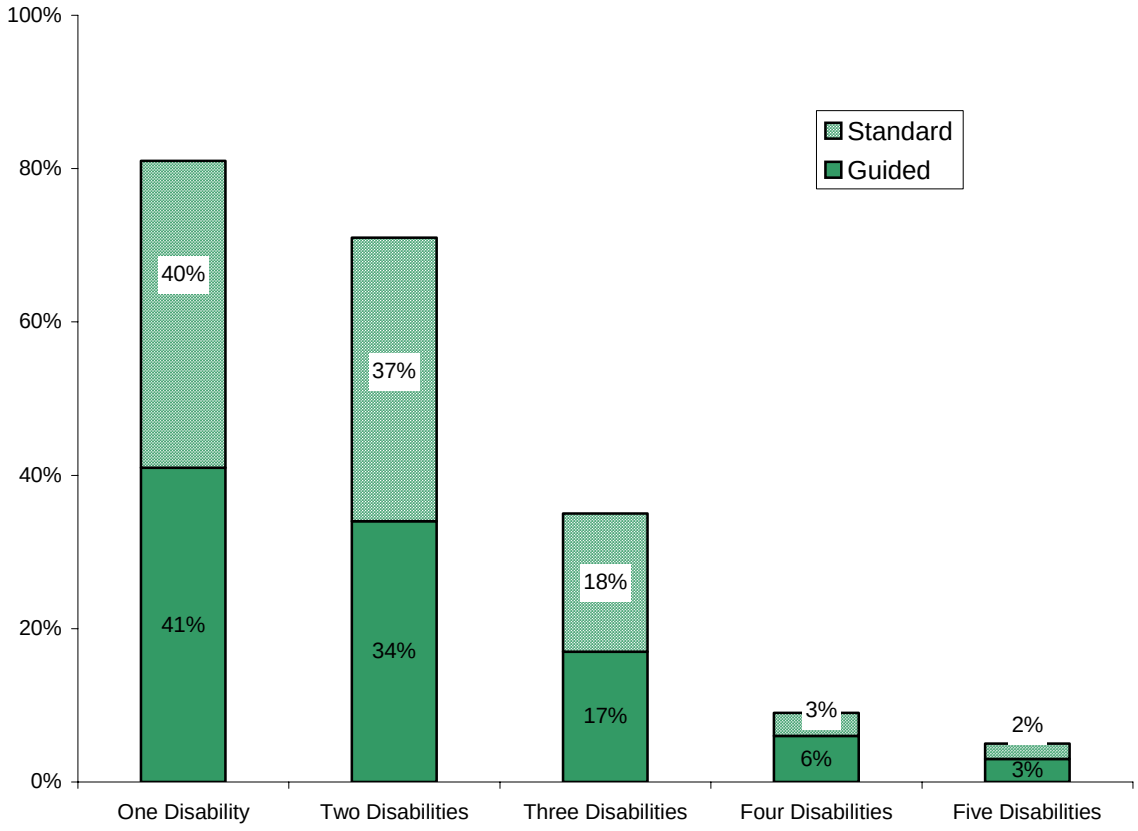
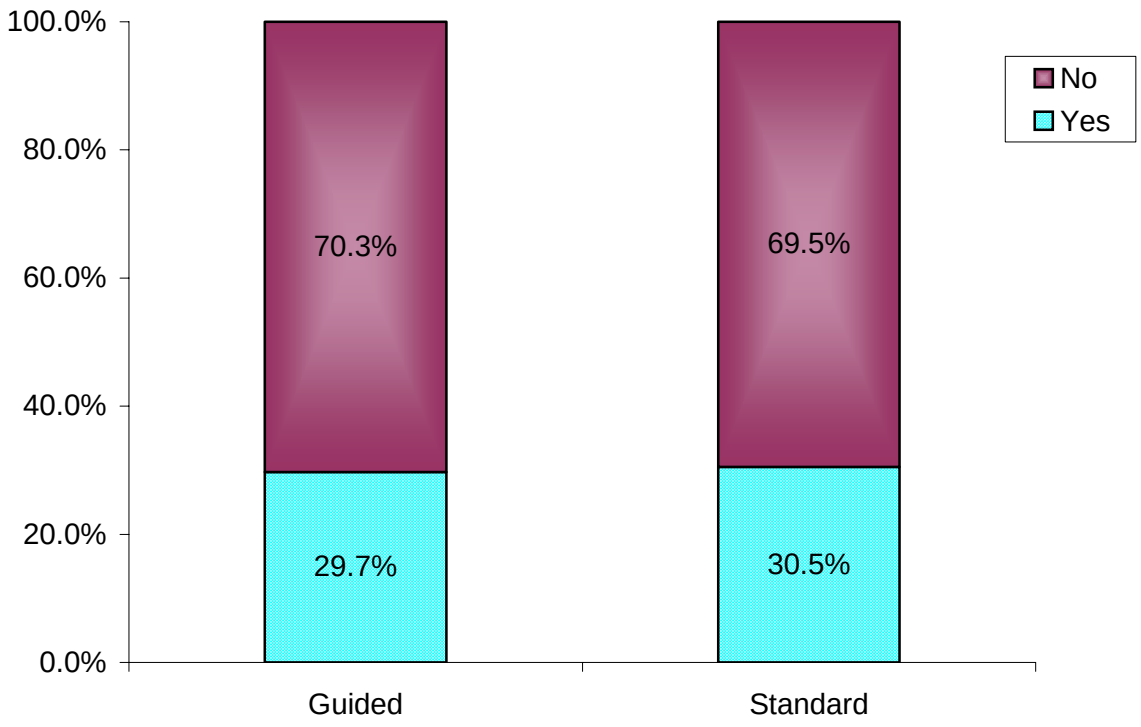


Chart 9
Percent of Children Taking Behavioral/Emotional Medication Reported By Parent - Baseline
December 2004



a. MAGS Children Compared To The Overall Adoption Population

We obtained data from the Maine Automated Child Welfare Information System (MACWIS) in order to compare the children in this study to the overall population of adopted children in Maine. The major variables for which compared the groups were age, gender, race, special needs, length of time in care and number of previous placements.

Our analysis showed no significant differences between MAGS children and all adopted children in gender, race, special needs, and number of previous placements. The data we obtained from the state for length of time in care was insufficient for analysis. Our calculations based on the data we had for 273 MAGS children was an average of four years in foster care (4.1 years). The state reported that overall, as of January 5, 2005, the average length of time for the 2,757 kids currently in care was 3.5 years. This difference seems to be significant. We also found a significant difference in the age of kids in care. The average age for MAGS children was found to be 0.55 years younger than the average for all adopted children in Maine (p=.000).

2. SELECT FAMILY LEVEL VARIABLES

The following are a set of results on some of the key family level variables for this study. Unless otherwise noted, the between group comparisons were not statistically significant.

Table 31
Satisfaction with Marriage/Partnership at Baseline Only
December 2004
1 = Very High to 5 = Very Low

Guided Services	Standard Services
N=138 Mean = 1.51 SD = .922	N=109 Mean = 1.49 SD = .587

Table 32
Concerns about Adopting a Child - Baseline Only
December 2004
Respondents could indicate more than one concern.

	GUIDED SERVICES (n=149)	STANDARD SERVICES (n=124)	TOTAL (n=273)
HOW TO MEET CHILD'S NEEDS	69%	66%	68%
CHILD ACCEPTING ME	49%	46%	48%
OTHER CHILDREN'S REACTION	52%	43%	48%
ABLE TO AFFORD ADDITIONAL COSTS	39%	33%	36%
ABILITY TO CONTINUE TO WORK	39%	32%	36%
EFFECT ON MARRIAGE	36%	27%	32%
HOW RELATIVES/FRIENDS WOULD FEEL	27%	29%	28%
BEING QUALIFIED ENOUGH TO DEAL WITH CHILD NEEDS	27%	27%	27%
OTHER CONCERNS	17%	19%	18%
MEETING LEGAL OBLIGATIONS	13%	11%	12%

Table 33
Reasons for Adopting a Child – Baseline of Total Study Population
December 2004

Respondents could indicate more than one reason to adopt. Respondents were asked different questions depending on relationship to child. Reasons are in order of most to least common.

	GUIDED SERVICES	STANDARD SERVICES	TOTAL
WANTED TO MAKE IT LEGAL	94.1%	93.5%	93.8% (n = 211)
WANTED CHILD TO FEEL SECURE	97.5%	89.2%	93.8% (n = 211)
FELT CLOSE TO CHILD	92.4%	92.5%	92.4% (n = 211)
OUR CHILDREN WERE ATTACHED TO CHILD	52.6%	62.4%	56.9% (n = 209)
DID NOT WANT TO LOSE CONTACT WITH CHILD	52.5%	44.1%	48.8% (n = 211)
WANTED TO PREVENT STRANGERS FROM RAISING CHILD	42.7%	48.4%	45.2% (n = 208)
COULD NOT HAVE ANY BIRTH CHILDREN	33.8%	38.7%	36.0% (n = 258)
PREFERRED ADOPTION TO FOSTER CARE	47.0%	32.6%	40.7% (n = 209)
CHILD WOULD FEEL REJECTED IF WE DID NOT ADOPT	40.2%	31.5%	36.4% (n = 209)
ALWAYS WANTED A BOY/GIRL	22.1%	26.0%	23.9% (n = 272)
HAD SUCCESS WITH OTHER ADOPTIONS	19.5%	27.4%	23.1% (n = 273)
CHILD WOULD BE GOOD COMPANION FOR OTHER CHILD(REN)	15.0%	24.6%	19.3% (n = 269)
OUR OTHER CHILDREN ARE GROWN	16.8%	17.1%	16.9% (n = 272)
TO PREVENT OTHER RELATIVE FROM RAISING CHILD	40.0%	44.4%	41.4% (n = 29)
FELT OBLIGATION TO CHILD	40.0%	44.4%	41.4% (n = 29)
HAD A CHILD WHO DIED	4.7%	3.2%	4.0% (n = 273)
FAMILY MEMBERS URGED US TO ADOPT	5.1%	0.0%	2.9% (n = 209)
AGENCY PRESSURED US TO ADOPT	2.0%	2.5%	2.2% (n = 91)

Table 34
Background of Adoptive Parents - Respondent/Primary Caregiver
December 2004

Respondents could indicate more than one characteristic.

	Primary Caregiver
CAME FROM LARGE FAMILY	147 (54%)
IS A RELATIVE/FRIEND OF FOSTER/ADOPTIVE PARENT	98 (36%)
WORKED WITH HANDICAPPED CHILDREN	99 (36%)
IS A RELATIVE/FRIEND OF ADOPTED/FOSTER CHILD	68 (25%)
WAS ABUSED AS A CHILD	35 (13%)
HAD ADOPTED/FOSTER SIBLINGS	27 (10%)
PARENT DIED IN CHILDHOOD	22 (8%)
WAS SERIOUSLY NEGLECTED AS A CHILD	15 (6%)
WAS AN ADOPTED CHILD	11 (4%)
WAS A FOSTER CHILD	8 (3%)
RAISED BY NON-RELATIVES	6 (2%)
ABANDONED BY PARENTS	6 (2%)
LIVED IN/OUT OF FOSTER HOMES/INSTITUTIONS AS A CHILD	5 (2%)
LIVED IN AN INSTITUTION AS A CHILD	1 (.4%)

Table 35
Background of Adoptive Parents - Spouse/Partner
December 2004
Respondents could indicate more than one characteristic.

	Primary Caregiver's Spouse/Partner
CAME FROM LARGE FAMILY	115 (47%)
IS A RELATIVE/FRIEND OF FOSTER/ADOPTIVE PARENT	59 (24%)
IS A RELATIVE/FRIEND OF ADOPTED/FOSTER CHILD	42 (17%)
WORKED WITH HANDICAPPED CHILDREN	27 (11%)
HAD ADOPTED/FOSTER SIBLINGS	13 (5%)
PARENT DIED IN CHILDHOOD	13 (5%)
WAS ABUSED AS A CHILD	12 (5%)
WAS SERIOUSLY NEGLECTED AS A CHILD	12 (5%)
WAS AN ADOPTED CHILD	6 (2%)
WAS A FOSTER CHILD	6 (2%)
RAISED BY NON-RELATIVES	5 (2%)
ABANDONED BY PARENTS	3 (1%)
LIVED IN/OUT OF FOSTER HOMES/INSTITUTIONS AS A CHILD	3 (1%)
LIVED IN AN INSTITUTION AS A CHILD	0 (0%)

Table 36
Spouse/Partner Attitude Toward Adoption – Baseline
December 2004

		Assigned Group		
		Guided (E)	Standard (C)	Total
Felt the Same Way You Did	Count	91	82	173
	% within Assigned Gp.	67.9%	75.2%	71.2%
Was More Eager to Adopt than You	Count	10	5	15
	% within Assigned Gp.	7.5%	4.6%	6.2%
Had More Concerns Than You	Count	29	21	50
	% within Assigned Gp.	21.6%	19.3%	20.6%
Was Indifferent To It	Count	3	0	3
	% within Assigned Gp.	2.2%	.0%	1.2%
Was Against the Adoption	Count	1	1	2
	% within Assigned Gp.	.7%	.9%	.8%
Total	Count	134	109	243
	% within Assigned Gp.	100.0%	100.0%	100.0%

Table 37
When Did You Feel Child was Permanently Yours -- at Baseline
December 2004
Caregiver answered for each adopted child.

		Assigned Group		
		Guided (E)	Standard (C)	Total
When he/she First Came to Live With You	Count	79	63	142
	% within Assigned Gp.	29.6%	32.5%	30.8%
When the Adoption Was Finalized	Count	36	17	53
	% within Assigned Gp.	13.5%	8.8%	11.5%
At Some Other Point In Time	Count	143	107	250
	% within Assigned Gp.	53.6%	55.2%	54.2%
Don't Know	Count	1	1	2
	% within Assigned Gp.	.4%	.5%	.4%
NA/Refused	Count	8	6	14
	% within Assigned Gp.	3.0%	3.1%	3.0%
Total	Count	267	194	461
	% within Assigned Gp.	100.0%	100.0%	100.0%

Other times families reported feeling that the child was permanently theirs included gradually over time, when they decided to adopt the child, or when they first met the child.

At baseline, 95% of respondents stated that they believed their child was permanently theirs. By 6 months in the study, approximately 96% agreed. From 12 months on, 99% agreed they believed the child was permanently theirs.

When asked at baseline about how having the child permanently in their home affected them, parents responded that they felt more complete or closer together (19%),

felt a sense of relief or security or reduced stress (19%), and that they were excited and happy about the future (18%).

When asked how the adoption changed their family life, the majority of parents (77%) said that it did not. Approximately 19% said that their family was complete. A small percentage reported that there was not enough time, or that there were financial issues. The number of parents who responded that there were time and financial issues rose slightly from the 12-month to the 24-month point of data collection.

Families were asked whether other people outside their family treated the family differently. The majority (78%) said that they were not treated differently. Thirteen percent said that they were treated differently in a negative way. Six percent felt that they were treated differently in a positive way. Responses to this question did not change over time.

When asked how life would be different if the child had been their biological child, more than half of all parents (56%) responded that their life would not be different. Other comments are displayed in the chart below:

Chart 10
How Family Would Be Different if Child Was Biological Child
December 2004

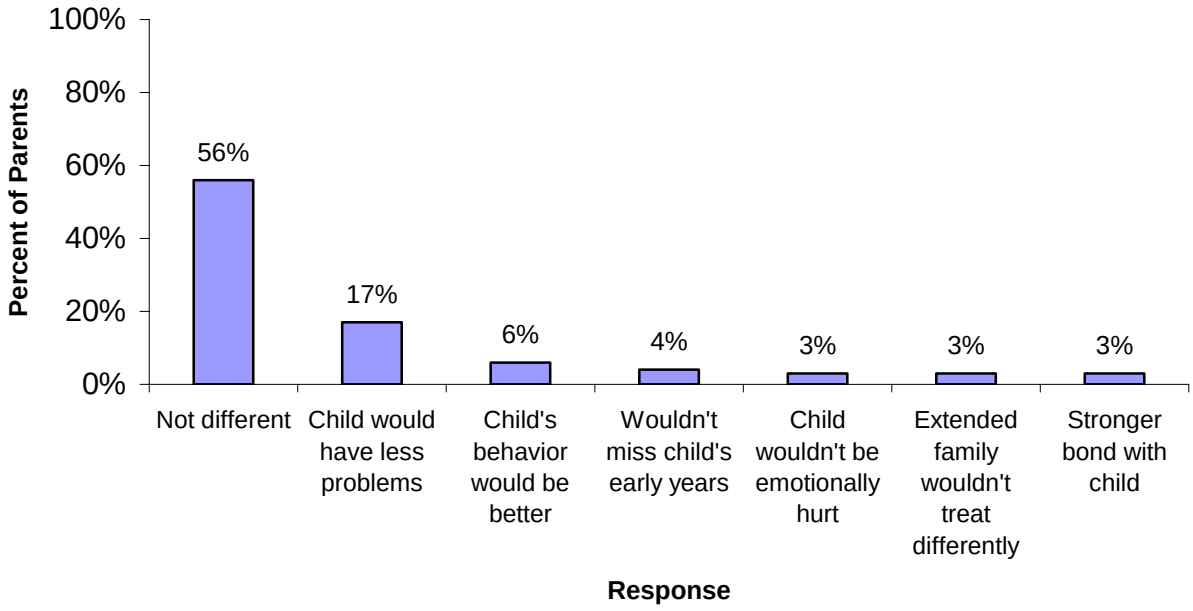


Table 38
Overall Satisfaction with Adoption – Baseline
December 2004
Respondent answers for each adopted child.
1 = Strongly Satisfied to 4 = Not at All Satisfied

	AssignedGroup	N	Mean	Std. Deviation	Std. Error Mean
Satisfaction with Adoption Process	Guided (E)	269	1.37	.865	.053
	Standard (C)	203	1.35	.746	.052
Spouse's Satisfaction with Adoption	Guided (E)	269	2.12	2.380	.145
	Standard (C)	200	1.97	2.144	.152
Other Children's Satis with Adoption	Guided (E)	269	2.66	2.900	.177
	Standard (C)	200	2.72	2.929	.207
Child's Satisfaction with Adoption	Guided (E)	268	1.81	2.046	.125
	Standard (C)	202	2.16	2.459	.173

Table 39
Child Contact with Birth Family - Baseline
December 2004

		Assigned Group		
		Guided (E)	Standard (C)	Total
Yes	Count	214	155	369
	% within Assigned Gp.	79.6%	76.4%	78.2%
No	Count	55	48	103
	% within Assigned Gp.	20.4%	23.6%	21.8%
Total	Count	269	203	472
	% within Assigned Gp.	100.0%	100.0%	100.0%

Table 40
Talk to Child About Birth Family – Baseline
December 2004
Caregiver answer for each adopted child.

		Assigned Group		
		Guided (E)	Standard (C)	Total
Yes	Count	208	154	362
	% within Assigned Gp.	77.3%	75.9%	76.7%
No	Count	61	49	110
	% within Assigned Gp.	22.7%	24.1%	23.3%
Total	Count	269	203	472
	% within Assigned Gp.	100.0%	100.0%	100.0%

Table 41
Talk to Child About Birth Family at 6 – 42 Months
December 2004

Caregiver answer for each adopted child.

Time by Wave		Strongly Agree		Agree		Undecided		Disagree		Strongly Disagree	
		Count	%	Count	%	Count	%	Count	%	Count	%
6 Months	Guided (E)	198	88.0%	19	8.4%	6	2.7%	1	.4%	1	.4%
	Standard	150	90.9%	8	4.8%	5	3.0%	1	.6%	1	.6%
12 Months	Guided (E)	155	91.2%	13	7.6%	1	.6%	1	.6%		
	Standard	120	95.2%	2	1.6%	2	1.6%	2	1.6%		
18 Months	Guided (E)	127	92.0%	10	7.2%	1	.7%				
	Standard	98	94.2%	5	4.8%	1	1.0%				
24 Months	Guided (E)	97	95.1%	4	3.9%	1	1.0%				
	Standard	56	96.6%	2	3.4%						
30 Months	Guided (E)	65	95.6%	2	2.9%	1	1.5%				
	Standard	36	97.3%	1	2.7%						
36 Months	Guided (E)	38	92.7%	3	7.3%						
	Standard	28	100.0%								
42 Months	Guided (E)	22	100.0%								
	Standard	15	83.3%	2	11.1%					1	6%

3. SELECT CHILD LEVEL VARIABLES

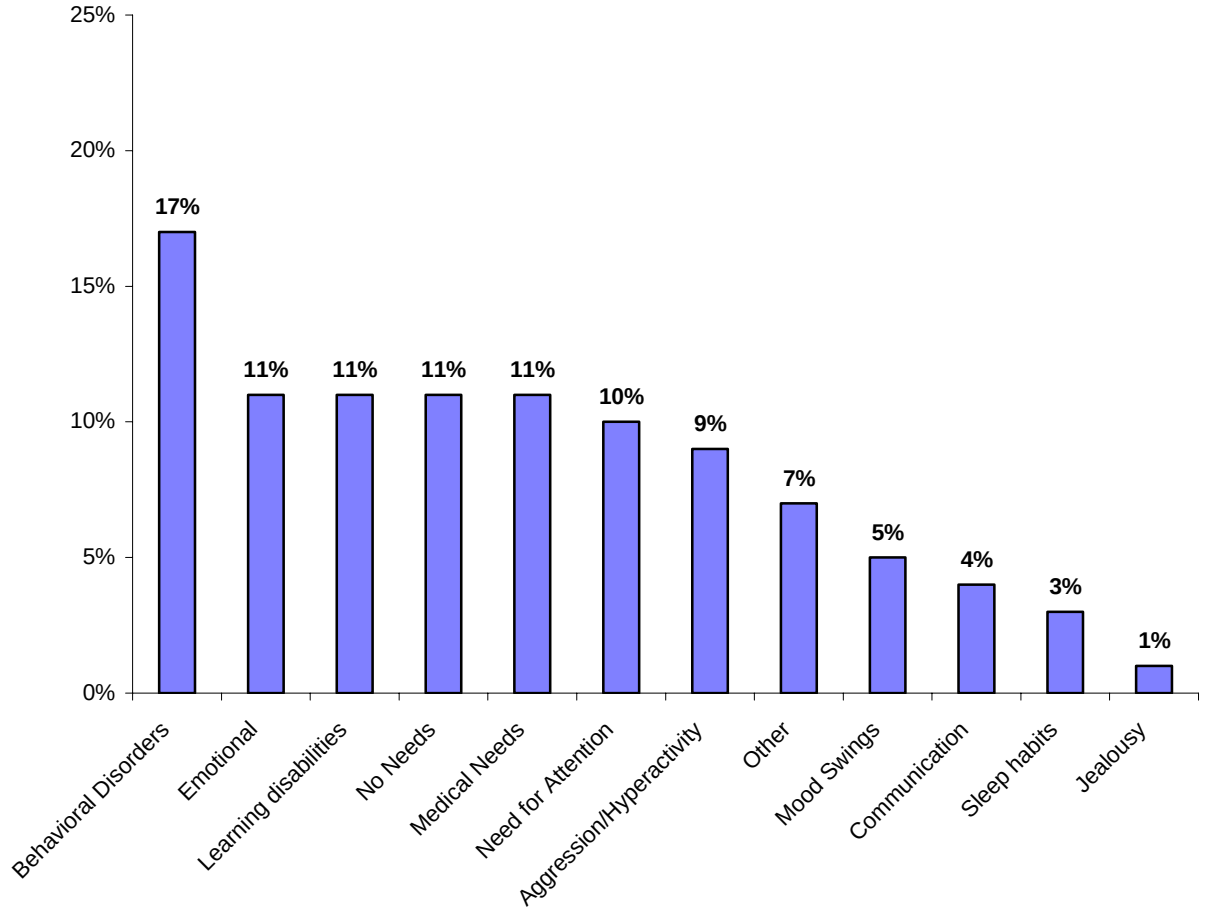
This section provides additional information intended to describe the sample of children in this study based on a select set of variables. Most of this information was collected through questionnaires that the self-selected caregiver completes, or was collected through a telephone interview with that same caregiver. Information was collected approximately once every 6 months.

Child Needs – Most Difficult

As part of the regular telephone interviews, caregivers were asked an open-ended question: "In the last six months, if you had to list two or three things about your adopted child/ren's particular needs that have been the most difficult for you and your family to deal with, what would they be?" The following is a compilation of responses collected at Baseline [When collected at the six – 42 month data collection periods, the reported needs remained the same]. The responses were coded into common thematic categories and then categories were counted. There were a total of 471 responses to the First most difficult need; 46 responses to the Second most difficult need; and 14 responses to the Third most difficult need—a total of 531 responses (all Cohorts combined). Parents' identification of the most difficult types of needs were:

1. **Behavioral Problems**: Of all comments mentioned some type of specific behavior that was of a primary concern to a parent. Behaviors mentioned were numerous and included violent tantrums, not listening, difficulties in school, and sexual acting out behaviors.
2. **Aggression/Hyperactivity**: Of all comments mentioned aggressive and hyperactive behavior specifically was difficult to deal with.
3. **Emotional Problems**: Of all comments mentioned some type of emotional problem that a child was experiencing as a primary need to be addressed. Most often mentioned were problems with attachment or connection to family members.
4. **Attention/Needy Behavior**: Of all responses concerned the attention needs or needy behavior of the child.
5. **Learning Disabilities**: Of all comments mentioned a learning disability was a concern of the parent.
6. **Medical Needs**: Of the responses focused on specific type of medical need that parents were having difficulty responding to: either through their own efforts or having difficulty finding appropriate professional services.
7. **Other Issues**: Some of these responses covered other areas such as lack of services, lack of social skills, internal family issues, and respondent's own frustrations.

Chart 11
Parents Most Difficult Child Needs - Totals - Baseline
December 2004



C. SERVICE CHARACTERISTICS

1. TYPES OF SERVICES FAMILIES UTILIZED

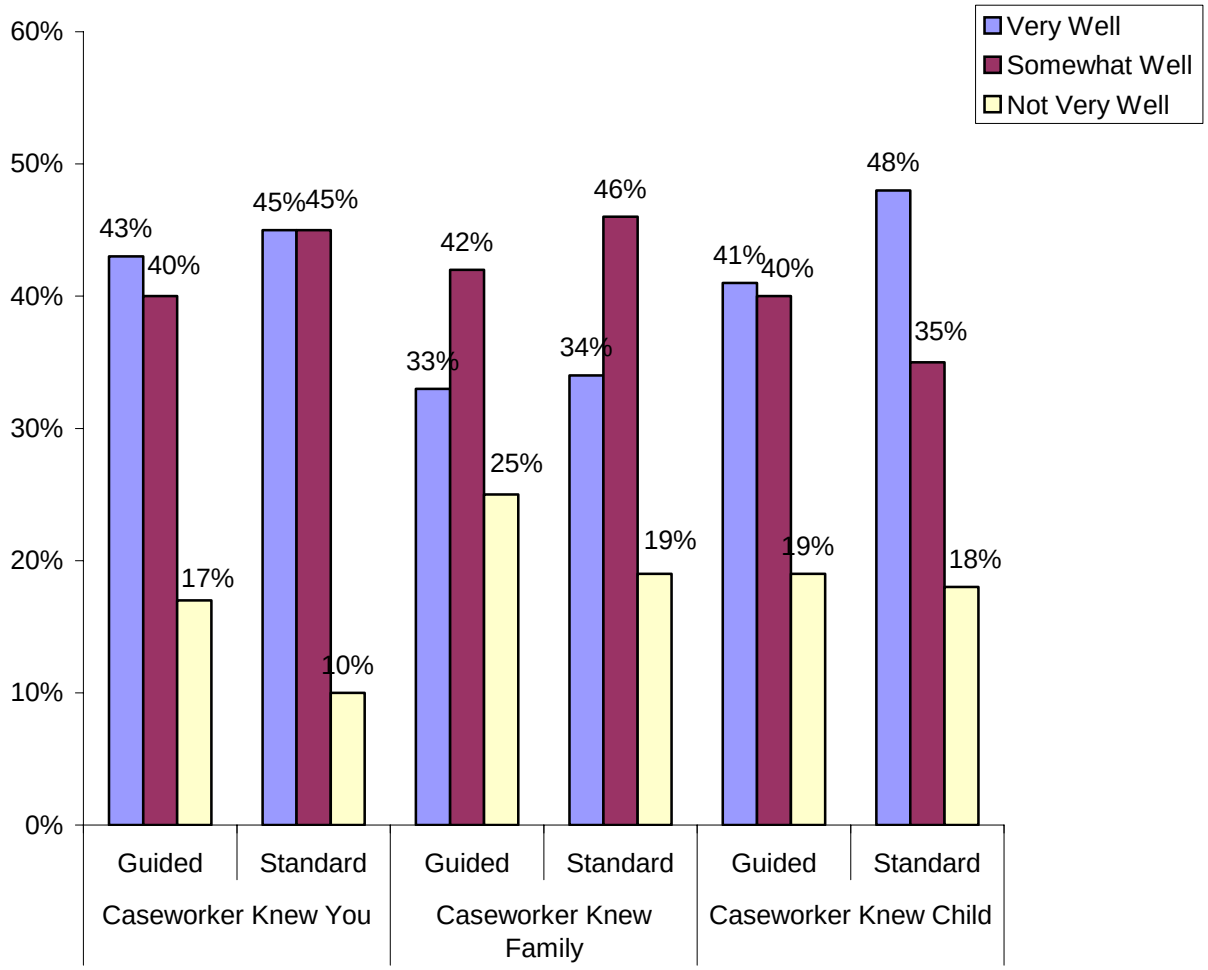
Families were asked about services they obtained pre- and post-legalization.

a. Pre-Legalization Services

When asked how often a DHHS caseworker visited them, respondents answered with a range from once a year to three times per week. The mean number of visits was approximately 11 visits per year (Mean = 11.04; Standard Deviation = 14.380). Guided families reported an average of 12 visits per year; Standard families reported an average of 10 visits per year.

Respondents were asked to rate how well the DHHS adoption caseworker knew the respondent, the respondent's family and the respondent's adopted child. Answers are as follows:

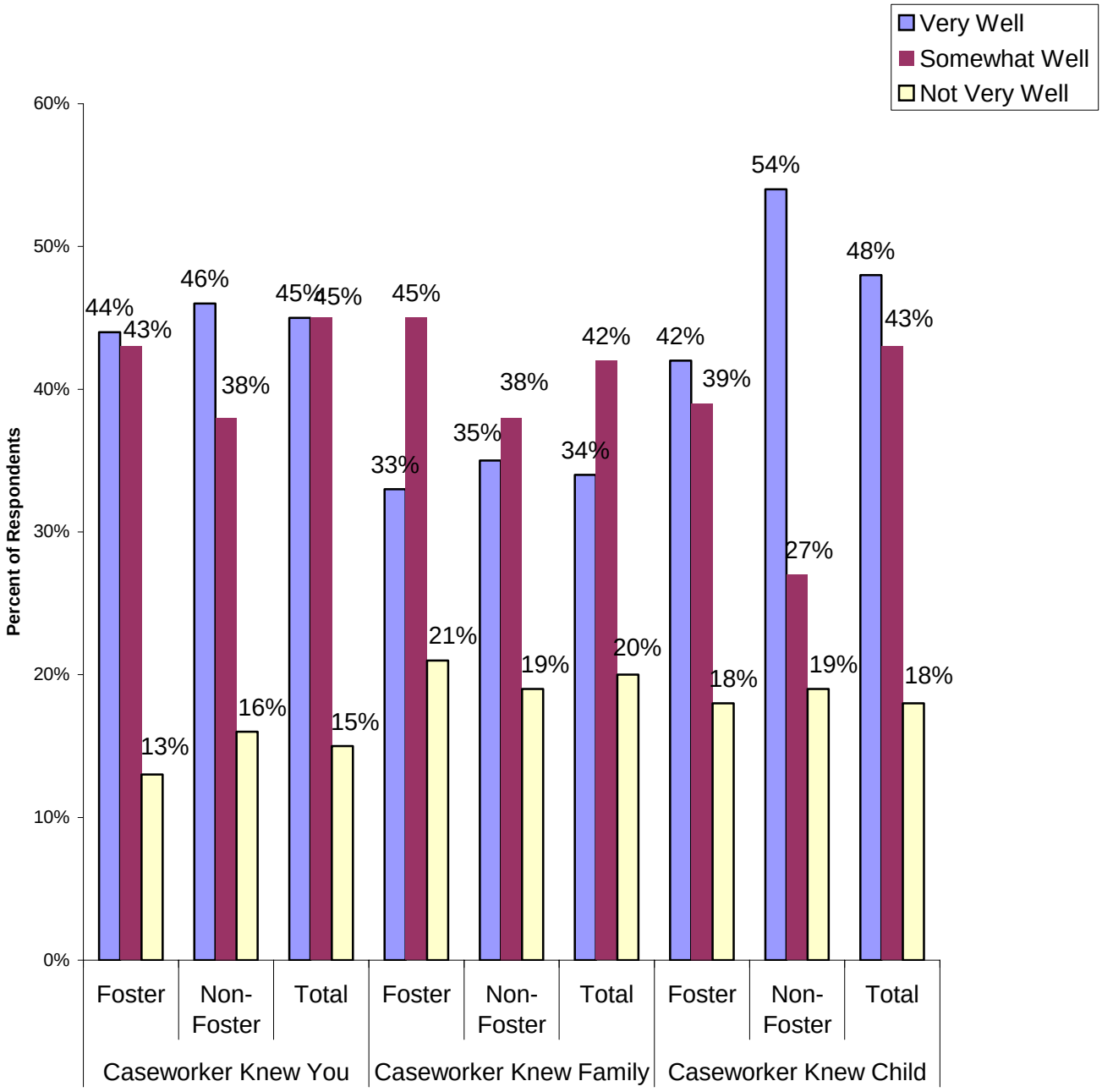
Chart 12
How Well DHHS Caseworkers Knew Family Members By Group – Prelegalization
December 2004



Guided=141; Standard=120

When looking at the responses for how well the DHHS caseworker knew family members by type of adoption (foster parent adoption or non-foster adoption) there were differences, as shown in the chart below.

Chart 13
How Well DHHS Caseworkers Knew Family Members By Foster and Non Foster Families – Prelegalization
December 2004



Respondents were asked how satisfied they were with pre-legalization services. Results are shown in the table below.

Table 42
Satisfaction with Pre-Legalization Services to Family/Child at Baseline by Assigned Group
December 2004
1 = Very Satisfied to 4 = Very Dissatisfied
Responses are from caregiver rating state DHHS Caseworker by each adopted child at time of entry to study.

Guided Services	Standard Services
N = 142 **Mean = 1.47** **SD = .731**	**N = 120** **Mean = 1.51** **SD = .789**

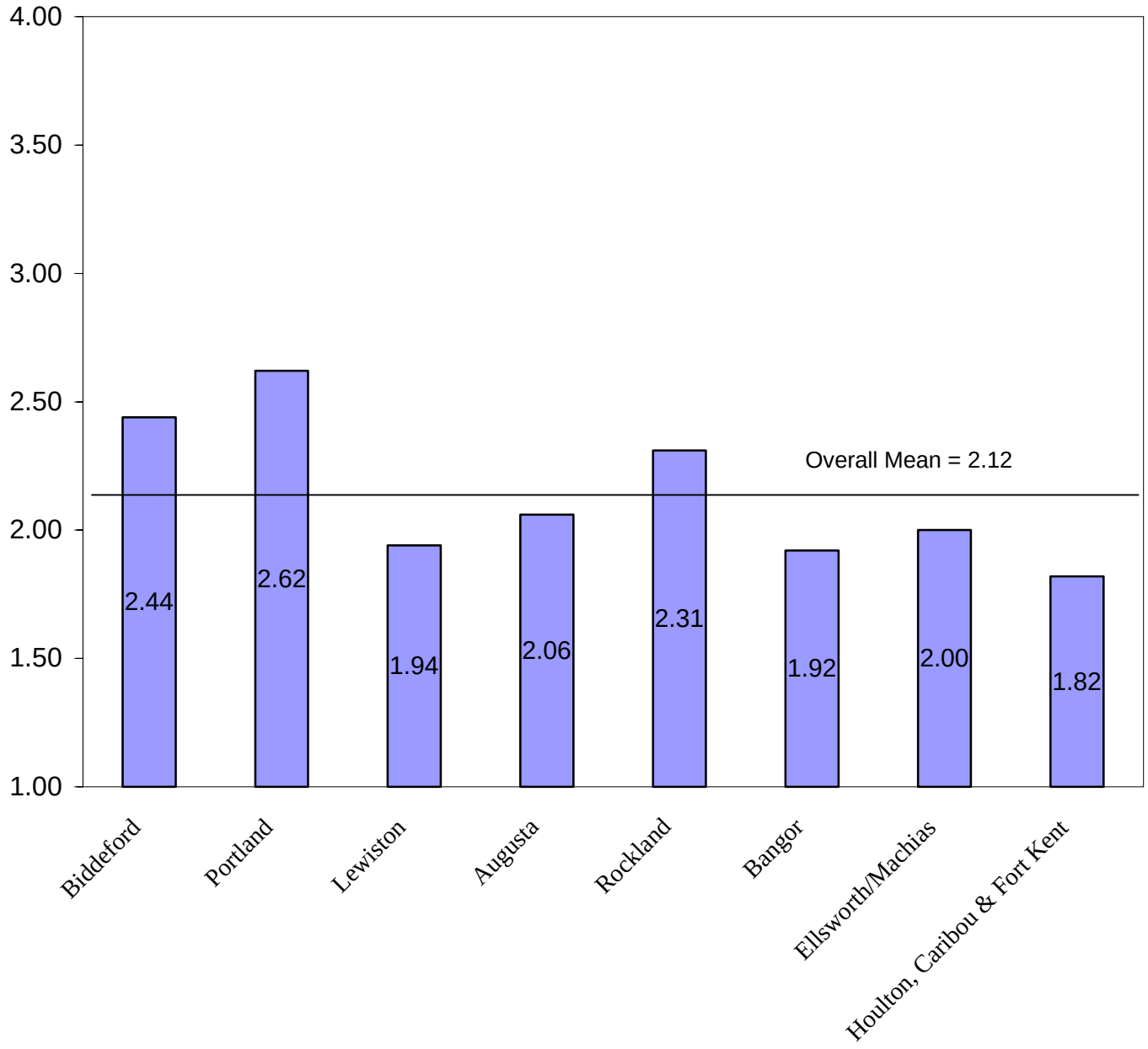
Table 43
Satisfaction with Pre-Legalization Services to Family/Child at Baseline By Type of Adoption
December 2004
1 = Very Satisfied to 4 = Very Dissatisfied

Responses are from caregiver rating state DHHS Caseworker by each adopted child at time of entry to study.

Foster	Non-Foster
N = 225 **Mean = 1.51** **SD = .763**	**N = 37** **Mean = 1.38** **SD = .721**

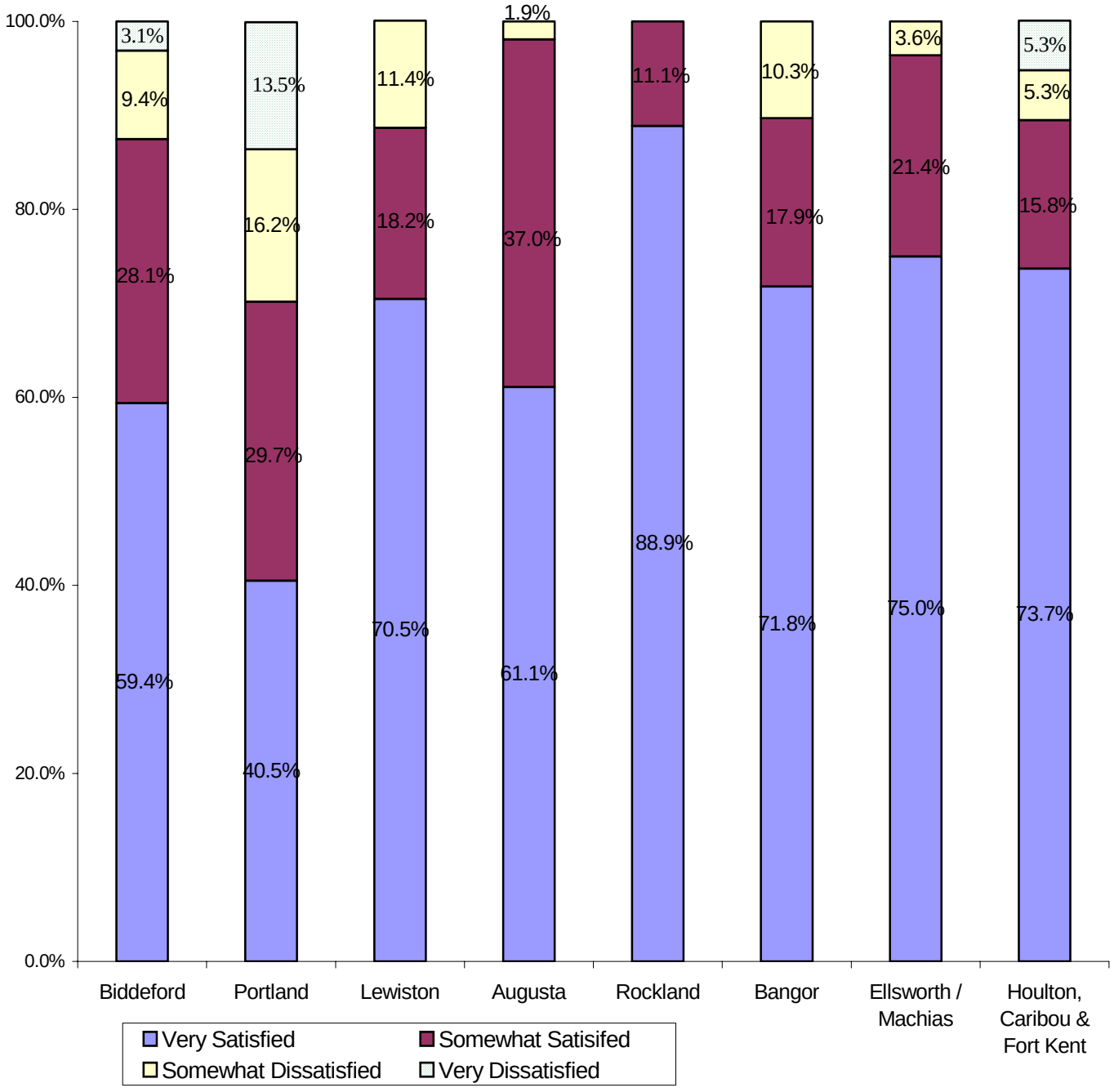
Chart 14
Satisfaction with Pre-Legalization Services to Family/Child at Baseline By DHHS District
December 2004
1 = Very Satisfied to 4 = Very Dissatisfied

Responses are from caregiver rating state DHHS Caseworker by each adopted child at time of entry to study.



Respondents were asked about the kinds of things a caseworker did before legalization that were helpful. The most cited activities were; provided a continuous flow of information, gave assistance with adoption papers, life book, and financing/subsidies, provided background information on the child, and made courtesy calls and visits.

Chart 15
Satisfaction With Pre – Legalization DHHS Services by District
December 2004



b. Post Legalization Services

Respondents were asked if they contacted their DHHS worker.

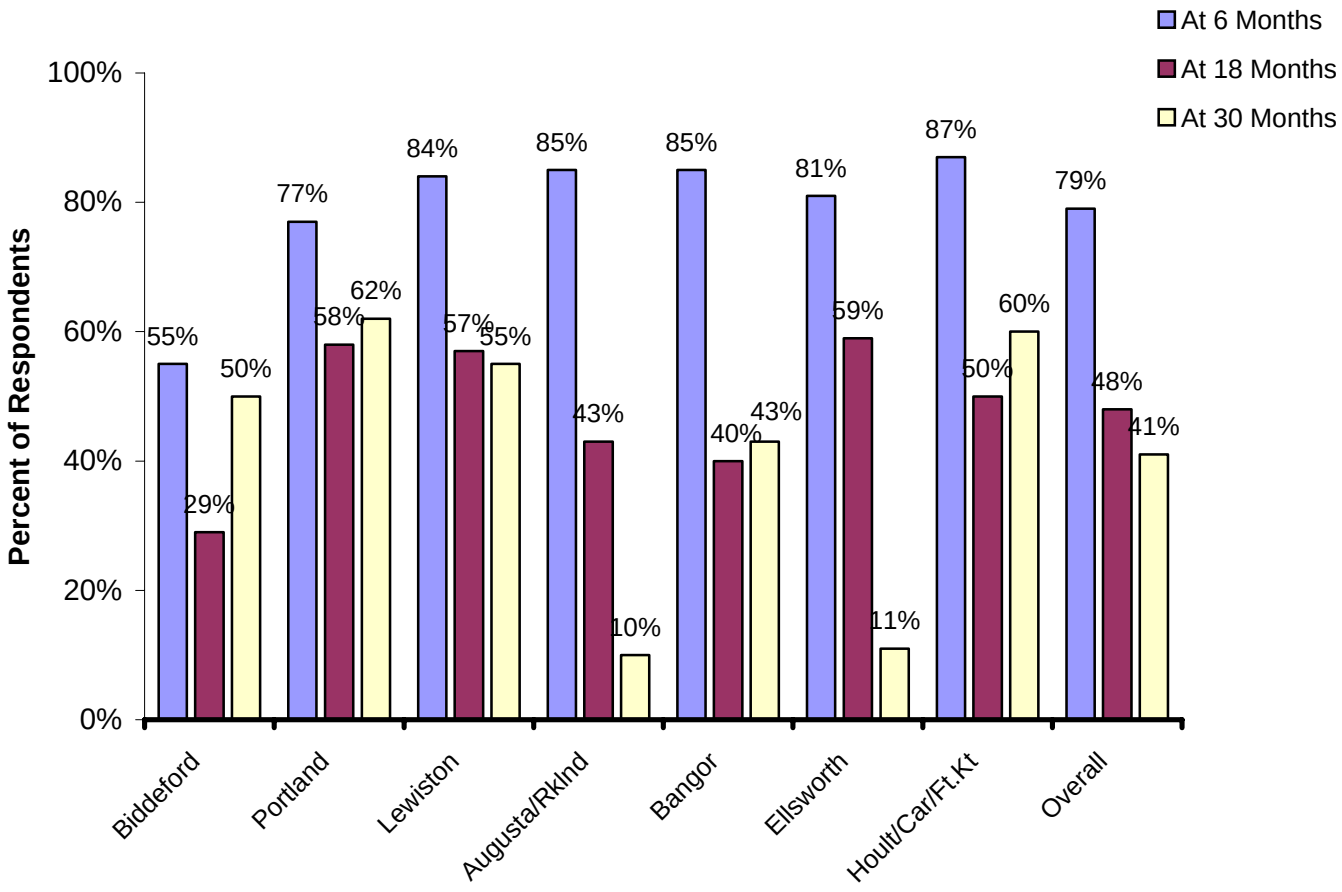
Table 44
Percentage of Respondents Who Have Had Contact with a Caseworker in the Past Six Months
By Assigned Group
December 2004

	6 Months	12 Months	18 Months	24 Months	30 Months	36 Months	42 Months
Guided	77%	60%	49%	41%	32%	40%	17%
Standard	82%	52%	46%	34%	54%	56%	39%

The reasons most often cited for contacting a DHHS worker were monthly subsidy payments, adoption/legalization questions, a child's new emotional needs, MaineCare coverage questions, or questions concerning the child's birth family.

After 24 months in the study, the percentage of Guided families who had contact with a DHHS Worker decreased while the percentage for Standard families did not—Standard families contacted a DHHS caseworker 22% more than Guided families at 30 months, 16% more at 36 months, and 22% more at 42 months.

Chart 16
Percent of Respondents Who Report Having Contact with a DHHS Caseworker By District
December 2004



Using a four-point scale (1 = Very Satisfied, 2 = Somewhat Satisfied, 3 = Somewhat Dissatisfied, 4 = Very Dissatisfied) respondents were asked to rate their satisfaction with their DHHS caseworker post-legalization. The mean scores were as follows:

Chart 17
Satisfaction with Post-Legalization Services to Family/Child by Assigned Group
December 2004
1 = Very Satisfied to 4 = Very Dissatisfied

Responses are from caregiver rating state DHHS Caseworker by each adopted child after entering study. Approximately 90% of all adoptions are finalized by this point in time; at least 6 months past baseline**.**

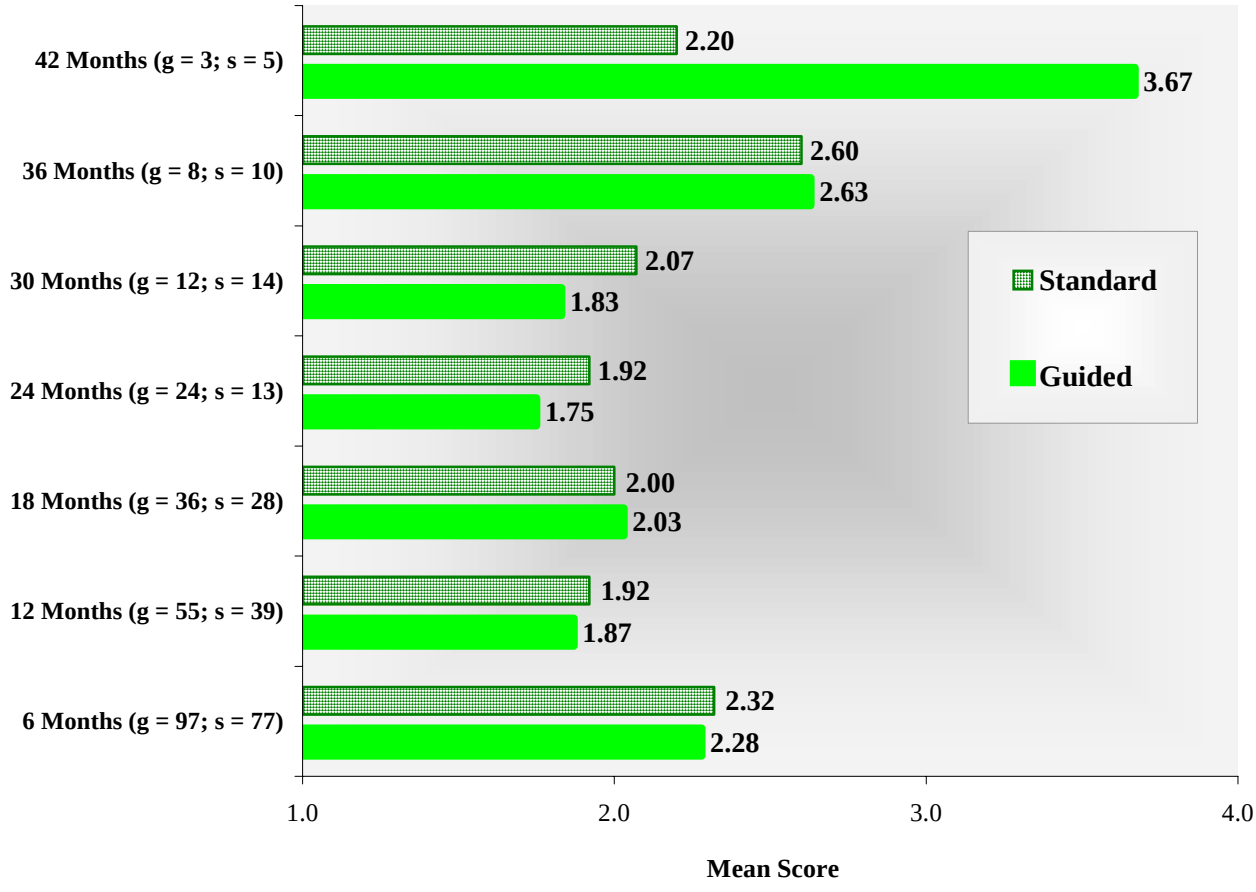
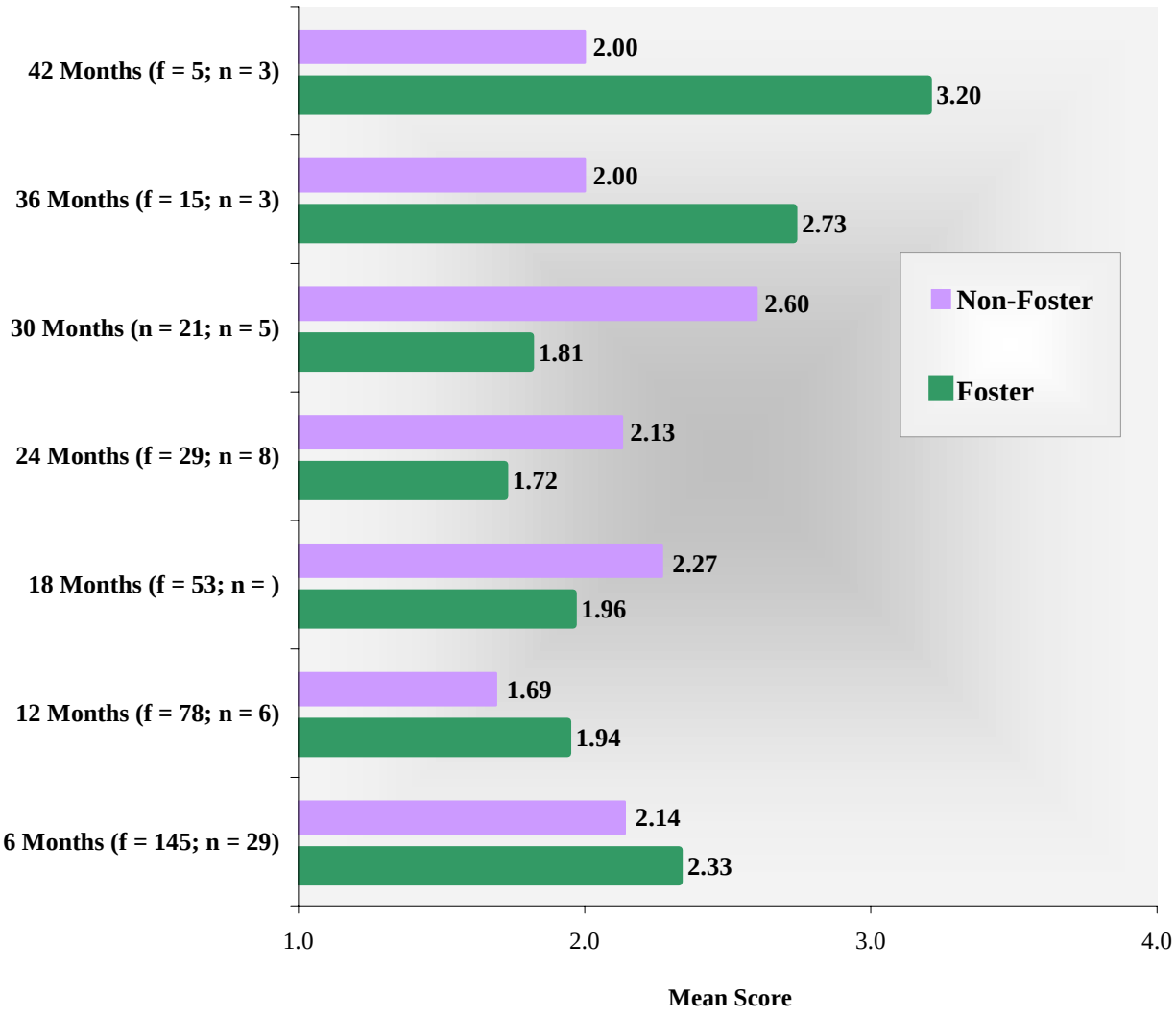


Chart 18
Satisfaction with Post-Legalization Services to Family/Child by Type of Adoption
December 2004
1 = Very Satisfied to 4 = Very Dissatisfied

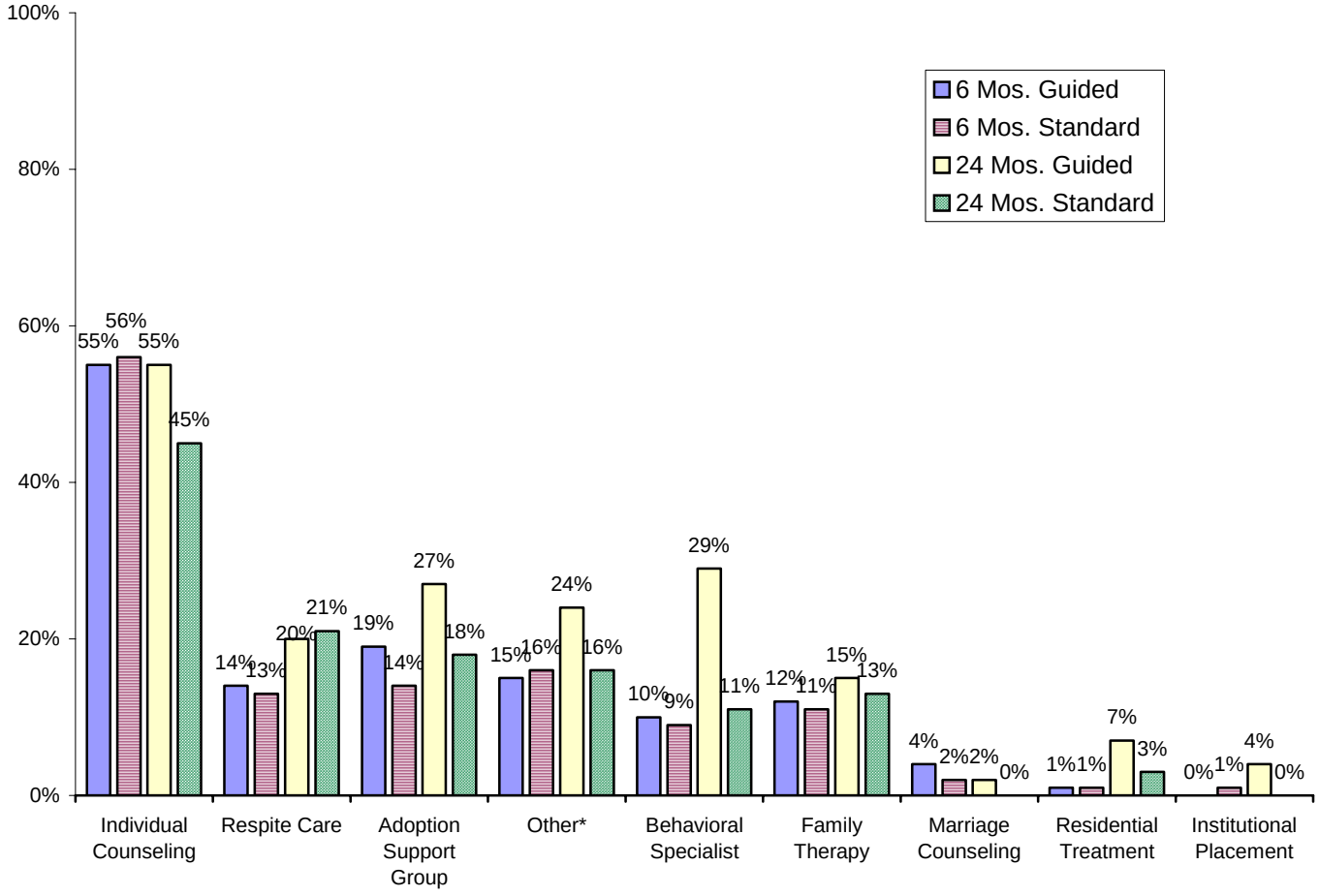


While the majority of respondents reported being very satisfied with post-legalization services, a few respondents indicated that they were dissatisfied with the services. The reason most cited for dissatisfaction with post-legalization services were: the legalization time frame was too long, caseworkers were overloaded and didn't have time; it was difficult to access the caseworker; not all background information on the child was provided, and there was a lack of support network for parents.

c. Services From the Community

Families were asked about the kinds of services they obtained from their community in the past six months. Results are shown below:

Chart 19
Percent of Caregivers Obtaining Services – Types of Service at 6 & 24 Months into Study By Assigned Group
December 2004
Respondents can choose more than one service type.



*Other services included psychiatrists, caseworker consultation, occupational therapy, speech therapy, physical therapy, and other medical services.

Table 45
Median Number of Hours of Service Time Reported by Family At 12, 24 & 36 Months into Study by Assigned Group
December 2004

Caregivers were then asked the number of hours spent with a service provider within that same six month time period. Occasionally, a small number of families used a very high amount of services (counseling, therapy, etc); more than 600 hours of any one type of service in the past six months, or 25 hours per week. In order to calculate averages that represented the majority of families, the median service hours amounts were used instead of the mean.

	At 12 Months Guided	At 12 Months Standard	At 24 Months Guided	At 24 Months Standard	At 36 Months Guided	At 36 Months Standard
Respite Care for Adopted Child	102	112	96	119	53	96
***Other Service for Adopted Child**	7.5	13.5	6	29	20	8
Counseling for Adopted Child	18	15	23	24	30	23
Adoption Support Group	18	7	13.5	12	12	10.5
Behavioral Specialist	11	30	12	334	42	22
Family Therapy	6	6	11	10	8	12
Marriage Counseling	5	2	3	0	0	4
Total Service Hours:	46.5	65	61.5	79.5	47	74

*Other services included occupational therapy, speech therapy, physical therapy, caseworker consultation, psychiatrists, substance abuse treatment, neuropsychological evaluations, and homeopathic medicine.

T-tests were used to examine whether there were significant differences between groups in service usage, and results were confirmed using a logarithmic transformation. We examined the number of service hours reported at 6 months (parents reported the service hours received since over the past 6 months) and again at 24 months into the study. We found that at 6 months, there was a significant difference—Guided children were reported to receive less service hours than Standard children (.023). At 24 months, the average mean for Guided children was still less but the difference was not statistically significant. The median amounts at these two time periods were also displayed—the median is the halfway point of all service hours (half received less, half received more).

Table 46
Average Number of Service Hours at 6 and 24 Months as Reported by Families
By Assigned Group
December 2004

	6 Month Mean	6 Month Median	24 Month Mean	24 Month Median
Guided (6 months n=221) (24 months n=113)	**96.1**	**21**	**129.3**	**31**
Standard (6 months n=154) (24 months n=65)	**191.8**	**20**	**143.1**	**12**
Total	**135.4**	**20**	**134.3**	**26**

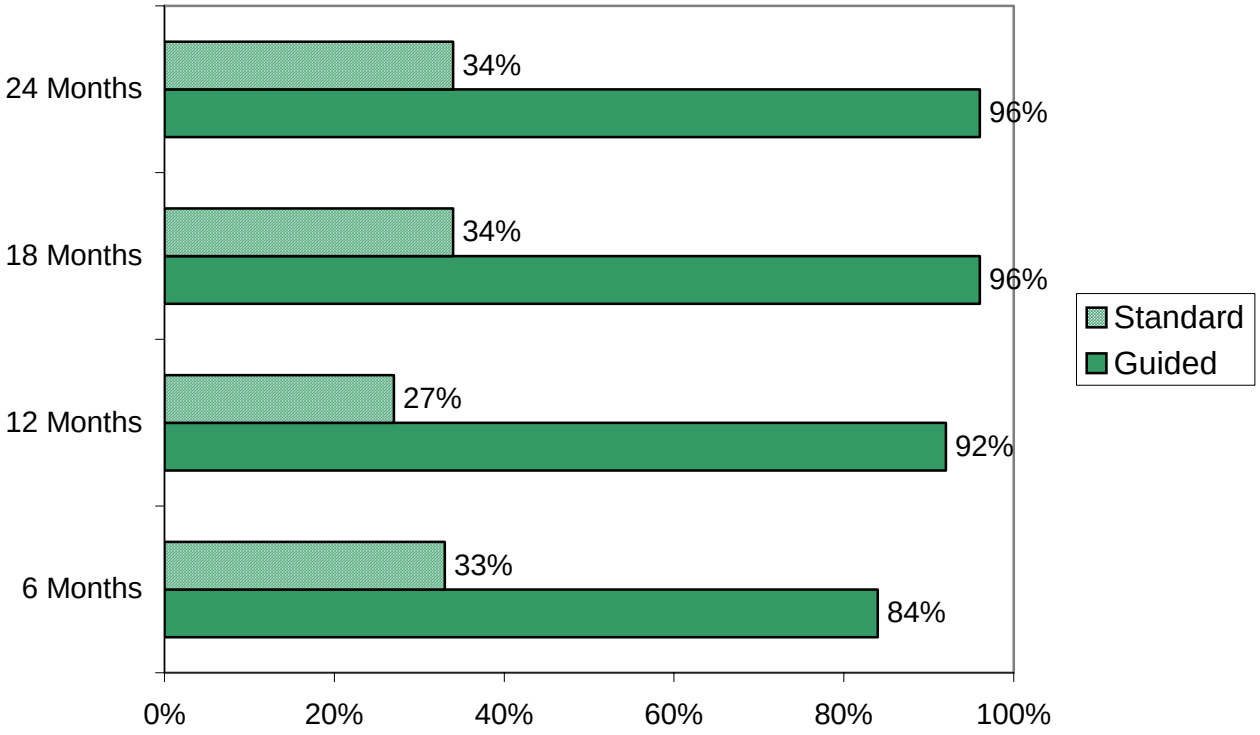
We also examined the differences in the groups defined as "Receiving the Intervention" [Guided children received the 50th percentile of service hours and higher], and "Not Receiving the Intervention" [all Standard children and the Guided children received less than the 50th percentile of service hours]. At 6 months, there was a significant difference between groups: those "Receiving the Intervention" reported receiving less overall service hours than those "Not Receiving the Intervention."(.003). At 24 months, those "Receiving the Intervention" reported more service hours than "Not Receiving the Intervention" but the difference was not statistically significant.

Table 47
Average Number of Service Hours at 6 and 24 Months as Reported by Families
By "Receiving the Intervention"
December 2004

	6 Month Mean	6 Month Median	24 Month Mean	24 Month Median
Receiving the Intervention (6 months n=139) (24 months n=80)	**103.3**	**29**	**153.4**	**70**
Not Receiving the Intervention (6 months n=236) (24 months n=98)	**154.3**	**15**	**118.7**	**8**
Total	**135.4**	**20**	**134.3**	**26**

d. Services From Case-manager/worker

Chart 20
Percentage of Families Who Report They Have a Regular Case Manager
At 6 - 24 Months into Study by Assigned Group
December 2004



At six months in the study, 81 percent of those who were assigned a caseworker had one caseworker assigned to them; at 12 months in the study, 75 percent had one caseworker; at 18 months in the study, 71 percent and at 24 months in the study, 75 percent had one caseworker. At 30 months in the study, the overall number begins to decrease: 68 percent had one caseworker; at 36 months in the study, 59 percent had one caseworker and by 42 months in the study, 58 percent had one caseworker. The table below displays the number who had more than one caseworker by Guided and Standard families.

Chart 21
Percentage of Families Who Report Having Two or More Caseworkers
At 6 - 24 Months into Study by Assigned Group
December 2004

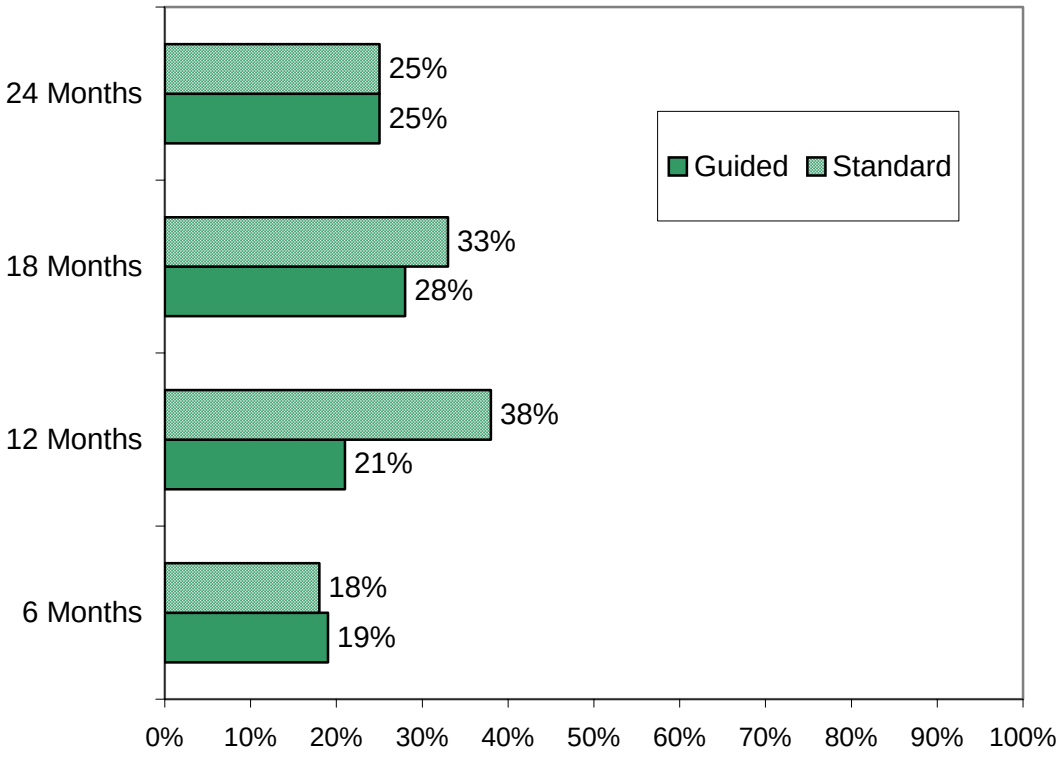


Table 48
Types of Services Provided by Primary Caseworker 12, 24 & 36 Months in Study by Assigned Group
December 2004
Respondent can choose more than one service type.

Case Manager:	Guided 12 Mos (N=86)	Standard 12 Mos (N=61)	Guided 24 Mos (N=50)	Standard 24 Mos (N=30)	Guided 36 Mos (N=21)	Standard 36 Mos (N= 16)
Develops/Brokers Services	79% (n=68)	34% (n=21)	84%* (n=43)	43%* (n=13)	81%* (n=17)	38%* (n=6)
Provides General Support/Educational Services	62% (n=53)	25% (n=15)	66%* (n=33)	30%* (n=9)	71%* (n=15)	38%* (n=6)
Advocates on Behalf of Family/Child	43% (n=37)	18% (n=11)	46% (n=23)	30% (n=9)	71% (n=15)	19% (n=3)
Provides Therapeutic Services	23% (n=20)	5% (n=3)	33% (n=17)	7% (n=2)	33%* (n=7)	0
Assists with Preparation/ Placement to Residential Setting	6% (n=4)	0	4% (n=3)	10% (n=3)	10% (n=2)	0

*Statistically significant differences between Guided and Standard Groups at these points in time. A higher number of Guided families report receiving these services than Standard families.

The table above shows that in general, at every point of data collection, Guided families reported receiving more services from their primary caseworker than Standard families. By 36 months, there was a large difference between the percentages of Guided and Standard families having reported receiving services from a primary caseworker.

2. FAMILIES ACCESS NATURAL FORMS OF SUPPORT

Caregivers indicated that they seek support from a paid professional slightly more so than from a natural source of support. Caregivers were asked the following open-ended question every six months: " What would you identify as the top three most important sources of aid or support available to you in helping care for your adopted child/ren? This may include natural as well as professional supports." The following results were totals from caregivers in at 6 - 36 months into study.

Table 49
Type of Aid – Support Caregivers Rely On Most Total Population
December 2004

First Most Important Aid –Support Note: A higher percentage of Guided families relied first on professional supports: Guided = 60% professional; 40% natural Standard = 49% professional; 51% natural Significance (p=.004)	**55% Relied On Professional Type Supports:** **1. Social Workers/Case Management** **2. Counseling/Therapy** **3. Respite** **4. Financial Supports/Subsidy** **45% Relied On Natural, Non-Professional Type Supports:** **1. Family Support** **2. Friends** **3. Support Groups**
Second Most Important Aid – Support Note: A higher percentage of Guided families relied first on professional supports: Guided = 61% professional; 39% natural Standard = 45% professional; 55% natural Significance (p=.000)	**54% Relied On Professional Type Supports** **1. Social Workers/Case Managers** **2. Counseling/Therapy** **3. School/School Services** **4. Respite** **5. Financial Supports/Subsidy** **46% Relied On Natural, Non-Professional Type Supports** **1. Family** **2. Friends** **3. Support Groups**
Third Most Important Aid – Support Guided = 56% professional; 44% natural Standard = 48% professional; 52% natural	**53% Relied On Professional Type Supports** **1. Social Workers/Case Manager** **2. Counseling/Therapy** **3. Financial Supports/Subsidy** **47% Relied On Natural, Non-Professional Type Supports** **1. Family** **2. Friends** **3. Support Groups**

In order to find out more about the kinds of natural supports caregivers were seeking, they were asked the following open-ended question as part of the regular 6-month telephone interview: "Sometimes when a family experiences stress or problems, family members receive important natural supports from friends, other family members/relatives and or others in the community. Natural supports are types of support that you receive on a regular basis that are not provided by a professional person or agency. In the past six months, have you had the need to seek natural supports from friends, other family members/relatives and or others in your community?"

Table 50
Percent of Respondents Who Routinely Access Natural Supports Total Sample Results
December 2004

6 Months in Study	**78%** **(n=165)**
12 Months in Study	**78%** **(n=125)**
18 Months in Study	**78%** **(n=101)**
24 Months in Study	**78%** **(n=70)**
30 Months in Study	**79%** **(n=48)**
36 Months in Study	**82%** **(n=33)**
42 Months in Study	**84%** **(n=21)**

A majority of caregivers reported that they accessed natural supports. In order to find out which types of natural supports were used primarily, a total of 1,230 responses were analyzed and types of supports were coded and counted.

1. **Family Members**: 44% of the respondents identified a family member, other than the spouse or partner, from which the caregiver routinely received support.

2. **Friends**: 32% of the respondents identified a friend from whom the caregiver routinely received support.

3. **Church/Pastoral**: 8% of the respondents identified the church as a source of support.

4. **Support Group**: 8% of the responses identified either a foster parent or adoptive parent support group as their natural source of support.

5. **Other Supports**: The remainder of the responses, approximately 9% of all responses, included the following sources of support: neighbors, school, other foster parents, spouse, co-workers, other caregiver/parent.

3. BARRIERS FAMILIES EXPERIENCE IN RESPONDING TO CHILD'S NEEDS

Caregivers were asked the following question as part of the regular telephone interview: "In the last six months, what would you say has been the biggest barrier to you in your attempts to deal with these things (child's needs)?" The following results are from an analysis of the respondents from all Cohorts. This initial analysis consisted of coding and counting similar responses across all four points in time. There were a total of 747 comments that were analyzed and coded, 334 from Cohort 1, 250 from Cohort 2, 130 from Cohort 3, and 33 from Cohort 4. There were 155 respondents (21%) who indicated that there were no barriers. The most common barriers noted related to:

1. **Child's Behavior**: 21% of all barriers were about the child's own issues as a barrier – not something external to the child of family.

2. **Lack of Accurate Information**: 12% of all barriers concerned a parent lacking sufficient information and nearby resources to respond effectively to the child's need.

3. **Self-Doubt – Inadequacy**: 11% of all barriers described what appeared to be concerns from the parents about their own ability to deal effectively with the child's needs.

4. **Time**: 8% of all barriers concerned the lack of time parents had to deal with the child's needs; often due to full-time employment.

5. **School Related Issues**: 6% of parents noted that school personnel and programs were a barrier to meeting the child's needs.

6. **Medical issues**: 5% of parents described that the child's current medication, need for medication and/or medical services were among the main barriers.

7. **Contacting Agencies:** 3% of parents mentioned difficulties contacting or obtaining information from the agencies involved.

8. **Funding**: 3% of all barriers indicated were related to the family's financial issues.

Other barriers mentioned included: lack of energy, lack of timely responsiveness from the state adoption agency, dealing with insurance agencies and difficulties in contacts with birth family.

When analyzed over time, the percentage of families who reported "no barriers" decreased. At 12 months, Lack of Accurate Information ranked first, followed by No Barriers. At 24 months, Lack of Support ranked first, followed by Lack of Accurate Information, Time, Child's Behavior and No Barriers.

CHAPTER IV – OUTCOMES

A. DESCRIPTION OF ANALYSES

This chapter presents results on the select outcome variables tracked for this study. Basically answering the question, are the results from the Guided Services group different than those findings from the Standard Services group? The changes over time on continuously distributed outcome variables were compared between treatment (Guided Services) and comparison (Standard Services) groups using a repeated measures design. The periods of observation were Baseline, and every six months until the end of study – 42 months. Outcomes were measured for both family and child level variables for those in the study for at least 24 months (2 years). Beyond that period of time, analysis was conducted dependent upon sufficient sample size. Of particular interest in these models are the F tests for the interaction of treatment group and time as these answered the question of whether the change in the outcome variable over time, if any, differed between treatment (Guided) and control (Standard) groups. For all models, the nature of any significant interactions are characterized as ordinal versus disordinal through plotting techniques. Examination of these plots allowed conclusions to be drawn regarding whether or not a significant interaction indicated a beneficial effect of the Guided Services model. For categorically distributed outcome variables, non-parametric tests were used in the analysis.

Process analyses indicated that there was no significant difference over time in terms of the quality of the intervention; participants in Cohort I were getting a similar type or quality of intervention compared to participants in Cohort II, III and IV. Therefore, these results were interpreted as measuring changes to outcome variables based on length of time in study irrespective of membership to cohort. The following tables provide sample sizes for the analyses. There are slight differences in actual sample size depending upon how missing data is handled; for example, for repeated measures analysis conducted with SPSS, any missing data for a single period of observation excluded that entire case for the analysis.

Table 51
Sample Size by Length of Time in Study
December 2004

TIME IN STUDY	GUIDED SERVICES (E)	STANDARD SERVICES (C)	Totals
Baseline	Child: n = 278 Family: n = 149	Child: n = 221 Family: n = 124	Child: n = 499 Family: n = 273
6 Months	Child: n = 226 Family: n = 124	Child: n = 166 Family: n = 95	Child: n = 392 Family: n = 219
12 Months	Child: n = 170 Family: n = 91	Child: n = 129 Family: n = 73	Child: n = 299 Family: n = 164
18 Months	Child: n = 138 Family: n = 71	Child: n = 105 Family: n = 59	Child: n = 243 Family: n = 130
24 Months	Child: n = 102 Family: n = 54	Child: n = 61 Family: n = 38	Child: n = 163 Family: n = 92
30 Months	Child: n = 69 Family: n = 37	Child: n = 41 Family: n = 27	Child: n = 110 Family: n = 64
36 Months	Child: n = 41 Family: n = 20	Child: n = 28 Family: n = 18	Child: n = 69 Family: n = 38
42 Months	Child: n = 22 Family: n = 12	Child: n = 19 Family: n = 13	Child: n = 41 Family: n = 25

B. RESULTS

The following tables and charts show results based on reports by the same, predominately female, caregiver at one a point in time – and then repeated approximately every six months. No single one of these results precisely indicates the status of a family or child, they are approximations at best. The intent is that taken together, these results help to build a mosaic of the lives of children and families after adoption. For each instance of statistical significance, an explanation is provided. There were no statistically significant differences at baseline between the two groups on any outcome variable. This finding supports the function of the randomization process in establishing the intervention and control groups.

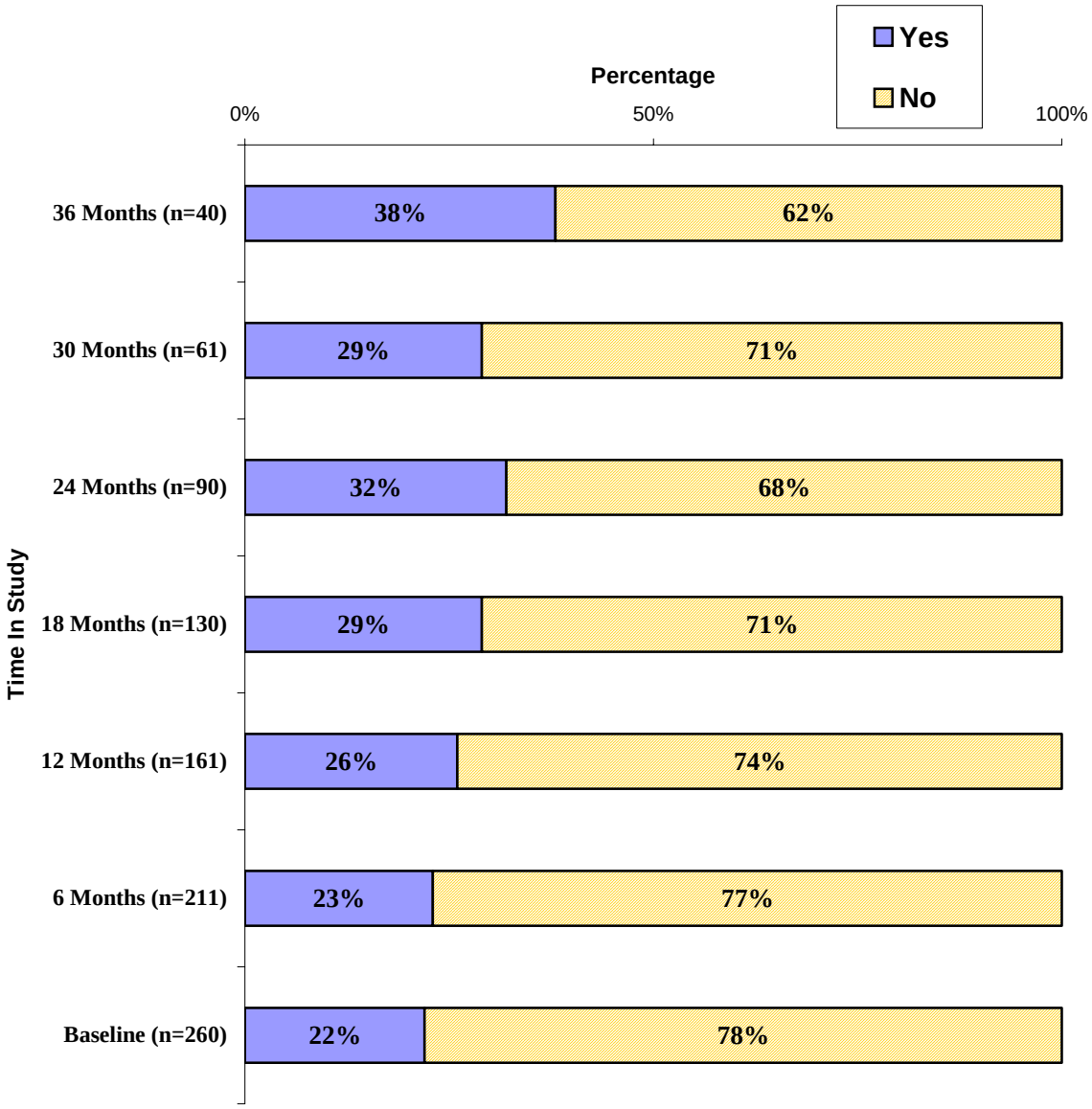
1. FAMILY LEVEL VARIABLES

a. Health Status of the Primary Caregiver

Members of the Parent Advisory Group to the research requested that 'parent stress/health' be considered in the analysis. One question that was asked of parents was, "In the past six months, do you think you had any physical or emotional health problems due to any stress caused by the adopted child/children being part of your family?" The following chart summarizes the responses to that general question. As time went on, a greater percentage of respondents indicated that they were experiencing negative impacts to their health that they attributed to stress related to caring for the adopted child. For

those in the study for at least 24 months, on average 32% reported a negative impact on their physical and or emotional health.

Chart 22
Parenting Stress Negative Impact on Health - All Respondents
December 2004



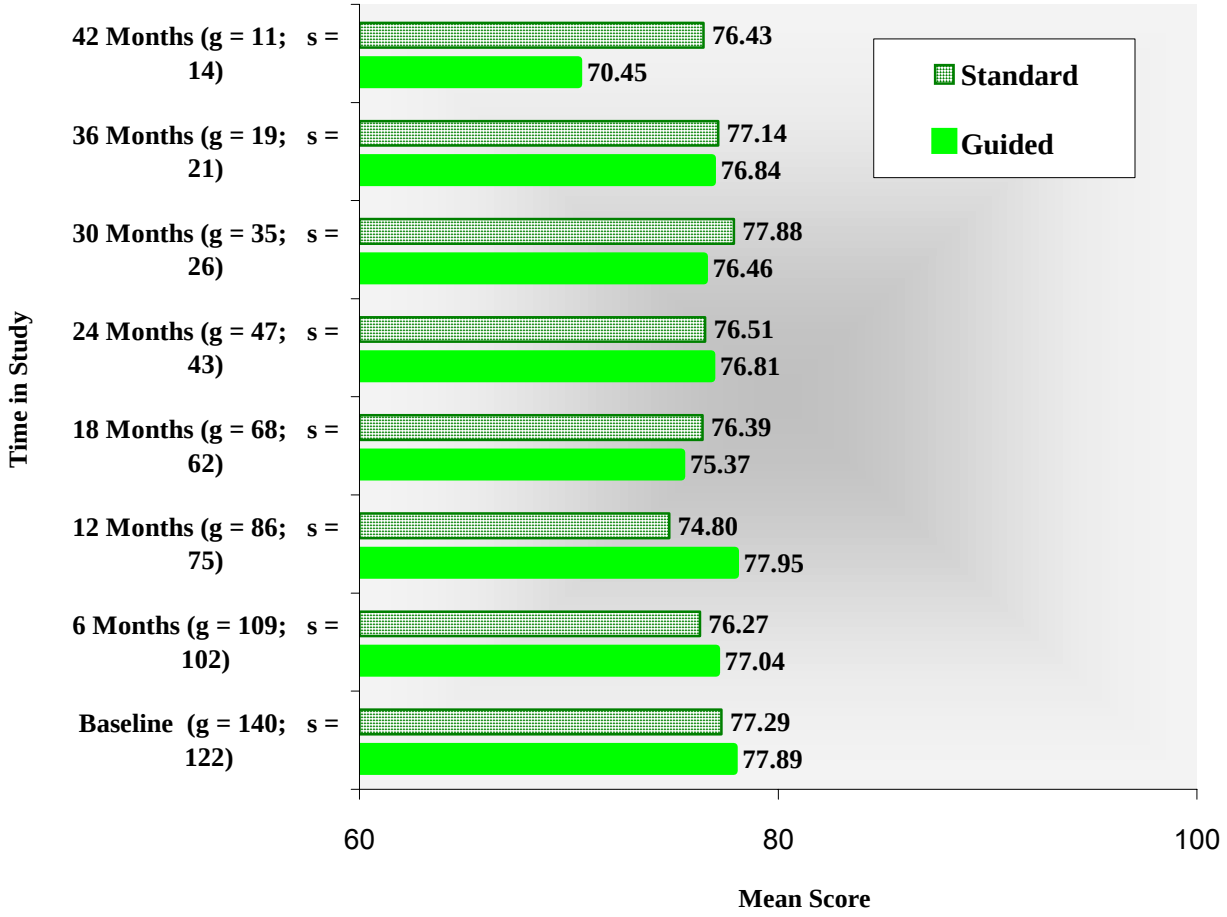
The Rand 36 – Item Health Survey 1.0 (1993) was also used to measure this outcome, Parent Health status. This instrument measures eight aspects of health concepts: physical functioning, bodily pain, role limitations due to personal or emotional problems, emotional well-being, social functioning, energy/fatigue, and general health perceptions.

The following results display total mean scores for the two groups on these eight domains. There were no significant statistical differences between groups over time.

Chart 23

Parent Health: General Health
December 2004

A higher (top score equals 100) score defines a more favorable health state.



A high score defines a more favorable health state and the general health scale consists of responses to the following items:

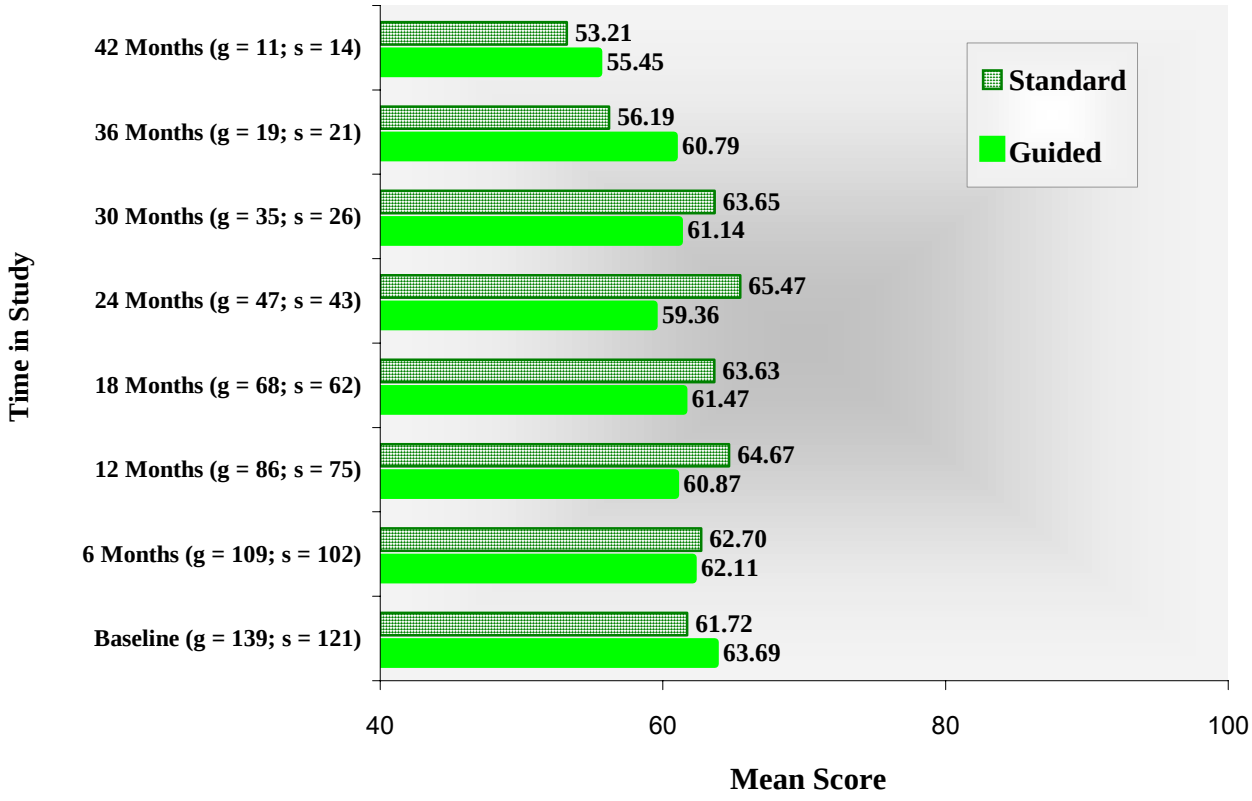
- Rating of overall general health
- Get sick more/less than others
- As healthy as others
- Expect health to get worse
- Rate health as excellent

There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 24

Parent Health: Energy/Fatigue
December 2004

A higher score (top score equals 100) defines a more favorable health state



A higher score defines a more favorable health state. This scale consists of the following types of items:

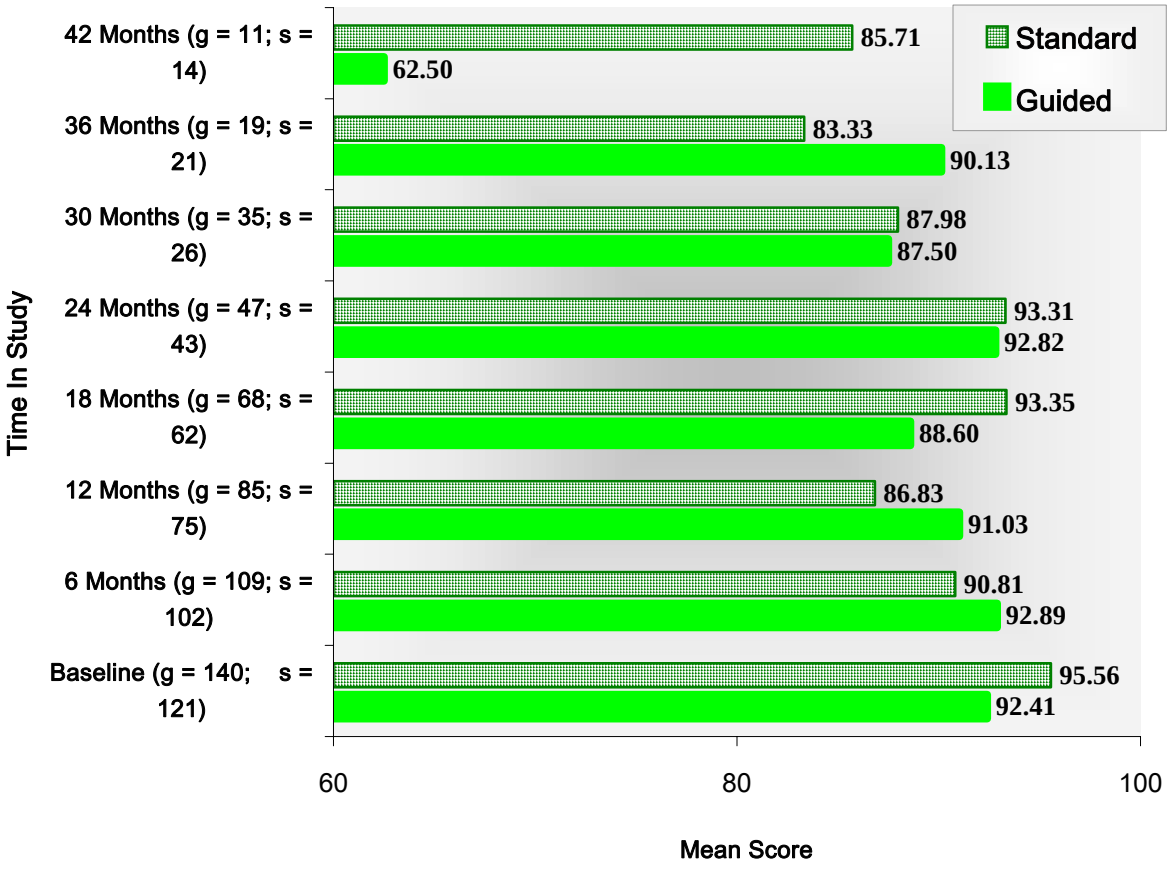
- Feeling "full of pep"
- Having lots of energy
- Feeling worn out
- Feeling tired

There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 25

Parent Health: Social Functioning
December 2004

A higher score (top score equals 100) defines a more favorable health state



A higher score defines a more favorable health state and this scale consists of the following types of items:

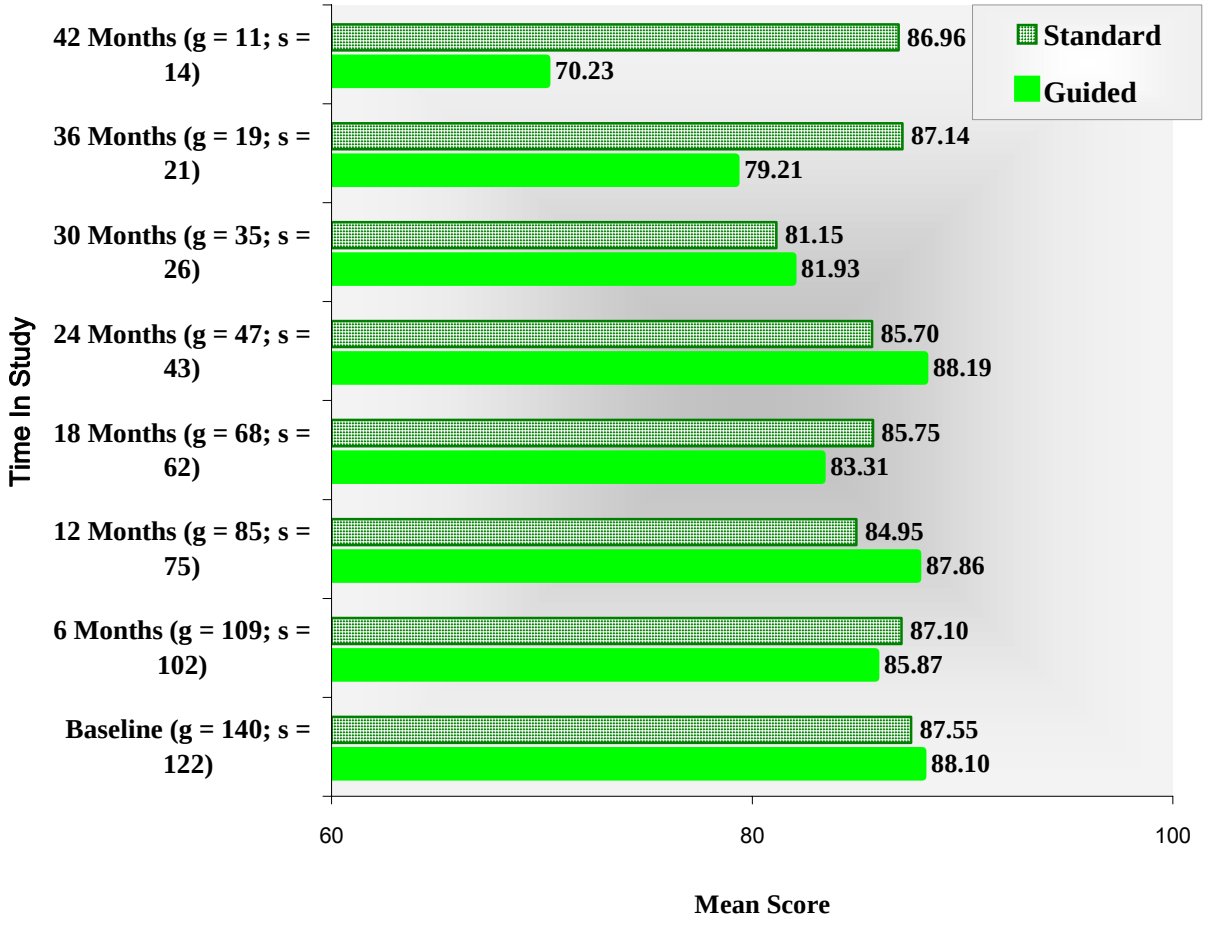
- Extent to which health/emotional problems interfered with normal social activities

There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 26

Parent Health: Physical Functioning
December 2004

A higher score (top score equals 100) defines a more favorable health state



A higher score defines a more favorable health state and this scale consists of the following types of items:

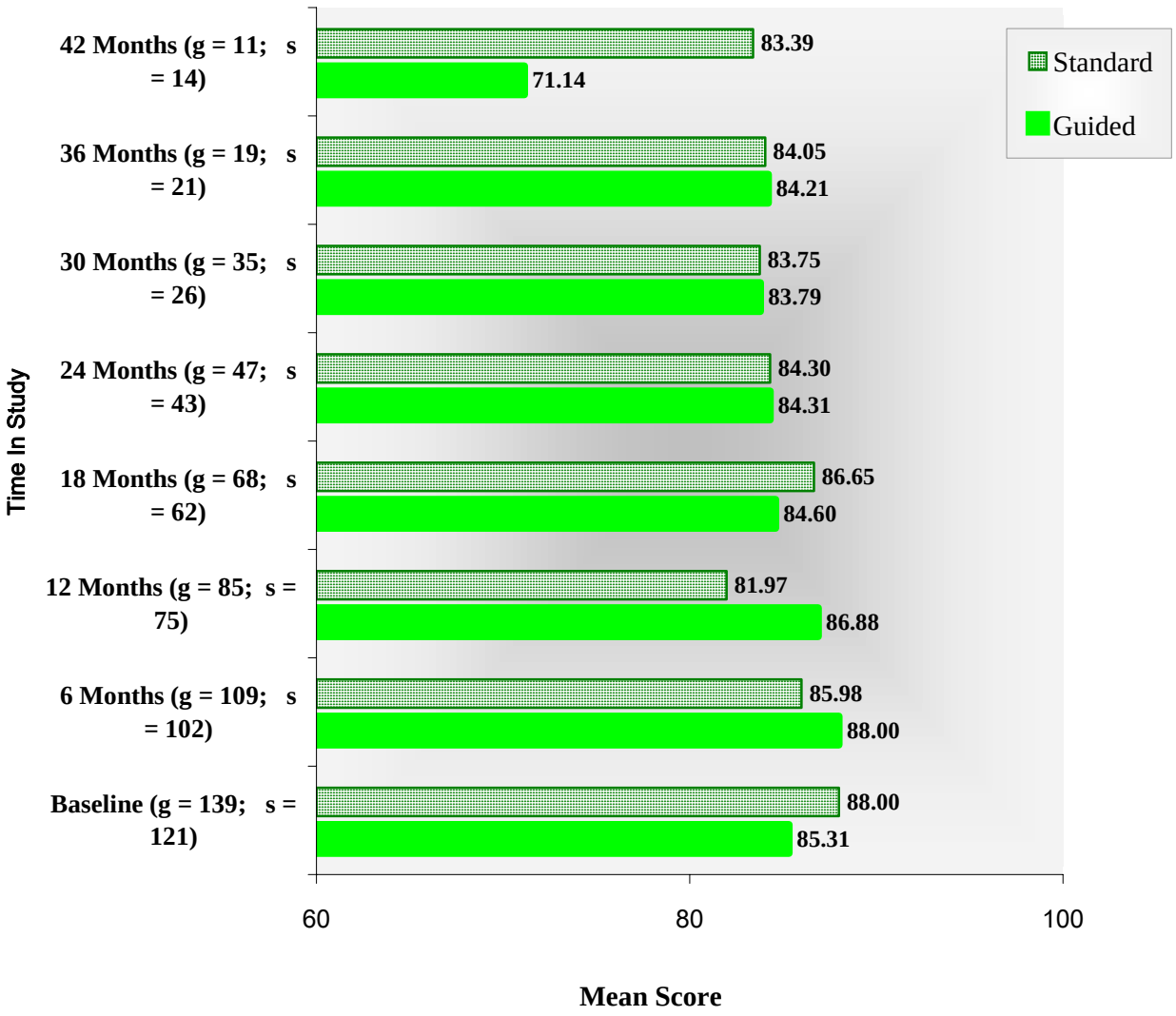
- Vigorous Activities
- Moderate Activities
- Carrying Groceries
- Climbing Stairs
- Bending, Kneeling, Stooping
- Walking
- Bathing/Dressing Self

For this outcome, there was no statistical difference for period of 24 months between the groups.

Chart 27

Parent Health: Physical Pain
December 2004

A higher score (top score equals 100) defines a more favorable health state.



A higher score defines a more favorable health state and this scale consists of the following types of items:

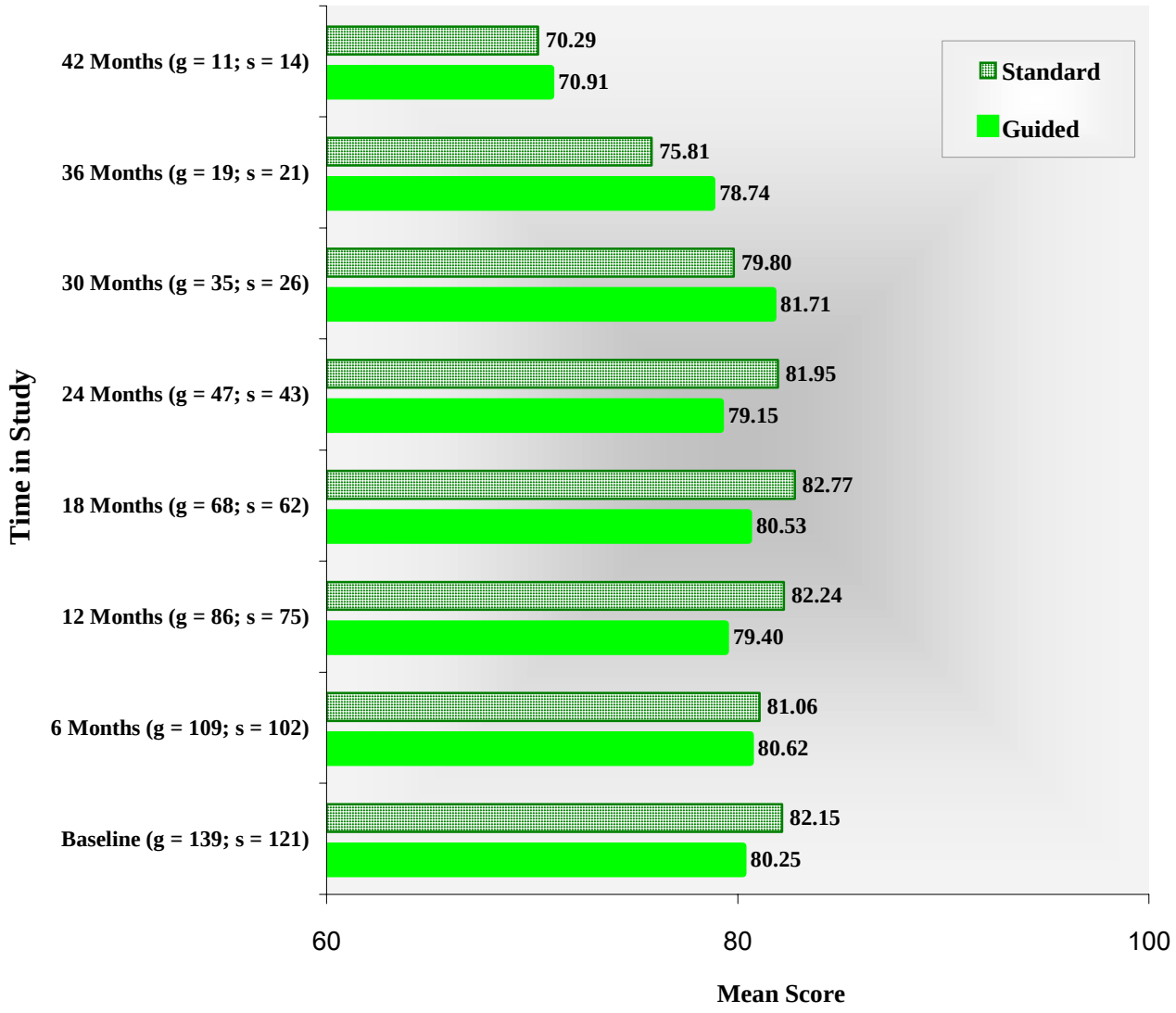
- Amount of bodily pain in past month
- Degree to which pain interfered with normal work

There was no statistical difference for the period of 24 months between the groups.

Chart 28

Parent Health: Emotional Well-Being
December 2004

A higher score (top score equals 100) defines a more favorable health state



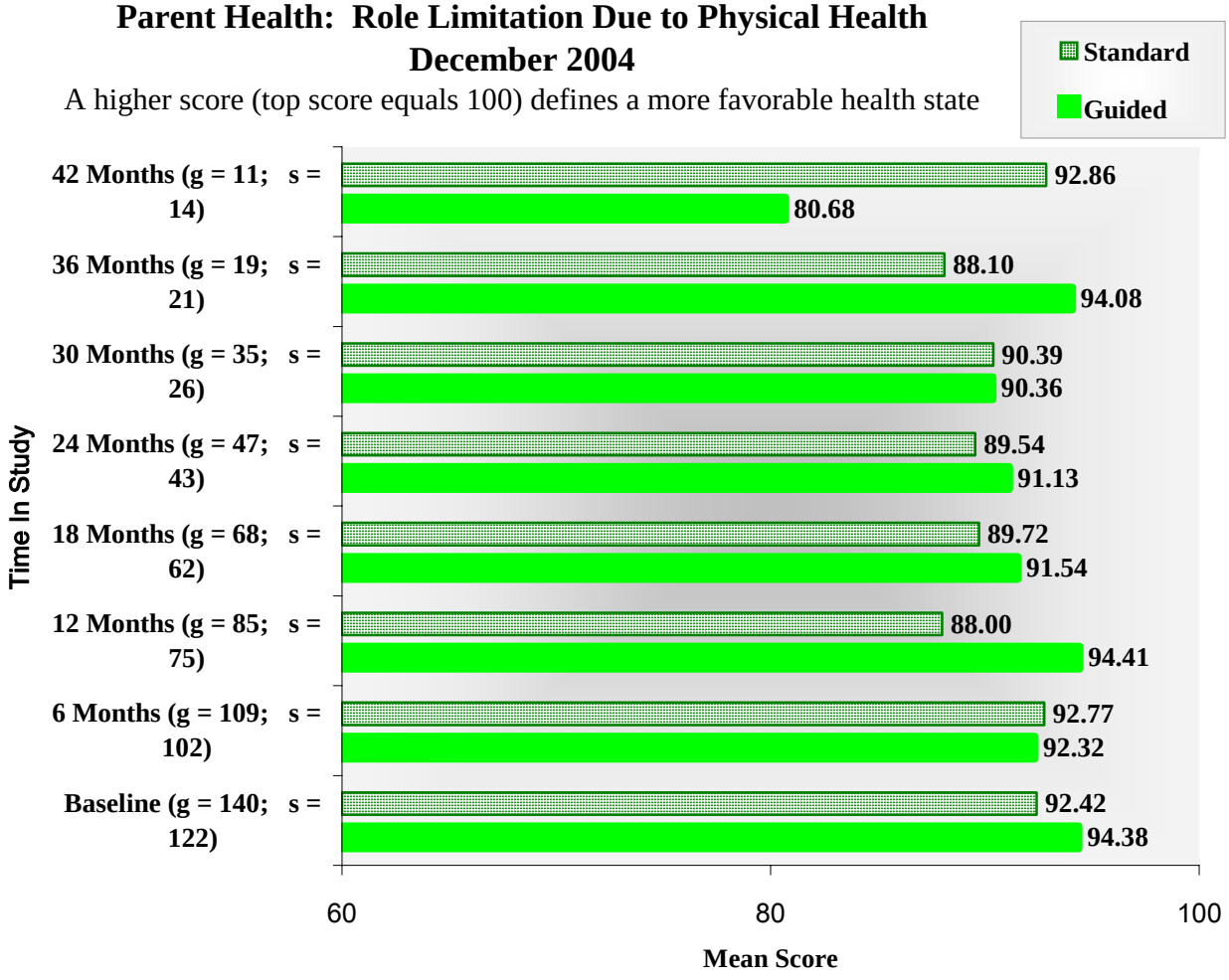
A higher score defines a more favorable health state and this scale consists of the following types of items:

- Frequency of feeling nervous
- Feeling "down in the dumps"
- Feeling "calm and peaceful"
- Feeling "downhearted and blue"
- Feeling happy

There was no statistical difference for period of 24 months between the two groups on this outcome.

Chart 29

Parent Health: Role Limitation Due to Physical Health
December 2004
A higher score (top score equals 100) defines a more favorable health state



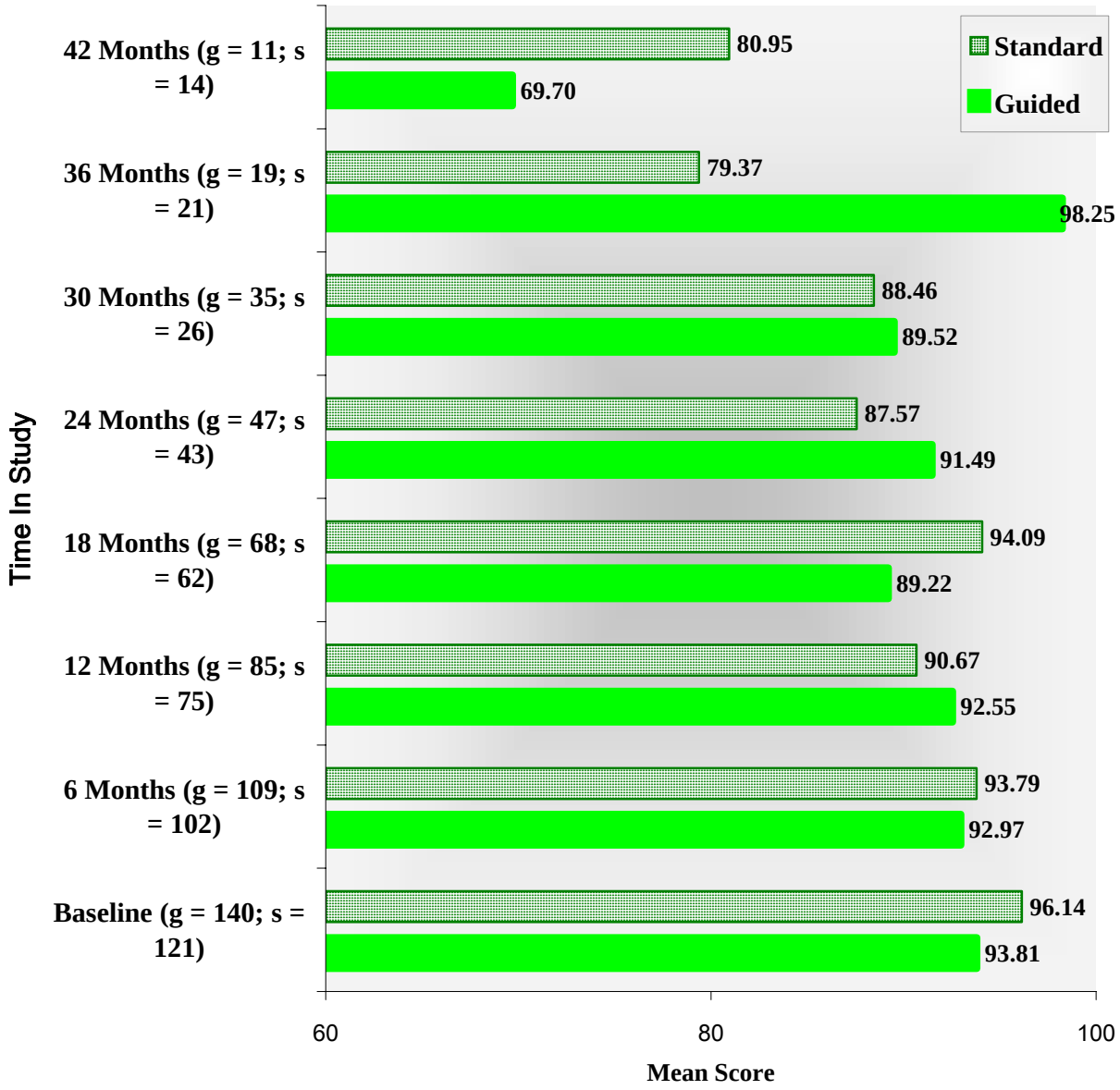
A higher score defines a more favorable health state and this scale consists of items such as:

- Health problems – had to cut down on time on activities
- Health problems – have accomplished less than would like
- Health problems – were limited in kind of work
- Health problems – had difficulty performing tasks

There was no statistical difference for period of 24 months between the two groups on this outcome.

Chart 30

Parent Health: Role Limitation Due to Emotional Problems
December 2004
A higher score (top score equals 100) defines a more favorable health state



A higher score defines a more favorable health state and items that make up this scale include:

- Emotional problems – have had to cut down on activities
- Emotional problems – have accomplished less than would like
- Emotional problems – didn't do work/activities as carefully as usual

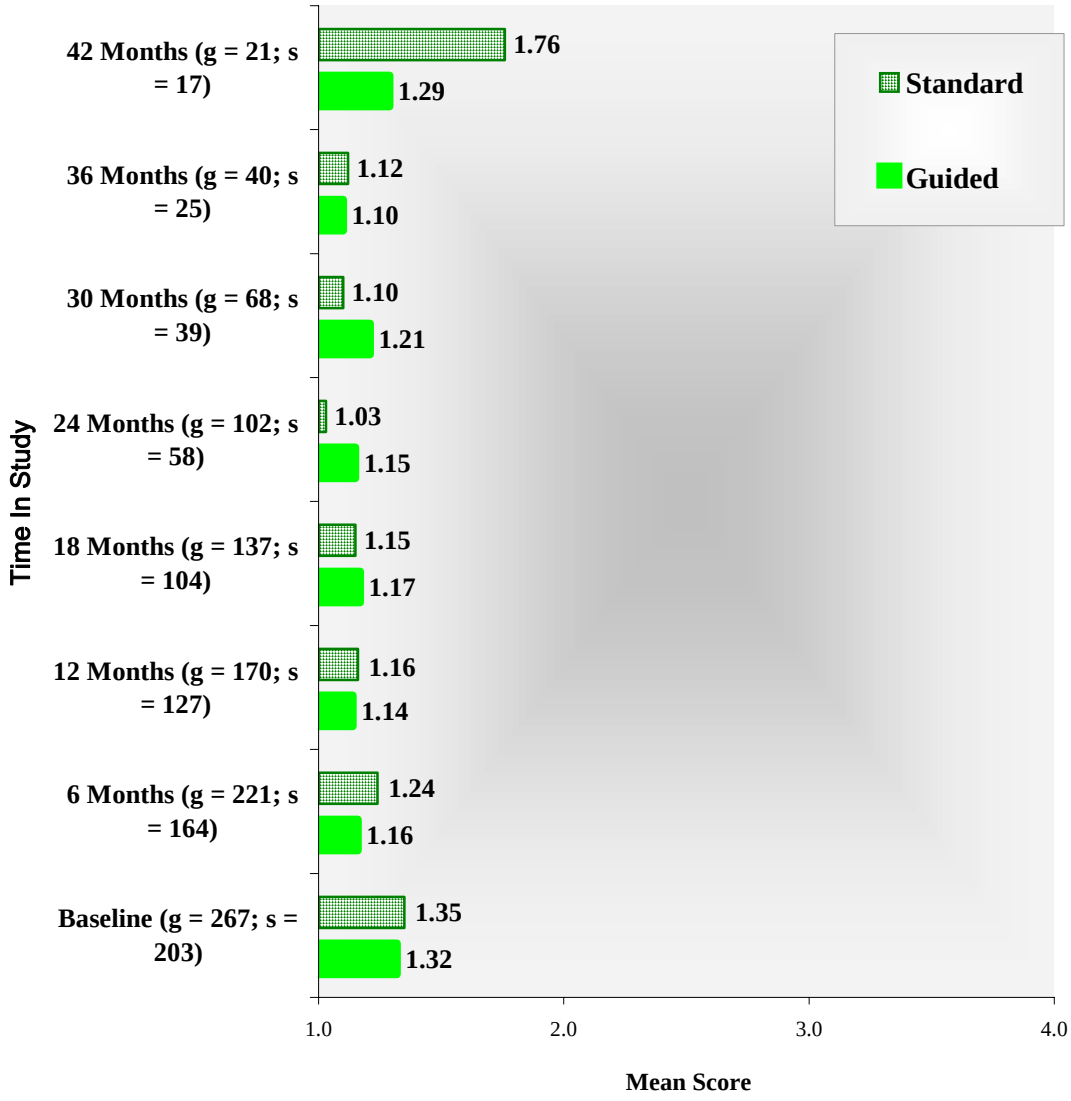
There was no statistical difference for period of 24 months between the two groups on this outcome.

Chart 31

Caregiver Satisfaction With Adoption

December 2004

1 = Strongly Satisfied 4 = Not at All Satisfied



Approximately every six months, caregivers were asked how satisfied they were with the adoption or adoption process to date. There was no statistically significant difference between groups for period of 24 months for this outcome variable. Both groups stated feeling strongly satisfied with the adoption process.

b. Parenting Styles of Adoptive Parents – Authoritarian /Authoritative

Previous research with caregivers post-legalization (Sedlak & Broadhurst, 1993) found that parenting styles or practices were the strongest predictors of adoption outcomes. For this study, two aspects of parenting style were considered, authoritative and authoritarian. Kaufman, Gesten et al (2000) define these concepts as follows: Authoritative parenting style is characterized by the display of affection toward the child, sharing feelings and experiences with the child, respect for and encouragement of the child's independence, as well as supervision of the child, and the establishment of family rules and responsibilities. The Authoritarian scale includes items endorsing restriction of the child's emotional expression, limited involvement of the child in family decisions and the establishment of rules, as well as an emphasis on physical and verbal punishment as a consequence of disobedience.

Cohort One – Baseline Results

For the first year of the study, researchers selected a CRPR instrument that proved to be very cumbersome for parents to complete. The following results are only for Cohort One at baseline; those parents who entered the study in the first year.

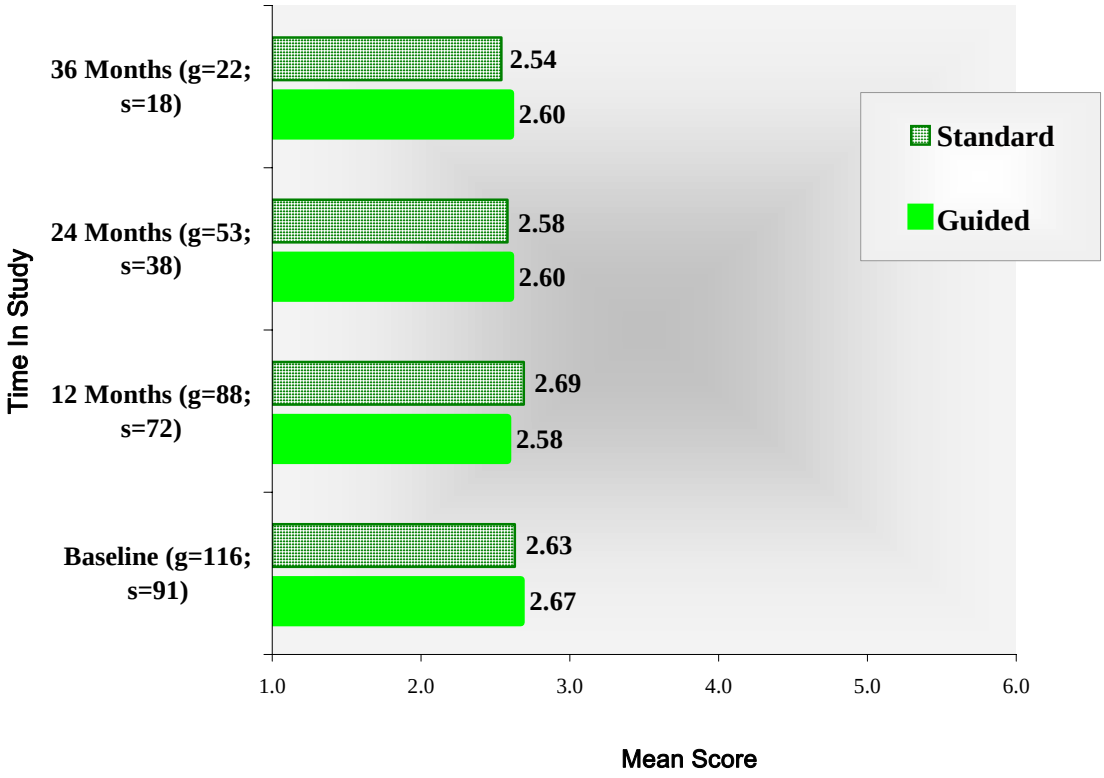
Table 52
CRPR Results – Authoritarian / Authoritative Practices
Cohort One - Baseline
December 2004

	Authoritarian Score (1 = More Authoritarian to 5 = Less Authoritarian)	Authoritative Score (1 = More Authoritative to 5 = Less Authoritative)
Guided Services (n = 31)	**Mean = 3.58 SD = .27**	**Mean = 2.17 SD = .30**
Standard Services (n= 42)	**Mean = 3.52 SD = .29**	**Mean = 2.04* SD = .21**
Total for Cohort One at Baseline (n = 73)	**Mean = 3.55 SD = .28**	**Mean = 2.09 SD = .26**

*These results indicate that this group of parents view themselves as more Authoritative than Authoritarian in their parenting style. Standard Services parents reporting that they are significantly less Authoritative than Guided Services parents at baseline (p = .041).

Chart 32

Parenting Practices: Authoritarian
December 2004
1 = Not Authoritarian 6 = Highly Authoritarian



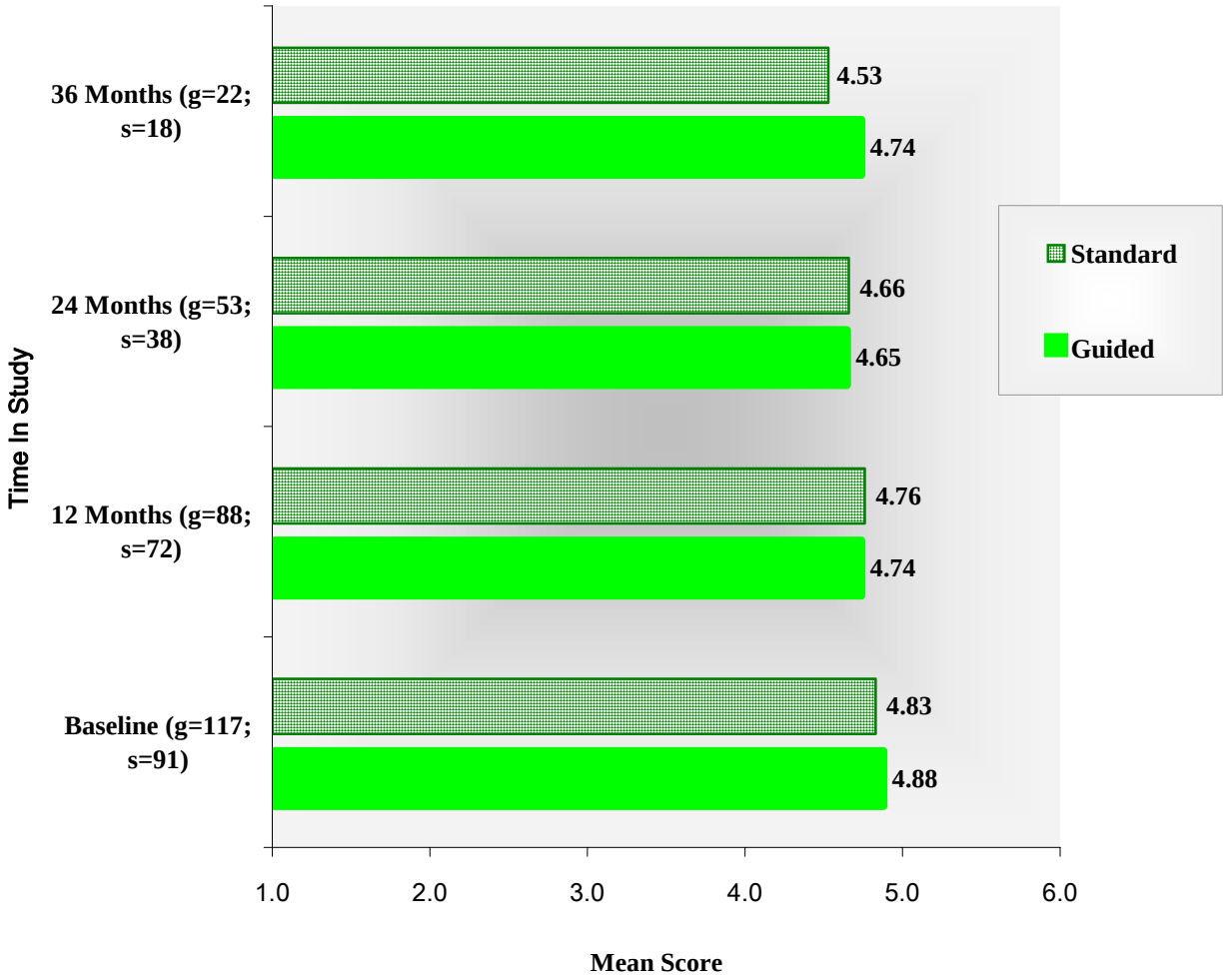
The Authoritarian scale includes items endorsing restriction of the child's emotional expression, limited involvement of the child in family decisions and the establishment of rules, as well as an emphasis on physical and verbal punishment as a consequence of disobedience. This chart displays data from the revised CRPR instrument that had been used from Year Two forward in the study; therefore there are no baseline results for Cohort One, see previous page. These results indicated that parents view themselves as just below mid-range in terms of Authoritarian approaches to parenting practices.

There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 33

Parenting Practices: Authoritative
December 2004

1= Not Authoritative 6 = Highly Authoritative



Authoritative parenting style is characterized by the display of affection toward the child, sharing feelings and experiences with the child, respect for and encouragement of the child's independence, as well as supervision of the child, and the establishment of family rules and responsibilities. This chart displays data from the revised CRPR instrument that was used from Year Two forward in the study; therefore there were no baseline results for Cohort One, see previous page. These results indicated that parents view themselves as predominantly Authoritative in their approaches to parenting practices.

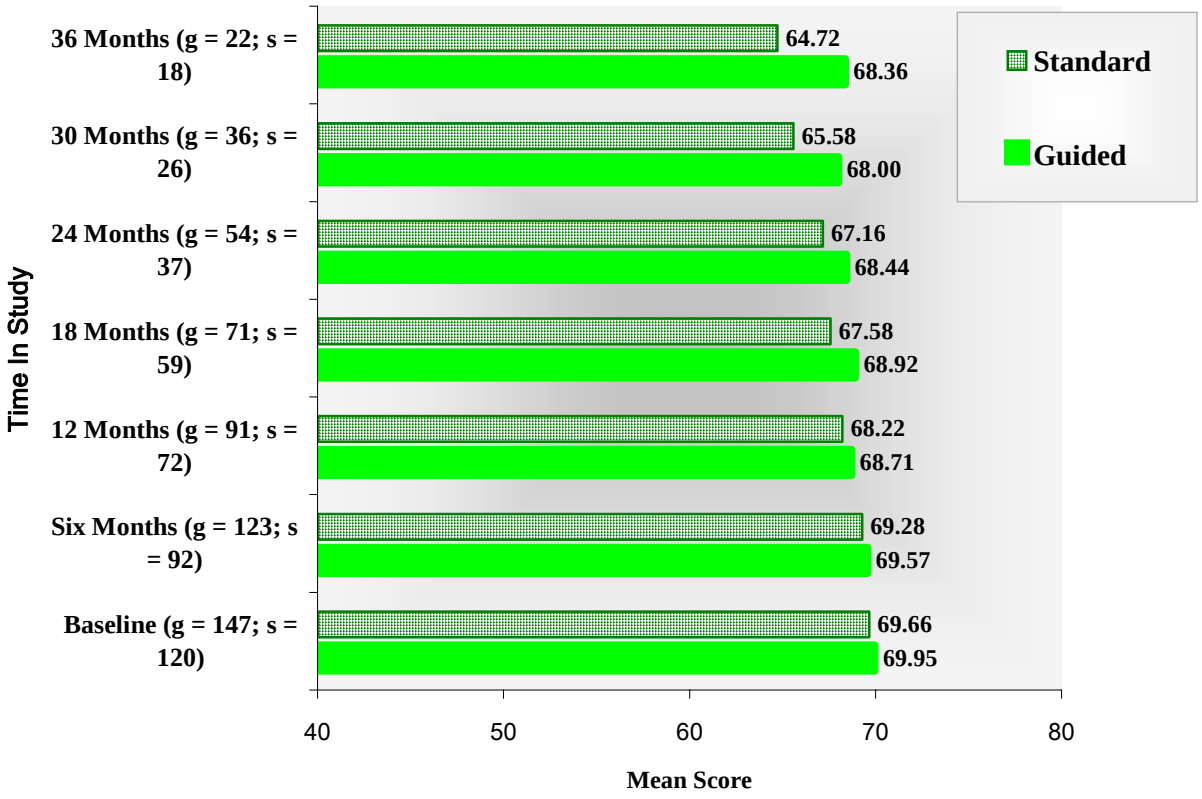
There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 34

Family Cohesion

December 2004

Moderate/Balanced family system scores range from 51 to 70.
Scores over 70 are considered enmeshed and not optimal.



The concepts of Family Adaptability and Cohesiveness are considered important in how families function, and especially in how families integrate a new member – the adopted child. To measure this family system process, the FACES II (Olson et al, 1992) Family Adaptability and Cohesion Scale was used in the study. For this measure, as for all others, the informant was the self-selected primary caregiver to the child. There was no attempt made to get the other spouse/partners assessment of family functioning as is recommended in the use of this measure. This was due to a concern with data collection burden to the family. Family Cohesion is defined as the emotional bonding that family members have toward one another.

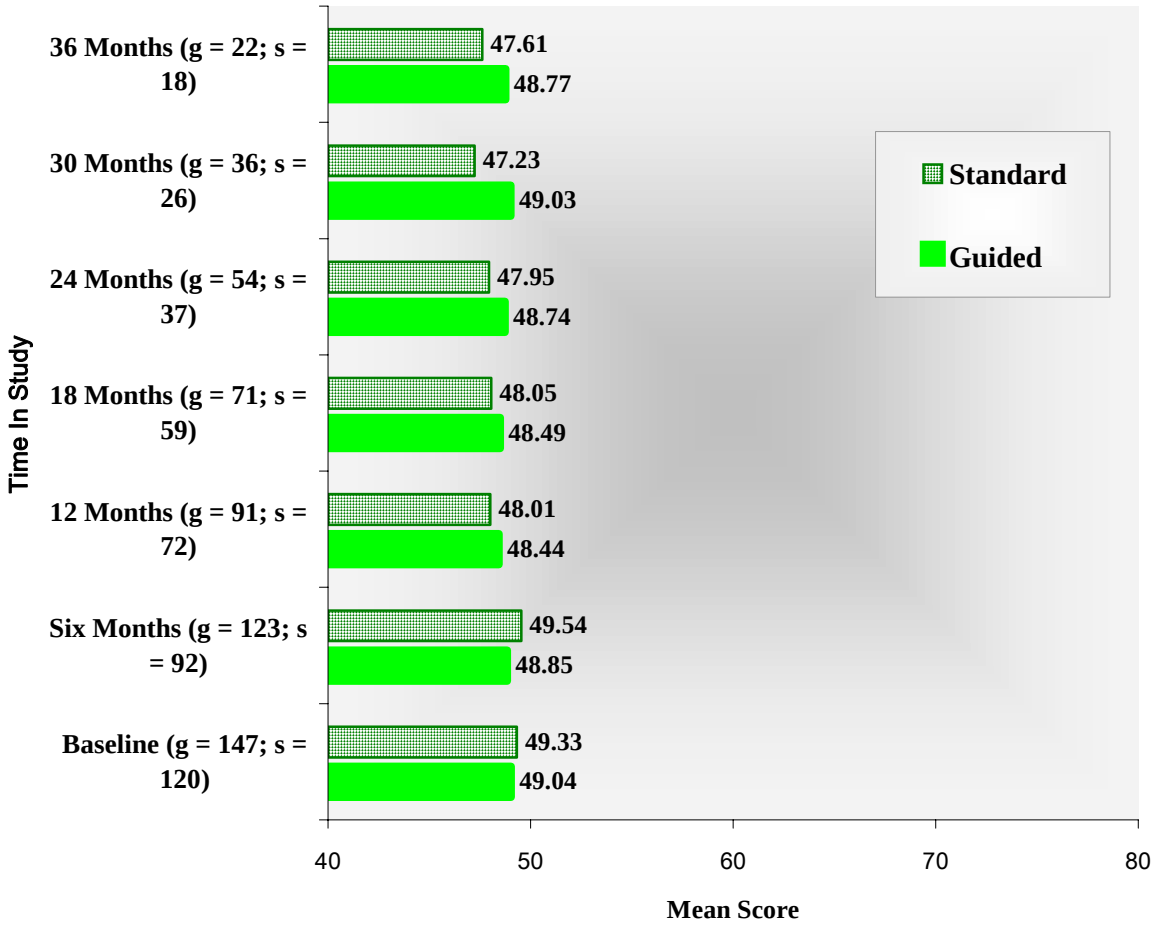
There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 35

Family Adaptability

December 2004

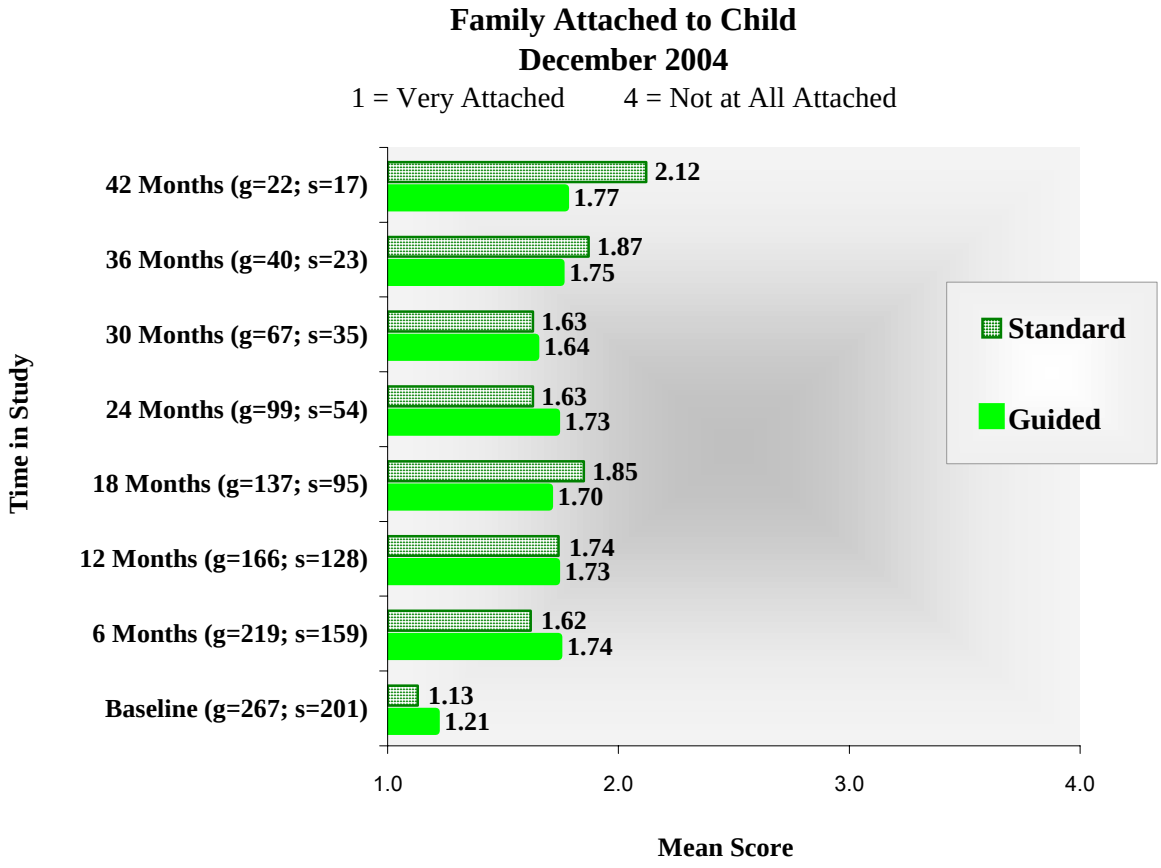
Moderate/Balanced family system scores range from 40 to 54.
Scores over 54 are considered "chaotic" family type and not optimal.



Family Adaptability is defined as the extent to which a family system is flexible and able to change.

There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 36

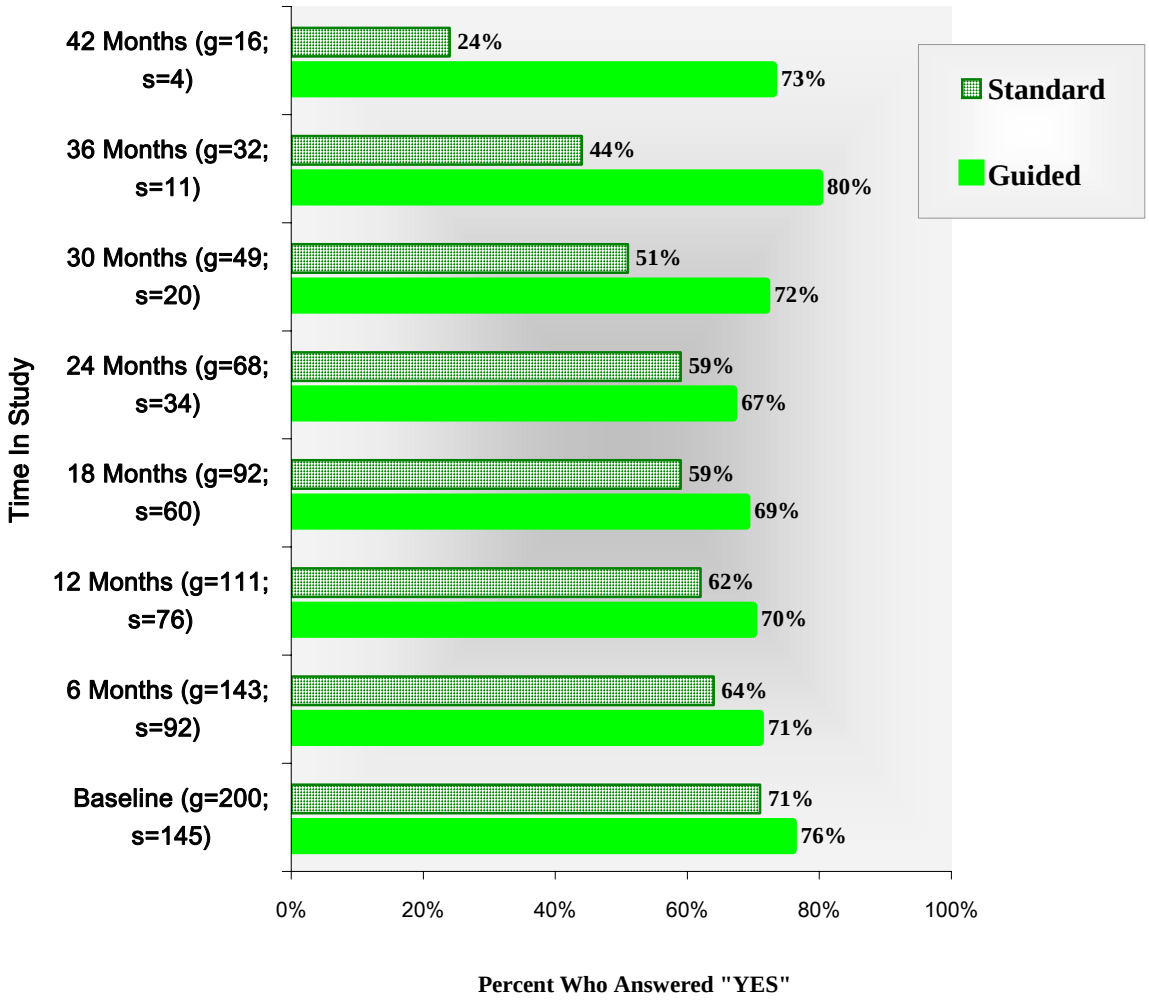


Caregivers are asked, "At the present time, how would you assess household or family members overall attachment to the adopted child(ren)? To what degree are they attached to the child?" Both sets of caregivers appeared to feel that family members were very attached to the adopted child.

There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 37

Percent of Caregivers Who Trust Child
December 2004

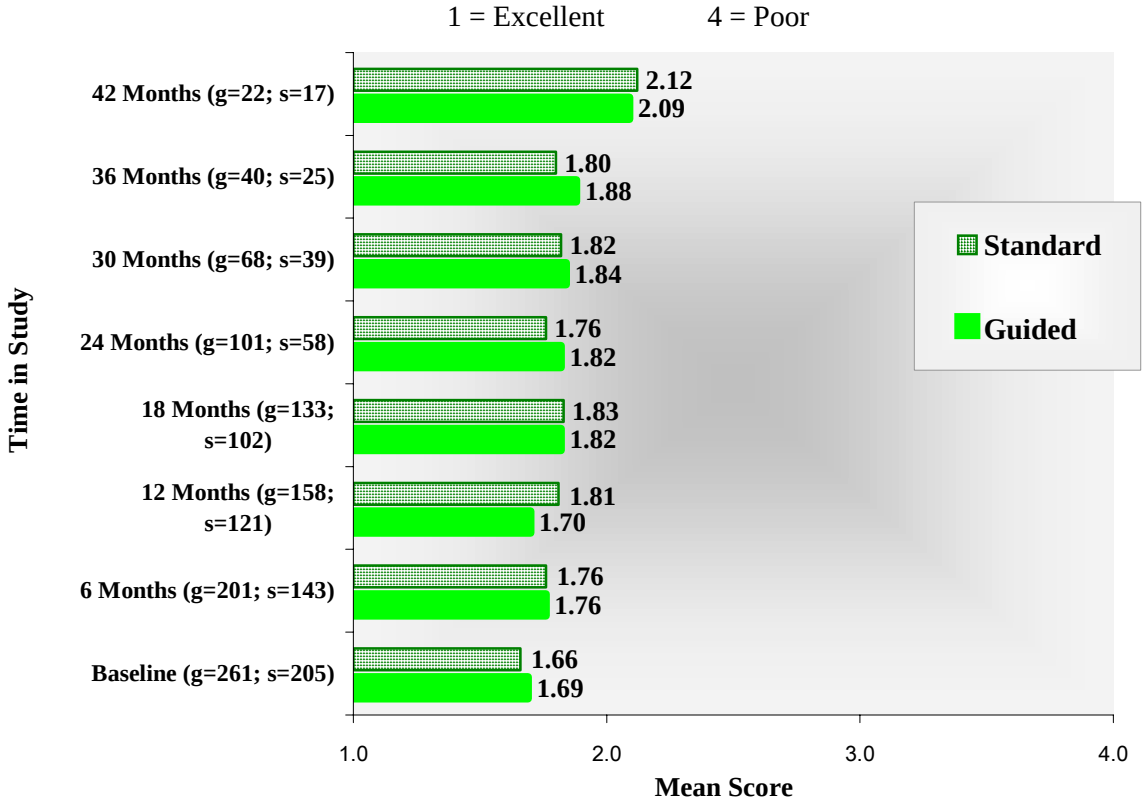


At entry to the study and every six months, caregivers were asked if they trusted their adopted child(ren).

For this outcome variable, at 30 months (chi square 4.67, df=1, p=.031) and 36 months (chi square 8.91, df=1, p = .003) parents in the Guided Services group stated more often that they do trust their child compared to those parents in the Standard Services group.

Chart 38

Parent and Child Communication
December 2004

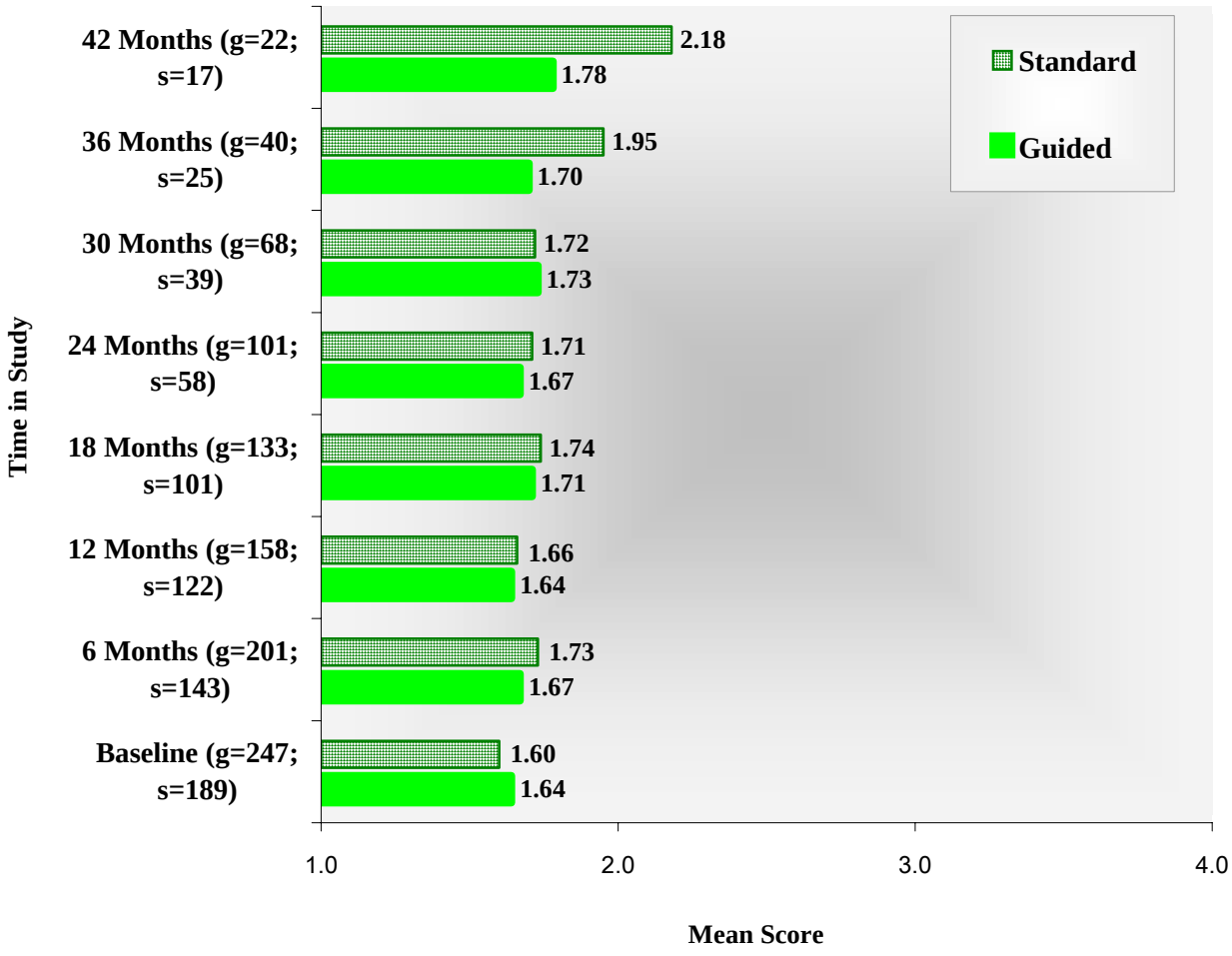


For this outcome variable, caregivers were asked "During the last six months, how would you rate your overall level of communication with your child?" There were no statistically significant between group differences over time for this outcome. The majority of both groups appeared to rate their overall levels of communication between excellent and good.

Chart 39

Frequency of Parent and Child Disagreements
December 2004

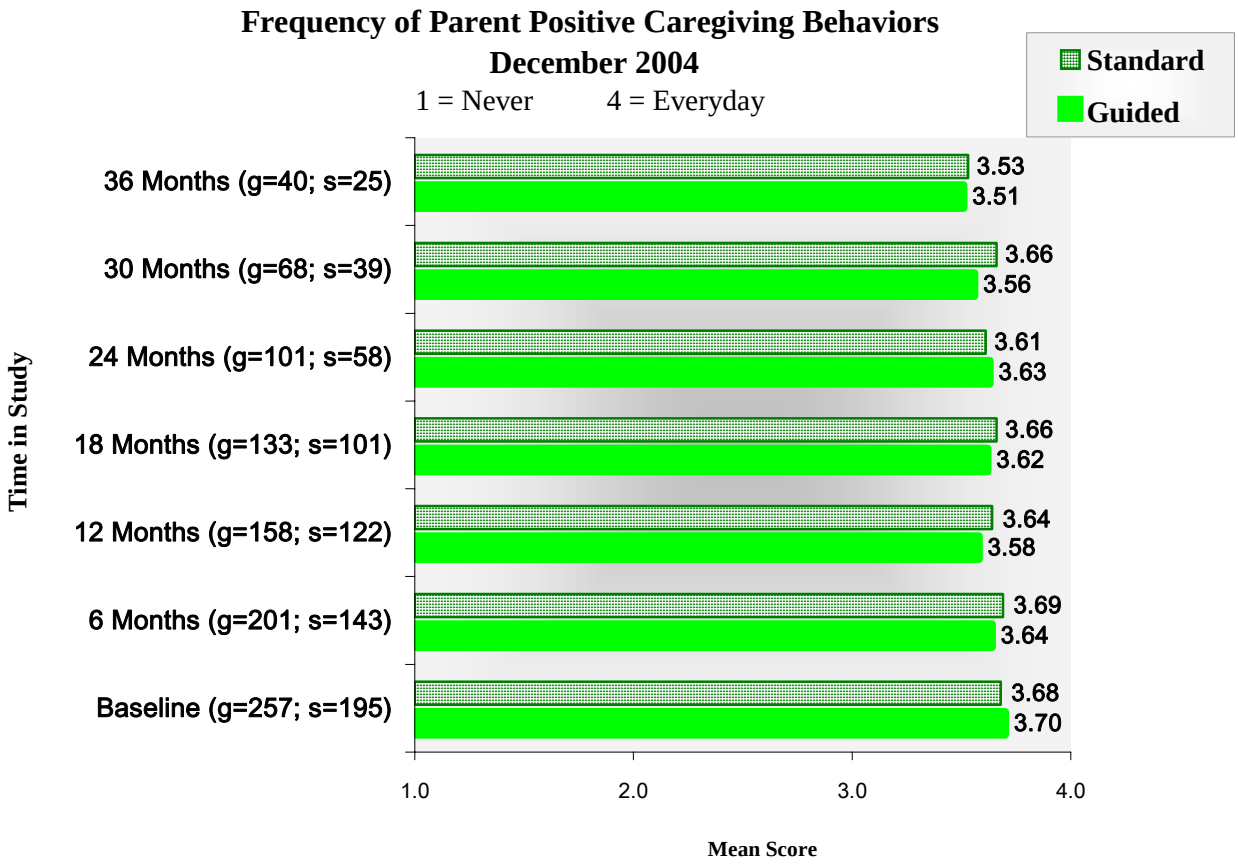
1 = Never 4 = Everyday



Caregivers were asked, "Now I would like to ask you about some of the areas where it is most common for parents and children to have disagreements. Choosing from the following answers, please tell me how often you and the child disagree on each issue." The items were: Spending money; Television; Friendships; Use of Drugs-Alcohol; Sexual behavior; Personal Appearance; Schoolwork and Respect to Parents.

For this outcome variable, there were no statistically significant differences between groups over a period of 24 months. Both groups of caregivers appeared to experience low levels of frequencies of disagreements with their child(ren).

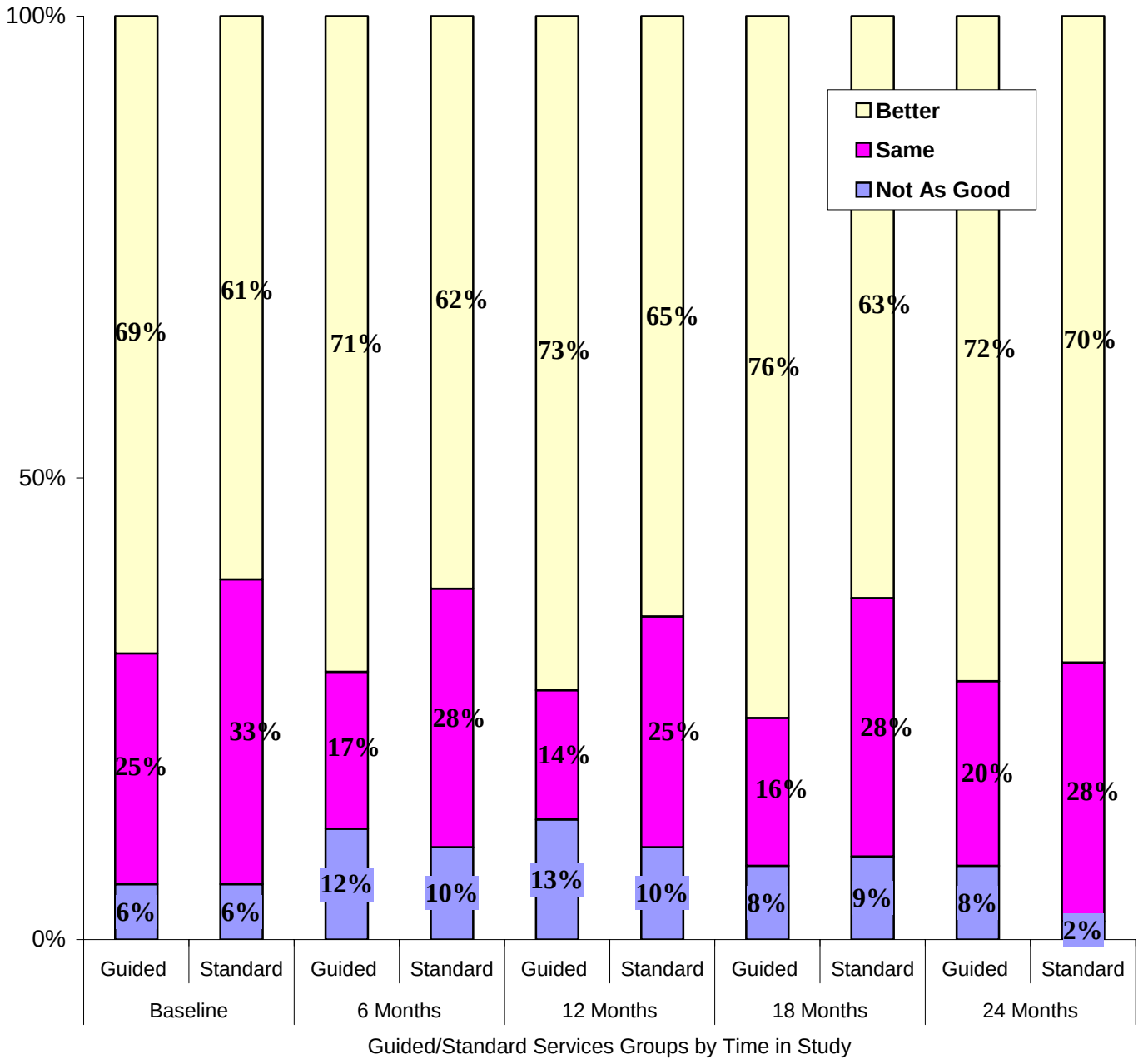
Chart 40



Caregivers were also asked in the past month how often they demonstrated certain positive behaviors to their child(ren). Those behaviors were: Helped with homework; Said nice things to child; Showed that you liked to have child around; Were thoughtful when child was tired; Kissed or hugged child; Comforted child when child had problems and Made child feel loved.

For this outcome variable, there were no statistically significant differences between groups over time. Both groups of caregivers appeared to demonstrate high levels of frequencies of positive care-giving behaviors to their child(ren).

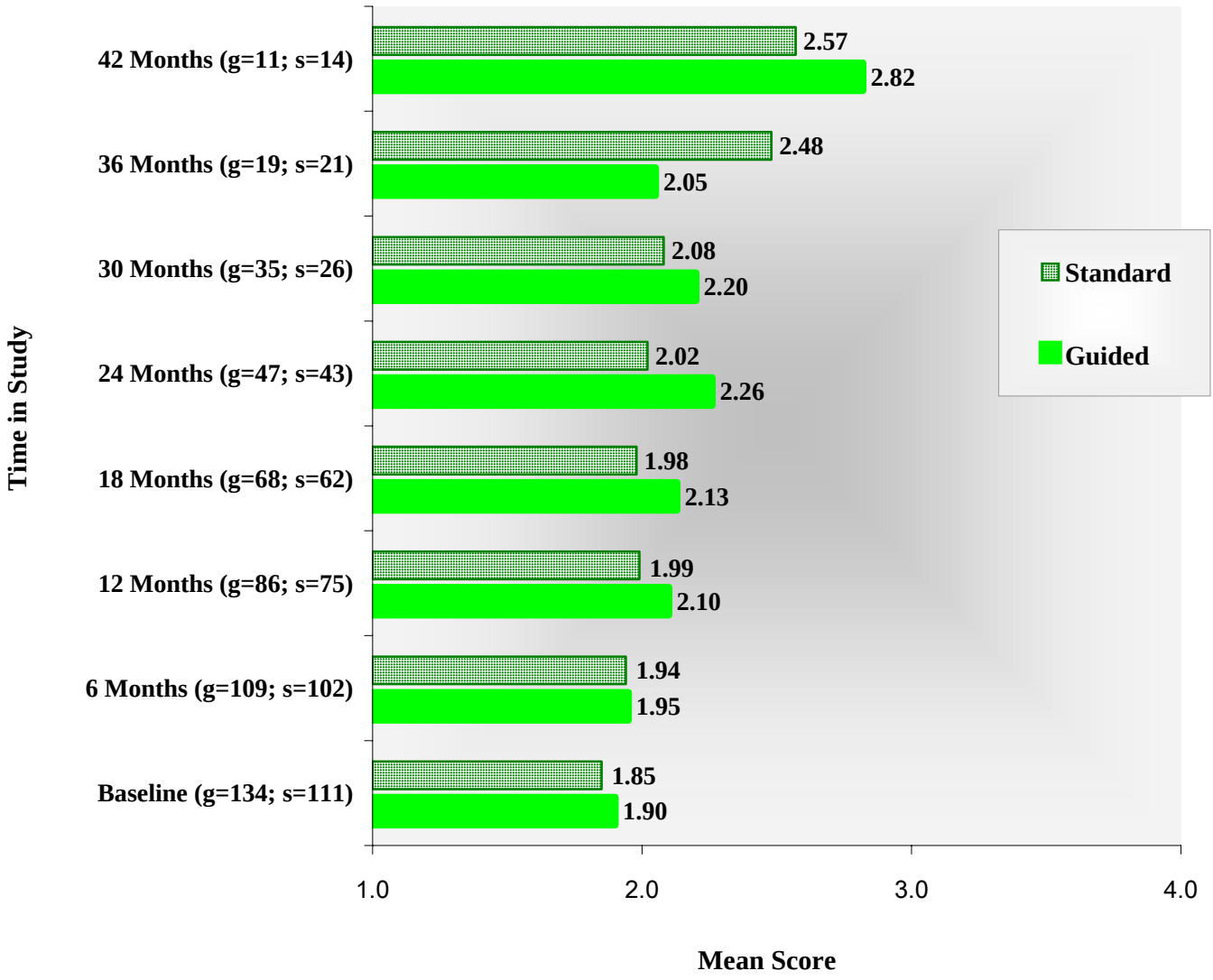
Chart 41
Life Now Compared to Before Child Came to Live with You…Parent Reported
December 2004



Caregivers were asked, "Comparing how things are now in terms of your family life, to how things were before [select child] came to your home, would you say that overall, things are now…?" There was no statistical difference for a period of 24 months between the two groups on this outcome.

Chart 42

Caregiver Report on Overall Quality of Home Life
December 2004
1 = Excellent 4 = Poor



Caregivers were asked to rate their overall quality of home life during the past six months. There were no statistical significant differences over a 24 month period between the two groups on this outcome. Both groups of caregivers appear to rate their home life between Excellent (1) to Good (3).

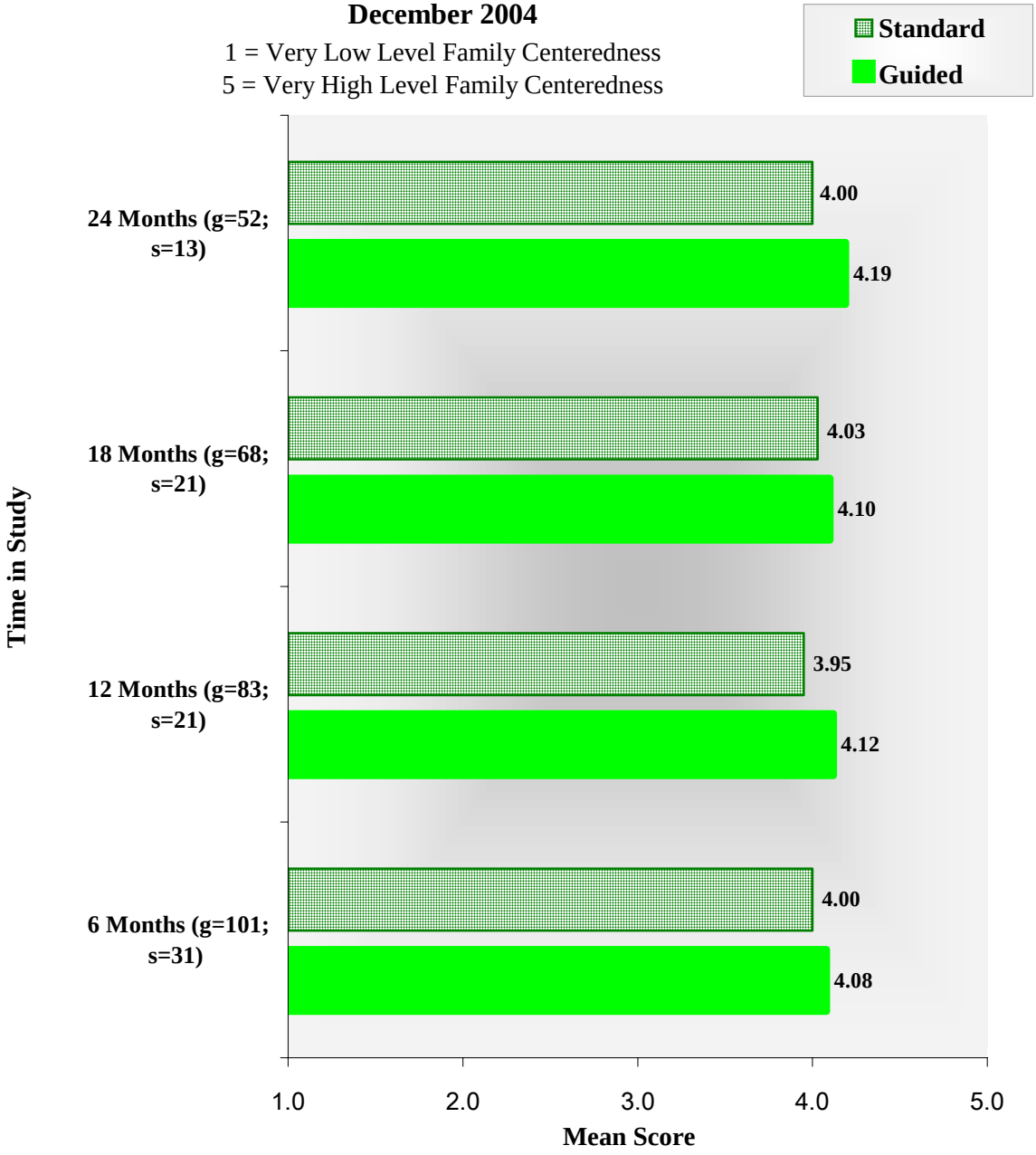
Chart 43

Caseworker Family Centeredness

December 2004

1 = Very Low Level Family Centeredness

5 = Very High Level Family Centeredness



As described earlier in the report, the Guided Services model was implemented with the intent that it be family-centered. The proposition was that the more family-centered the support, the more empowered the family (caregiver) would feel and perhaps be better able to function in support of the family and child. The intent was that the case-

management, family support intervention be done in such a way that it is neither driven solely by the needs of the child nor is it provided from a professional-centered model with the social worker viewed as sole expert on the family. Family-centered models emphasize that children – and adults – grow and develop within family systems. Family-centered service delivery recognizes the centrality of the family in the lives of individuals. For those caregivers who reported receiving regular services from a case-manager, there were no statistically significant differences between groups over time. According to Allen, Petr & Brown (1995) any score of 3 or below indicates practice that is not family-centered.

Of those caregivers who reported receiving case management services, the majority of those respondents reported that their caseworkers provided services in a family-centered manner. In terms of group differences, at 24 months there was a significant statistical difference in scores indicating that families receiving Guided Services were receiving a higher level of family-centered services than those families in the Standard Services group (Kruskis Wallis one-way analysis of variance; chi-square 6.39, df=1, and $p = .012$). The internal consistency of scale items was assessed at each period of observation using Cronbach's alpha coefficient; at baseline in this study (n=135), the alpha coefficient was .945 for all 26 items. At the time period of 24 months in the study, the alpha coefficient was .864 on a 25 item scale with one item, 'Caseworker makes negative judgements', removed from the reliability analysis due to lack of variance. Allen, Petr & Brown (1995) report an alpha coefficient of .974 (n=222) in their development of this 26 item scale.

The tables below illustrate scores on each item of the Family Centered Behavioral Scale for the two groups at 24 months into the study. Due to the small sample size, the nonparametric method Kruskis Wallis one-way analysis of variance, was used to analyze the results. The mean ranks represent all of the scores from the two groups that were then combined and ranked in a single series. The sum of the ranks for each group was computed, then an average rank for each group was computed and a comparison made between the two groups. The results indicated that parents in the Guided Services group reported a significantly higher level ($p < .05$) of Family Centered Behaviors from their caseworker on these four items:

- The caseworker helps us get all the information we want and/or need.
- The caseworker helps us get the help we want from our family, friends, and community.
- The caseworker suggests things that we can do for our child that fit into our family's daily life.
- The caseworker helps my family get services from other agencies or programs as easily as possible.

There were no statistical differences between groups on the other 22 items.

Table 53
Mean Ranks - Family Centered Behavior Scale Scores at 24 Months
December 2004
(Guided Services n = 52, Standard Services n = 13)

FCBS ITEMS *The Caseworker…*	GUIDED SERVICES	STANDARD SERVICES	EXACT SIGNIFICANCE p value…
ACCEPTS OUR FAMILY AS IMPORTANT MEMBERS OF THE TEAM THAT HELPS OUR CHILD.	33.61	28.15	.077
HELPS US GET ALL THE INFORMATION WE WANT AND/OR NEED.	34.82	23.38	.008*
HELPS US GET THE HELP WE WANT FROM OUR FAMILY, FRIENDS, AND COMMUNITY.	33.86	19.33	.003*
BLAMES ME FOR MY CHILD'S PROBLEMS.	31.98	29.50	.578
POINTS OUT WHAT MY CHILD AND FAMILY DO WELL.	33.74	27.65	.228
LISTENS TO US.	33.12	30.08	.510
RESPECTS OUR FAMILY'S BELIEFS, CUSTOMS, AND WAYS WE DO THINGS IN OUR FAMILY.	32.97	30.65	.593
HELPS US DO THE SAME KINDS OF THINGS THAT OTHER CHILDREN AND FAMILIES DO.	29.45	24.15	.301
MAKES IT CLEAR THAT WE AS A FAMILY, NOT THE PROFESSIONAL, ARE RESPONSIBLE FOR DECIDING WHAT IS DONE FOR OUR CHILD AND FAMILY.	32.58	29.77	.607
PLANS MEETINGS AT TIMES AND PLACES THAT ARE GOOD FOR OUR FAMILY.	33.08	30.23	.646
CRITICIZES WHAT WE DO WITH OUR CHILD.	32.53	32.38	.830
TREATS US WITH RESPECT.	32.61	32.08	1.00

Table 53 Continued
Mean Ranks - Family Centered Behavioral Scale Scores at 24 Months
December 2004
(Guided Services n = 52, Standard Services n = 13)

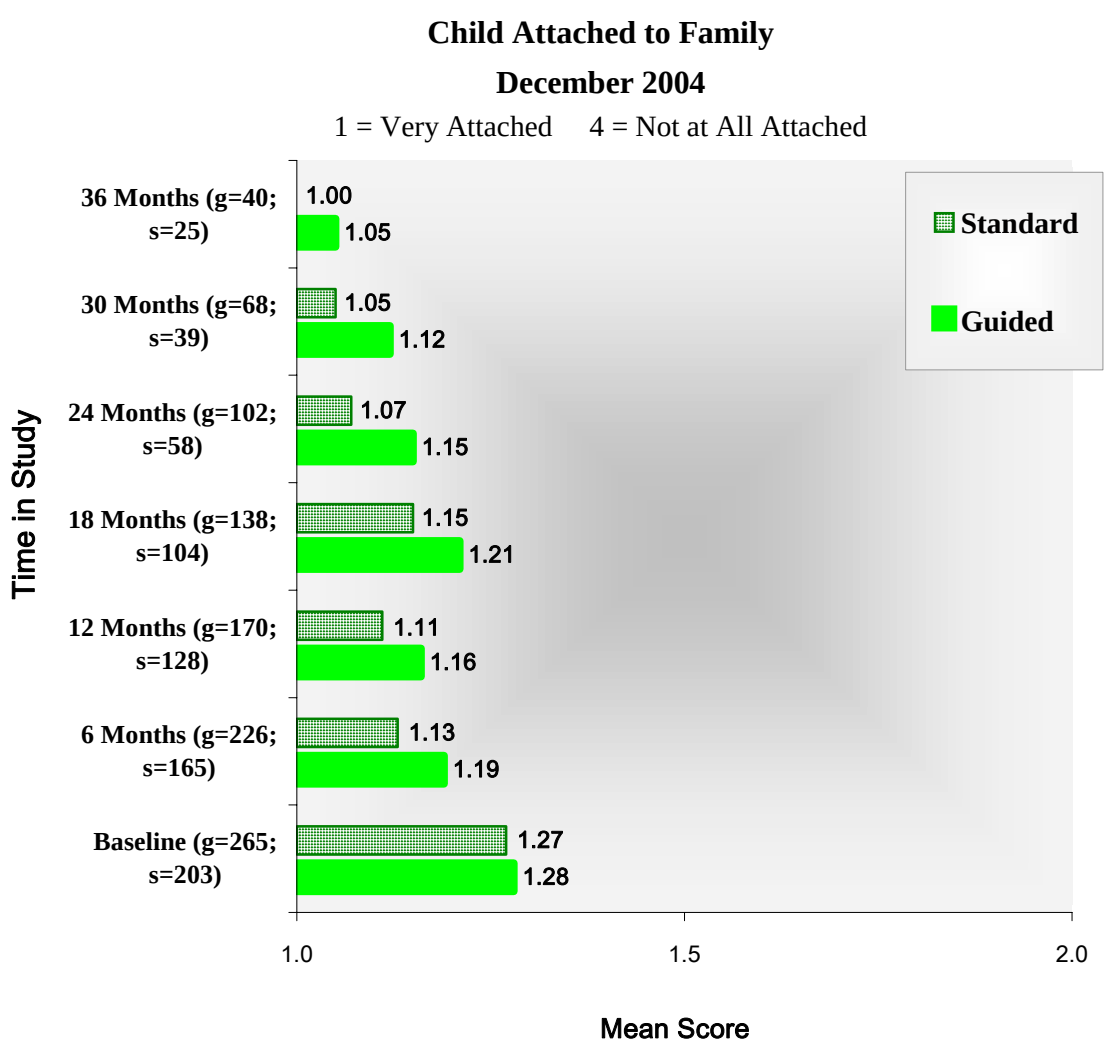
FCBS ITEMS *The Caseworker…*	GUIDED SERVICES	STANDARD SERVICES	EXACT SIGNIFICANCE p value…
MAKES NEGATIVE JUDGEMENTS ABOUT US BECAUSE OF WAYS THAT WE ARE DIFFERENT FROM THE STAFF MEMBER (SUCH AS RACE, INCOME LEVEL, JOB, OR RELIGION).	32.00	32.00	1.00
CARES ABOUT OUR ENTIRE FAMILY, NOT JUST THE CHILD WITH SPECIAL NEEDS.	32.52	32.42	.949
MAKES DECISIONS ABOUT MY CHILD'S CARE WITHOUT ASKING ME WHAT I WANT.	31.92	34.77	.574
HELPS MY FAMILY MEET OUR NEEDS AS WE SEE THEM.	34.57	26.73	.065
SUGGESTS THINGS THAT WE CAN DO FOR OUR CHILD THAT FIT INTO OUR FAMILY'S DAILY LIFE.	32.98	20.54	.003*
UNDERSTANDS THAT I KNOW MY CHILD BETTER THAN ANYONE ELSE DOES.	33.44	28.81	.243
HELPS MY FAMILY GET SERVICES FROM OTHER AGENCIES OR PROGRAMS AS EASILY AS POSSIBLE.	33.68	23.27	.032*
TALKS IN EVERYDAY LANGUAGE THAT WE CAN UNDERSTAND.	32.11	34.04	.683
HELPS OUR FAMILY EXPECT GOOD THINGS IN THE FUTURE FOR OUR CHILDREN AND OURSELVES.	31.45	29.27	.621
MAKES SURE WE UNDERSTAND OUR FAMILY'S RIGHTS.	31.53	33.81	.637
ACCEPTS OUR FEELINGS AND REACTIONS AS NORMAL FOR OUR SITUATION.	32.69	29.35	.376
WANTS TO HEAR WHAT WE THINK ABOUT THIS PROGRAM.	34.00	29.00	.181
SUPPORTS MY MAKING AS MANY DECISIONS AS I CHOOSE TO ABOUT WHAT IS DONE FOR MY CHILD AND FAMILY.	32.69	29.35	.376
ENCOURAGES ME TO SPEAK UP DURING MEETINGS WITH PROFESSIONALS WHEN THERE IS SOMETHING THAT I WANT TO SAY.	29.59	31.63	.595

2. CHILD LEVEL VARIABLES

a. Number of Adoption Dissolutions

During the study period, there were no reported adoption dissolutions. However, anecdotal reports from the State Agency indicated that three of the families that dropped out of the study had left due to adoption dissolutions (one Guided family and two Standard families). This resulted in a dissolution rate of 1% for this study sample. The official state estimate for adoption dissolutions is at 6%.

Chart 44



There was no statistical difference between groups over time. Caregivers in the both groups report a high level attachment of child to family.

b. Child's Level of Mental Health Needs (CBCL Syndrome & Scale Scores)

The sample considered for the analysis of the child functioning variables are in two age categories, younger children age 1 to 5 years and older children age 6 and above. The following table provides approximate totals for each age category used in the analysis unless chart specifically states g (Guided Services Group) = number of children and s (Standard Services group) = number of children. Specific sample sizes varied depending upon age of child at point of data collection.

Table 54
Age Categories
December 2004

Time in Study	Guided Services	Standard Services	Total
Baseline	1 – 5 : 96 6 – 18 : 199	1 – 5 : 82 6 – 18: 146	1 – 5 : 178 6 – 18: 345
6 Months in Study	1 – 5 : 70 6 – 18 : 162	1 – 5 : 55 6 – 18 : 107	1 – 5 : 125 6 – 18 : 269
12 Months in Study	1 – 5 : 40 6 – 18 : 120	1 – 5 : 41 6 – 18 : 79	1 – 5 : 81 6 – 18 : 199
18 Months in Study	1 – 5 : 24 6 – 18 : 96	1 – 5 : 30 6 – 18 : 65	1 – 5 : 54 6 – 18 : 161
24 Months in Study	1 – 5 : 13 6 – 18 : 75	1 – 5 : 11 6 – 18 : 41	1 – 5 : 24 6 – 18 : 116
30 Months in Study	1 – 5 : 7 6 – 18 : 53	1 – 5 : 8 6 – 18 : 27	1 – 5 : 15 6 – 18 : 80
36 Months in Study	1 – 5 : 2 6 – 18 : 32	1 – 5 : 0 6 – 18 : 21	1 – 5 : 2 6 – 18 : 53
42 Months in Study	1 – 5 : 0 6 - 18 : 17	1 – 5 : 0 6 – 18 : 12	1 – 5 : 0 6 – 18 : 29

Chart 45

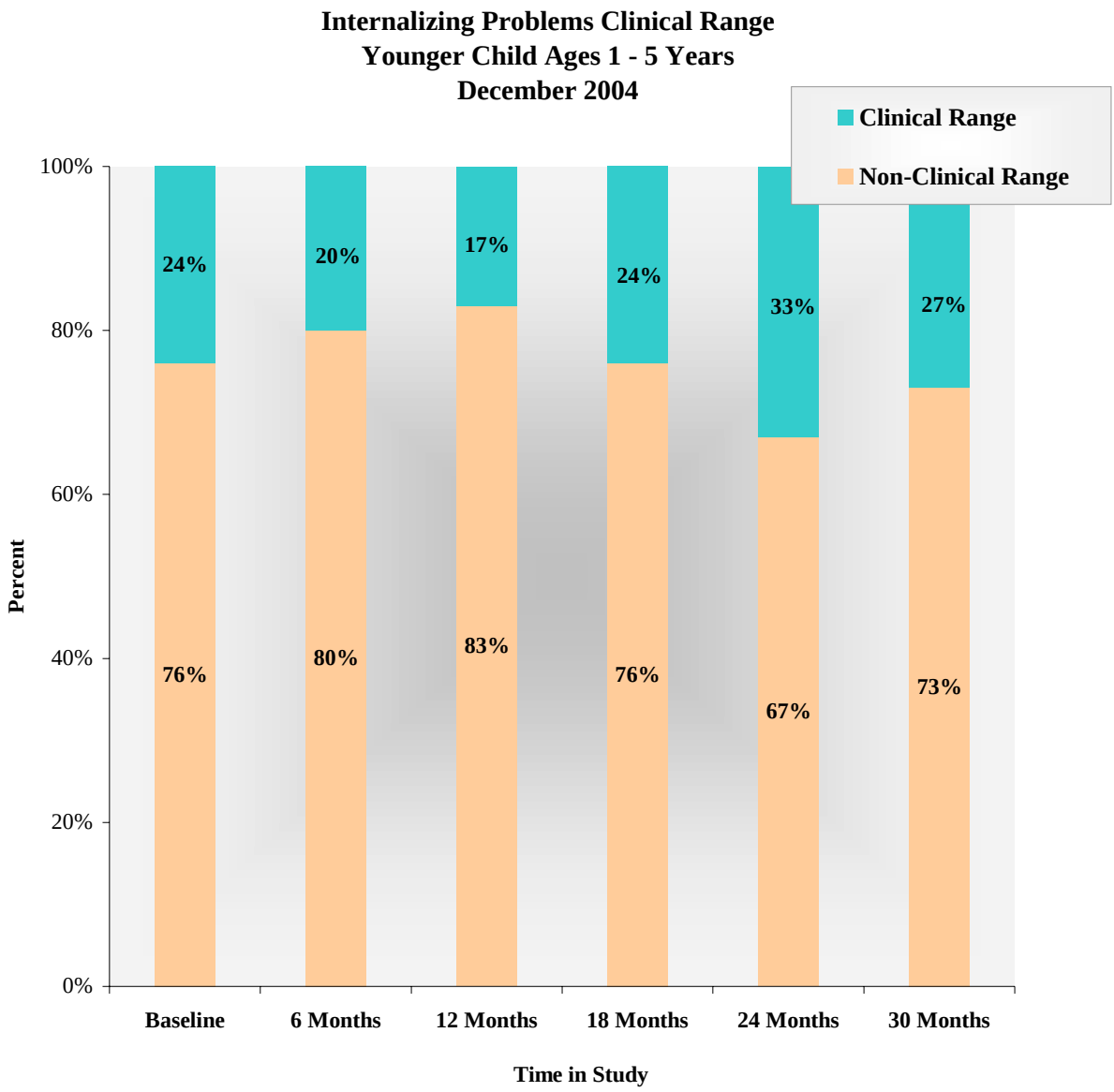

Internalizing Problems Clinical Range
Younger Child Ages 1 - 5 Years
December 2004
Clinical Range
Non-Clinical Range
100%
80%
60%
40%
20%
0%
Percent
24%
20%
17%
24%
33%
27%
76%
80%
83%
76%
67%
73%
Baseline
6 Months
12 Months
18 Months
24 Months
30 Months
Time in Study

Chart 46

Internalizing Problems Clinical Range Child Ages 6 - 18 Years
December 2004

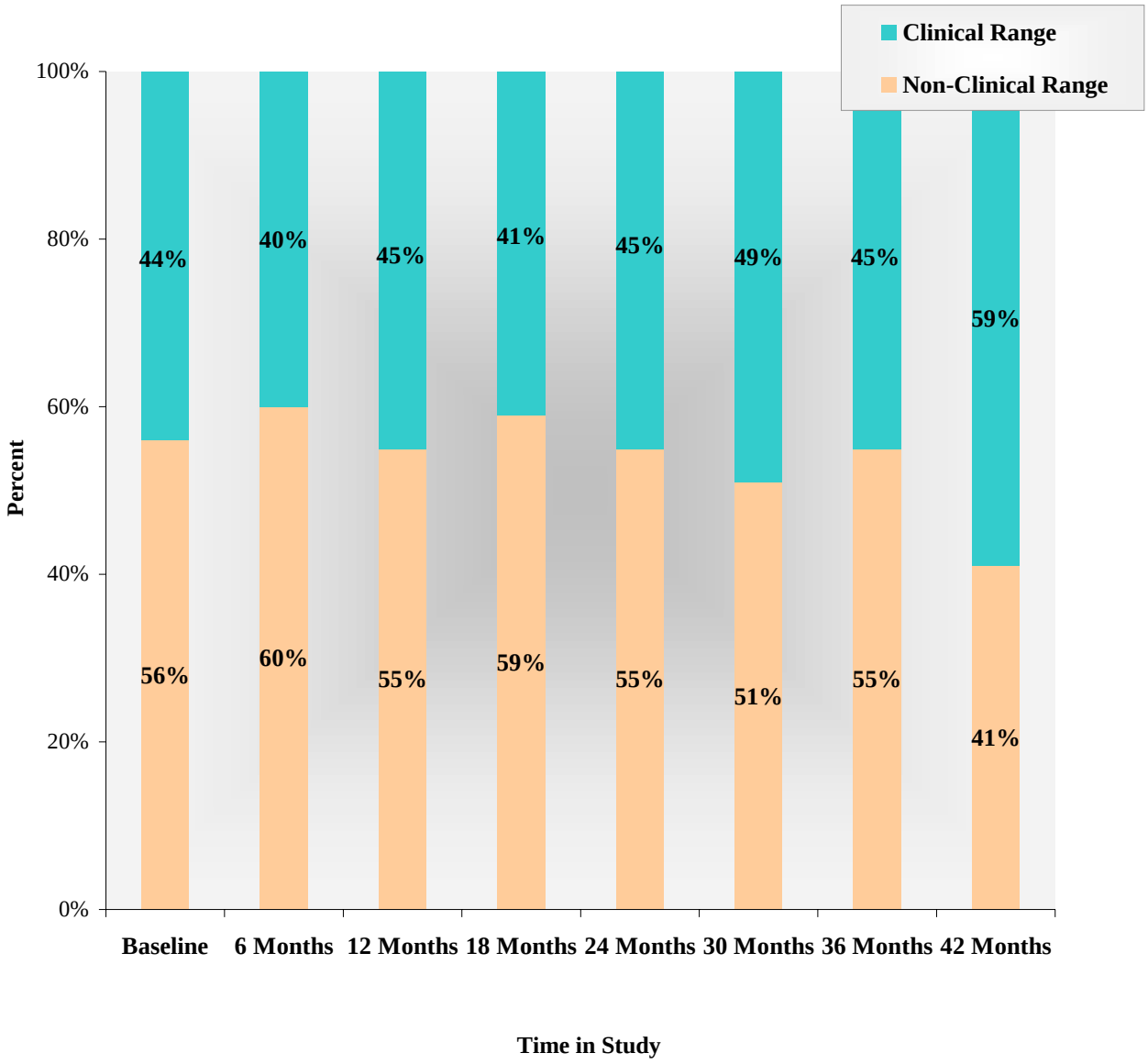
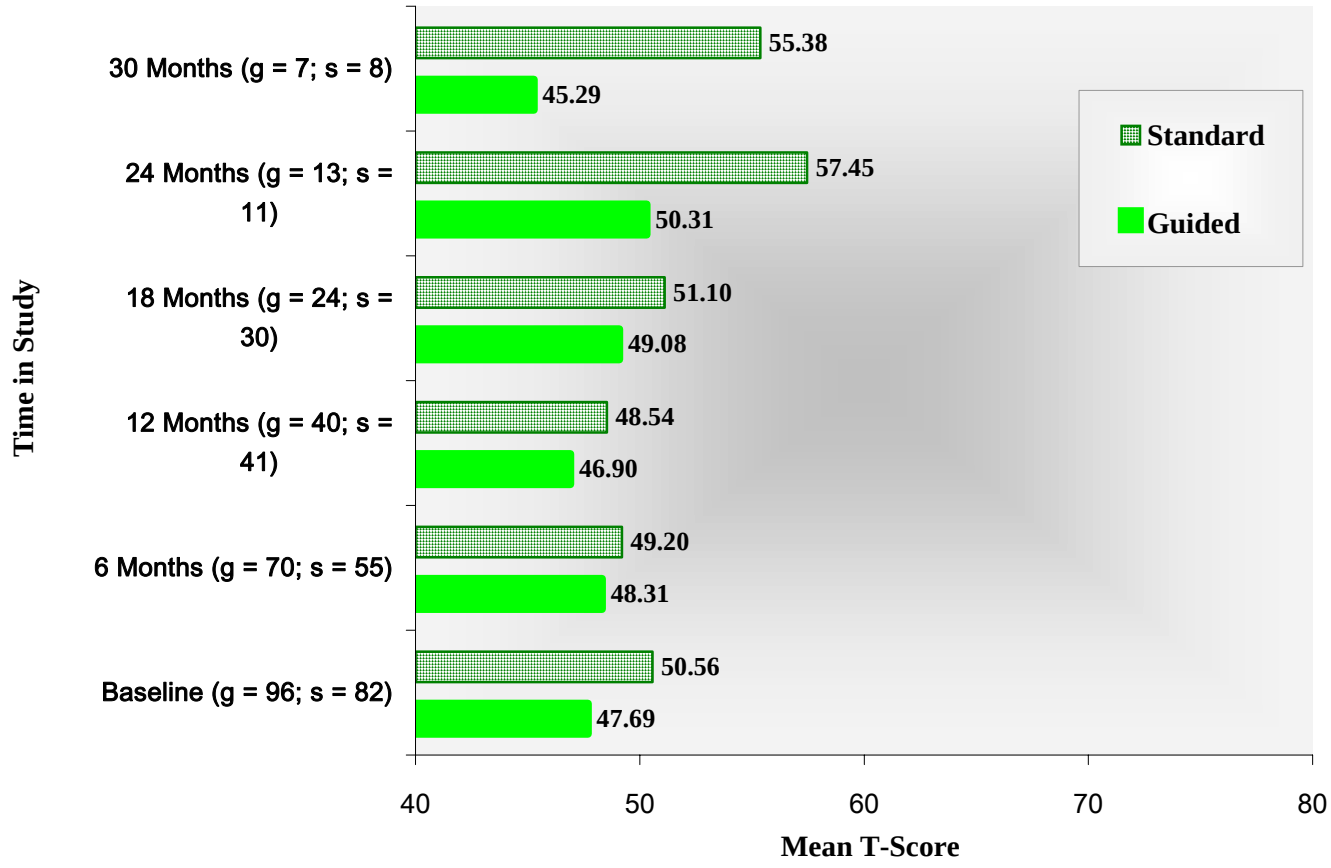


Chart 47

Internalizing Problems Child Behaviors Younger Child Ages 1 - 5 Years
December 2004

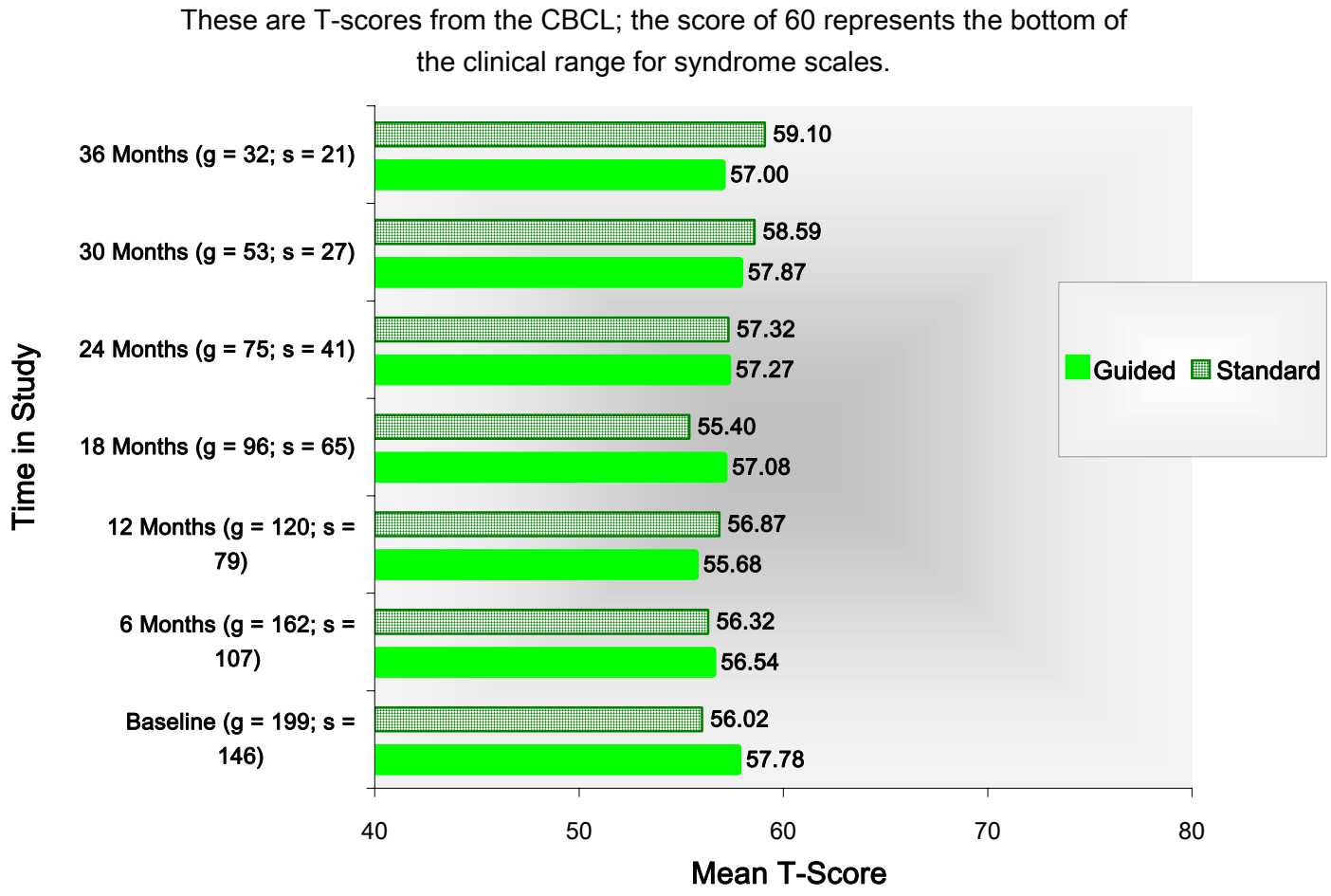
These are T-scores from the CBCL; the score of 60 represents the bottom of the clinical range for syndrome scales.



The Internalizing scale is developed from the Emotionally Reactive, Anxious/Depressed, Somatic Complaints, and Withdrawn syndrome scores. All internalizing scores are below the clinical range and there was no statistical difference over a 24 month period between the two groups on this outcome.

Chart 48

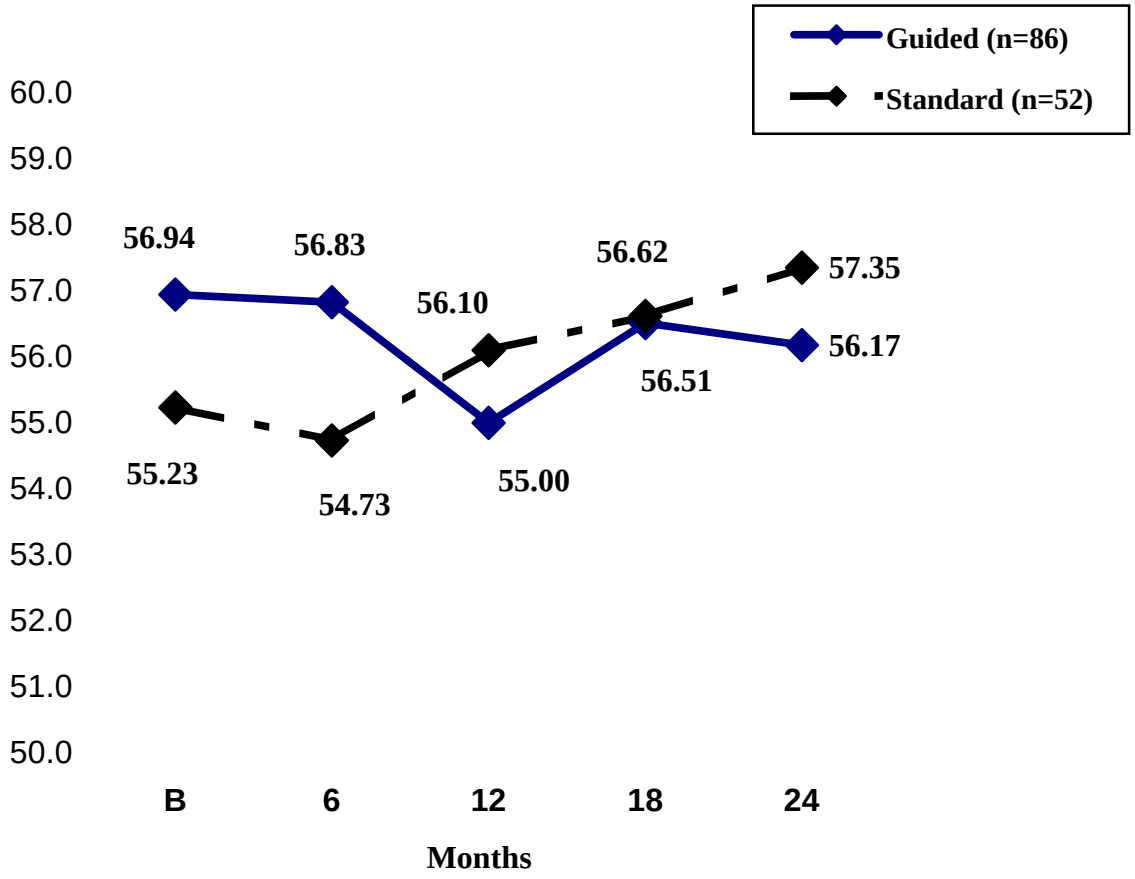
Internalizing Problems Child Behaviors Child Ages 6 - 18 Years
December 2004



For this scale score, Internalizing Problems, these scores are just below the clinical range. This scale was developed from the Withdrawn, Somatic Complaints and Anxious/Depressed syndrome scores.

There was no statistical difference over a 24 month period between the two groups on this outcome.

Graph 1
Internalizing Scores CBCL All Ages
December 2004



The graph above outlines the average scores of children over time, when data was combined from the 1.5 – 5 year-old, and the 6 – 18 year-old tables. For this scale score, Internalizing Problems, these scores are below the clinical range.

Repeated measures analysis indicated that there was no statistical differences over a 24 month period between groups on this Internalizing measure for all ages combined; F (3.393, 138) 2.055 and p = .097.

Chart 49

Externalizing Problems Clinical Range Younger Child Ages 1 - 5 Years
December 2004

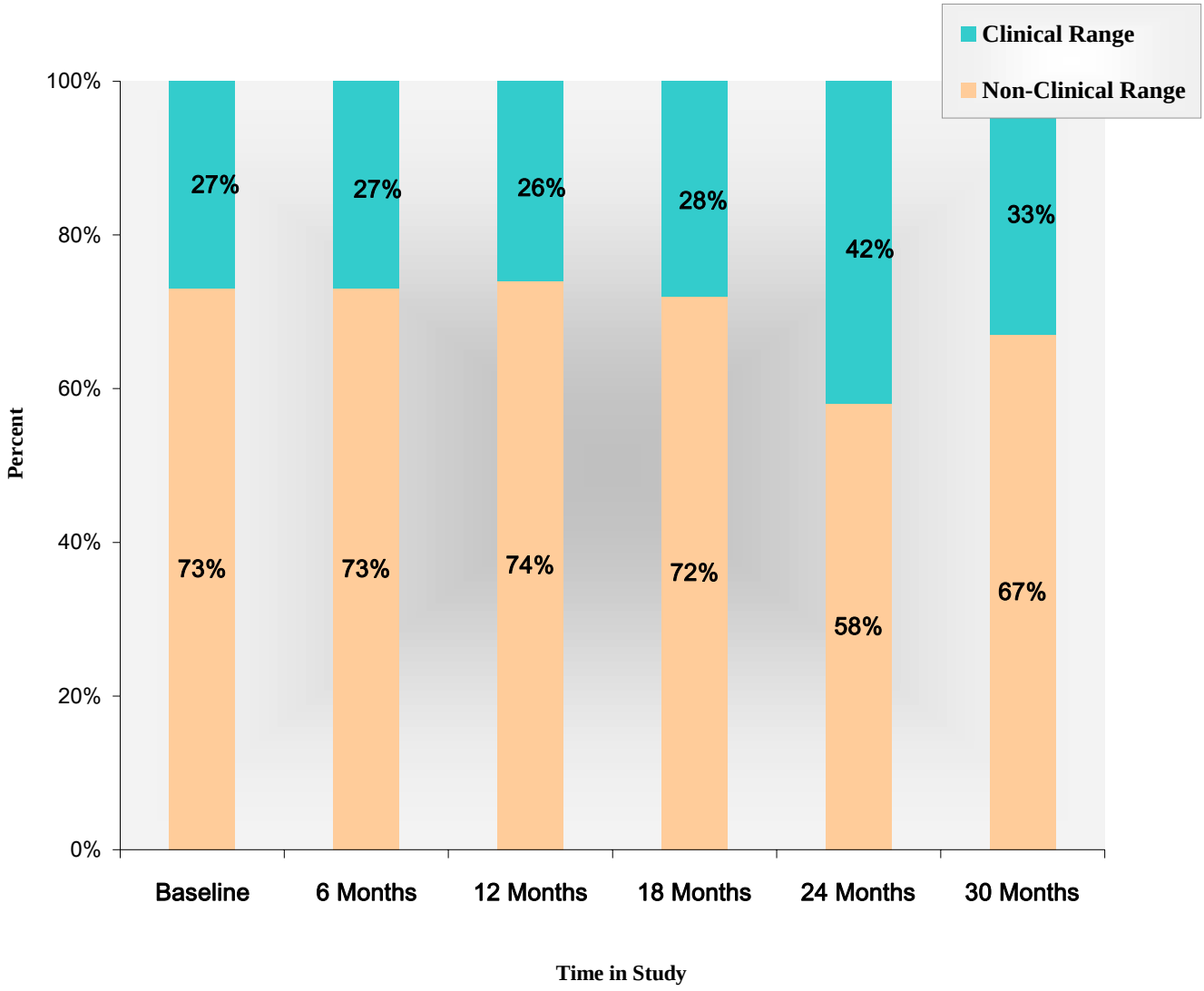


Chart 50

Externalizing Problems Clinical Range Child Ages 6 - 18 Years
December 2004

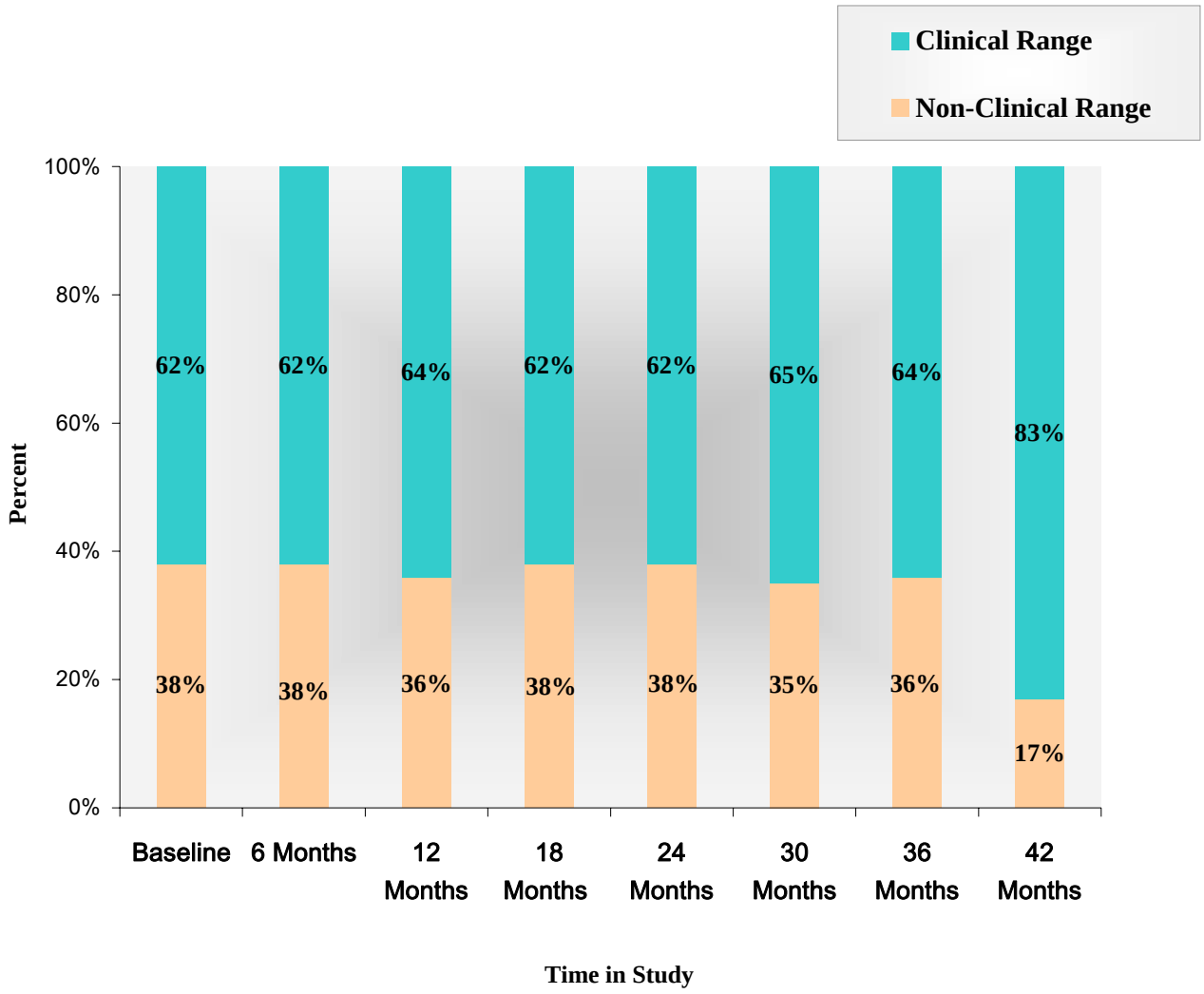
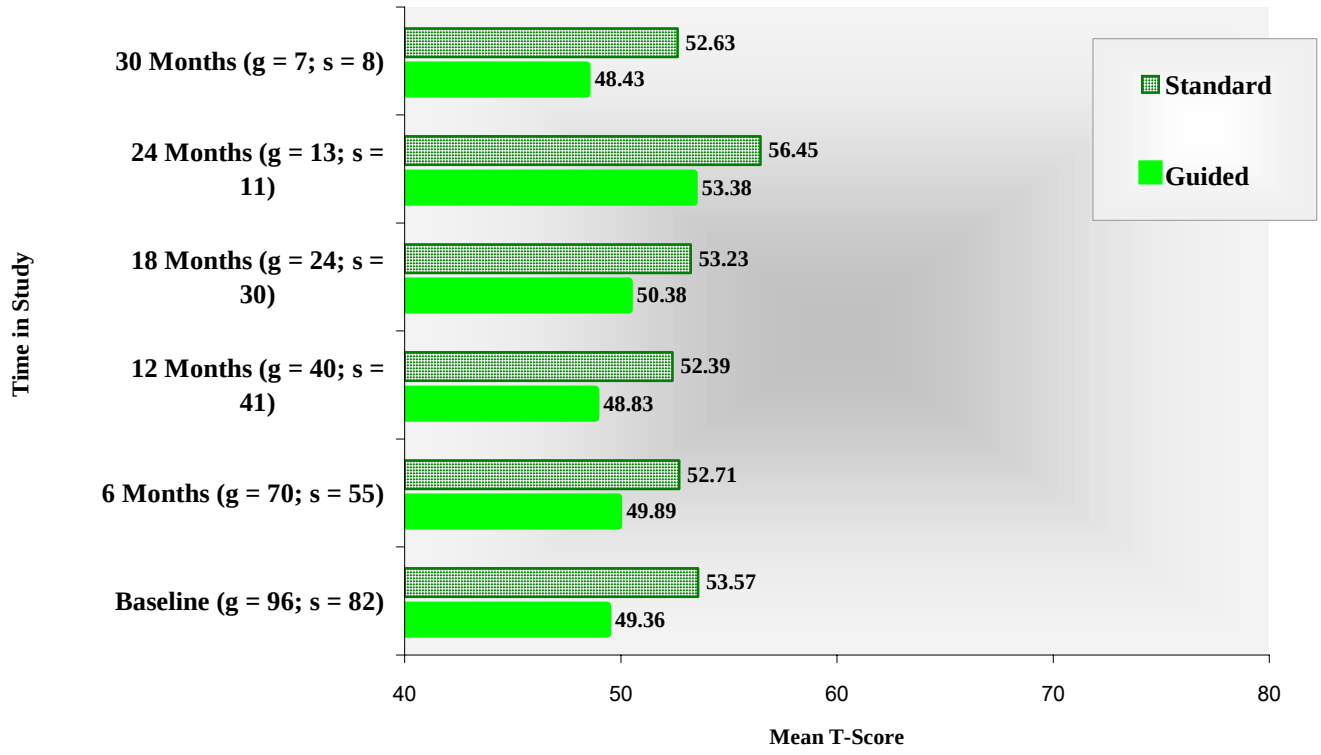


Chart 51

Externalizing Problems Child Behaviors Younger Child Ages 1 - 5 Years
December 2004

These are T-scores from the CBCL; the score of 60 represents the bottom ofthe clinical range for syndrome scales.

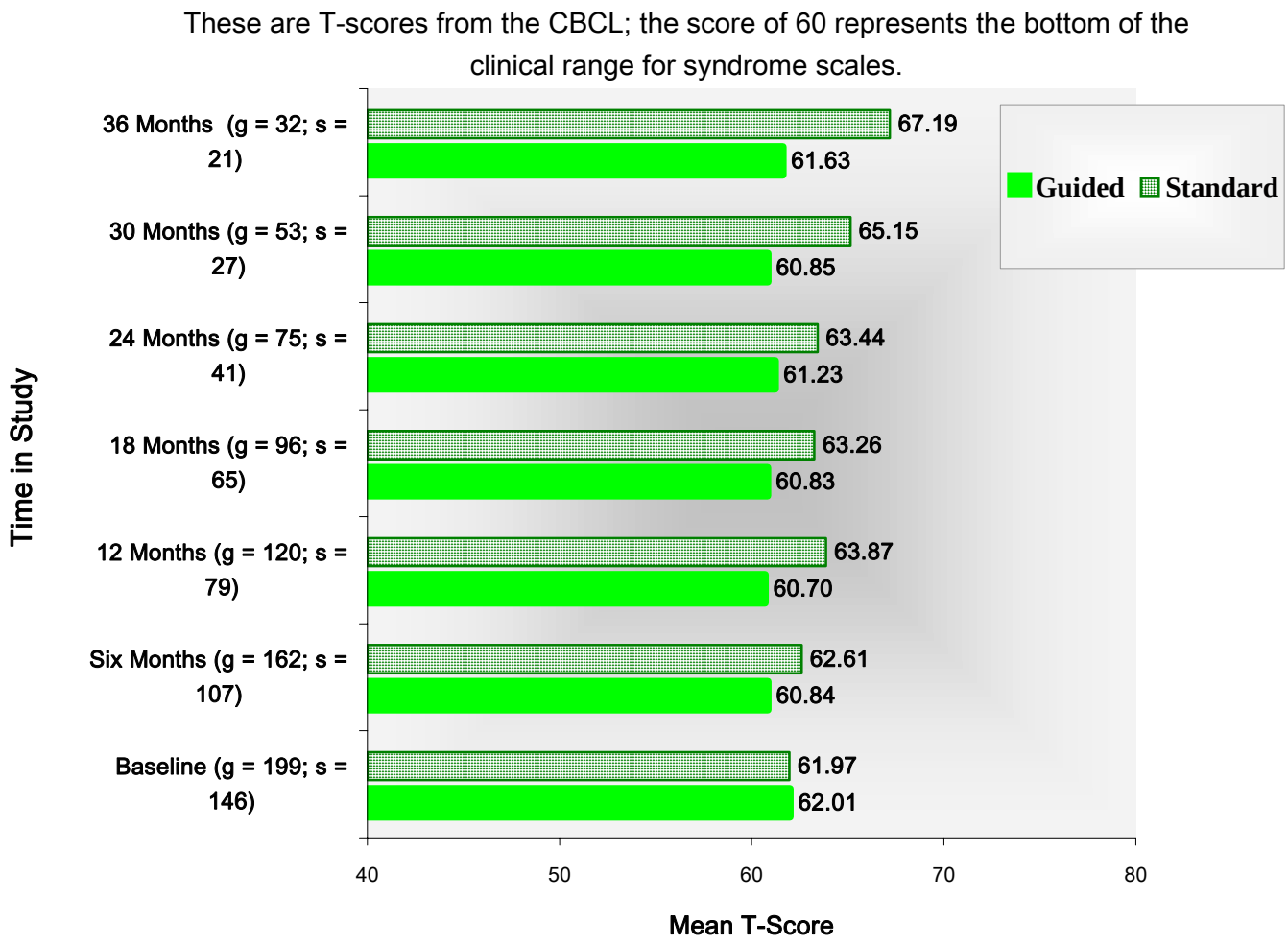


The Externalizing Problems scale was developed from the Attention Problems and Aggressive Behavior syndrome scores.

There was no statistical difference over a 24 month period between the two groups on this outcome.

Chart 52

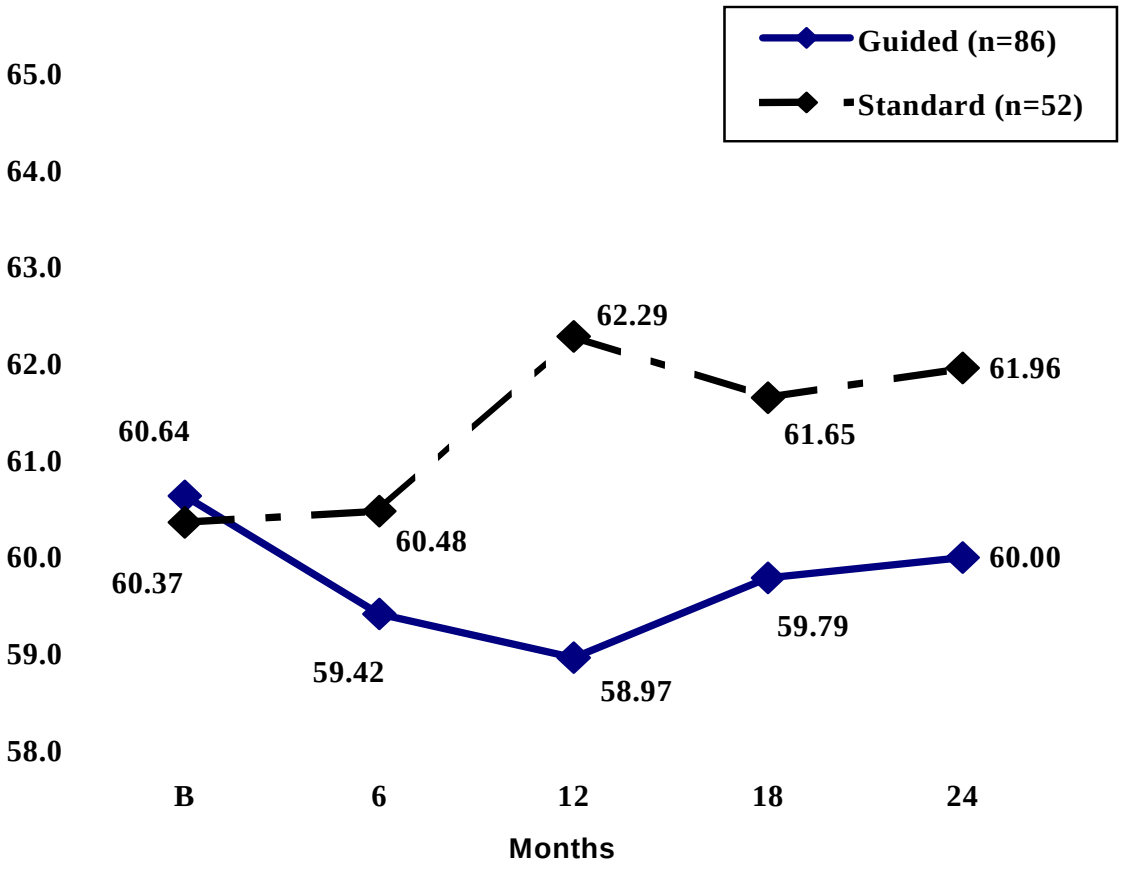
Externalizing Problems Child Behaviors Child Ages 6 - 18 Years
December 2004



For this scale score, Externalizing Problems, these mean scores are at or above the cut-point (60) indicating a need for referral to clinical services. This scale was developed from the Delinquent and Aggressive Behaviors syndrome scores.

There was no statistical difference over a 24 month period between the two groups on this outcome.

Graph 2
Externalizing Scores CBCL All Ages
December 2004



The graph above outlines the average scores of children over time, when data was combined from the 1.5 – 5 year-old, and the 6 – 18 year-old tables. Repeated measures analysis indicated that there were no statistical differences over a 24 month period between groups for this Externalizing measure for all ages combined; F (3.316, 138) 1.713 and p = .158.

Chart 53

Total Problems Clinical Range Younger Child Ages 1- 5 Years
December 2004

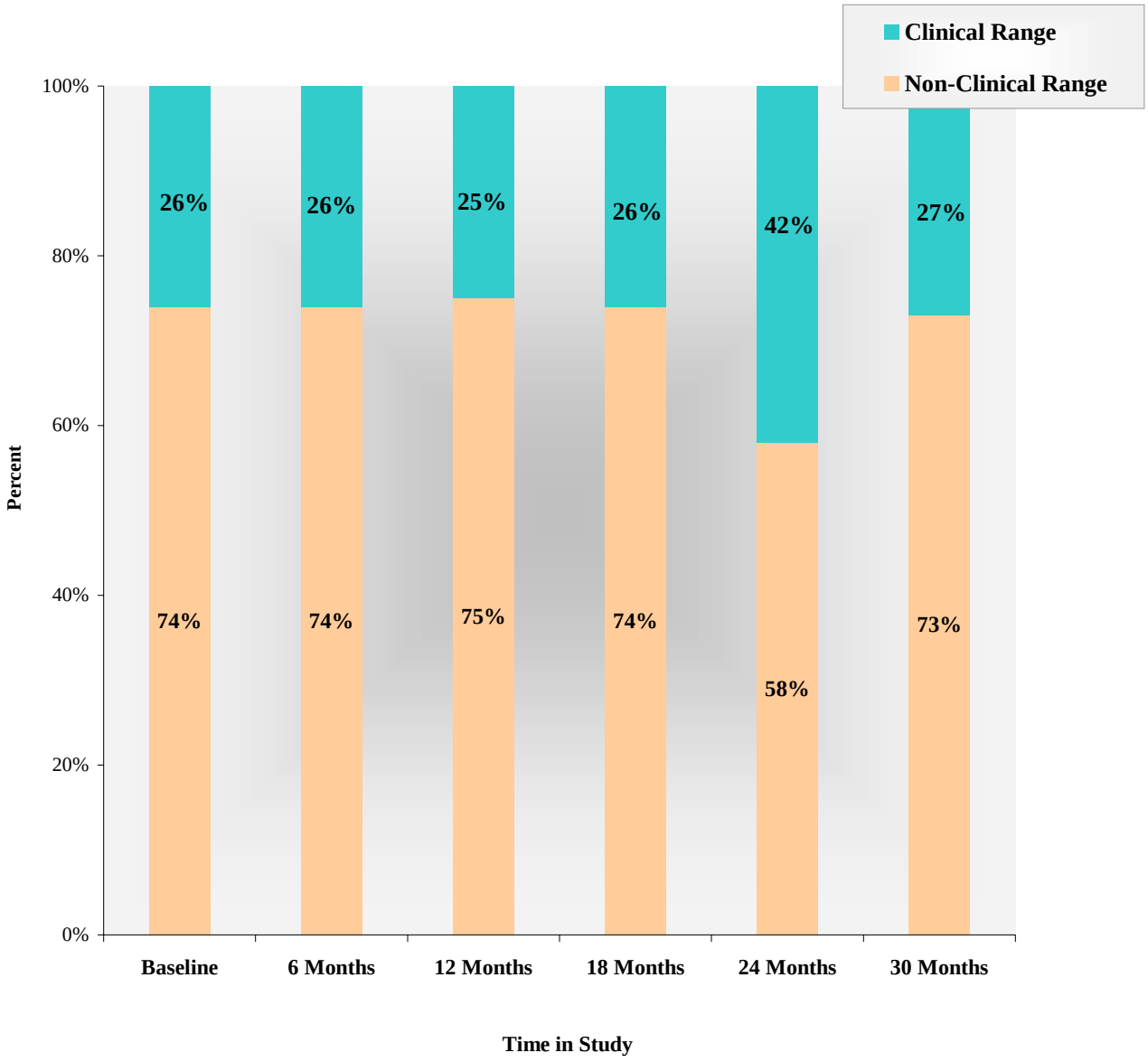


Chart 54

Total Problems Clinical Range Child Ages 6 - 18 Years
December 2004

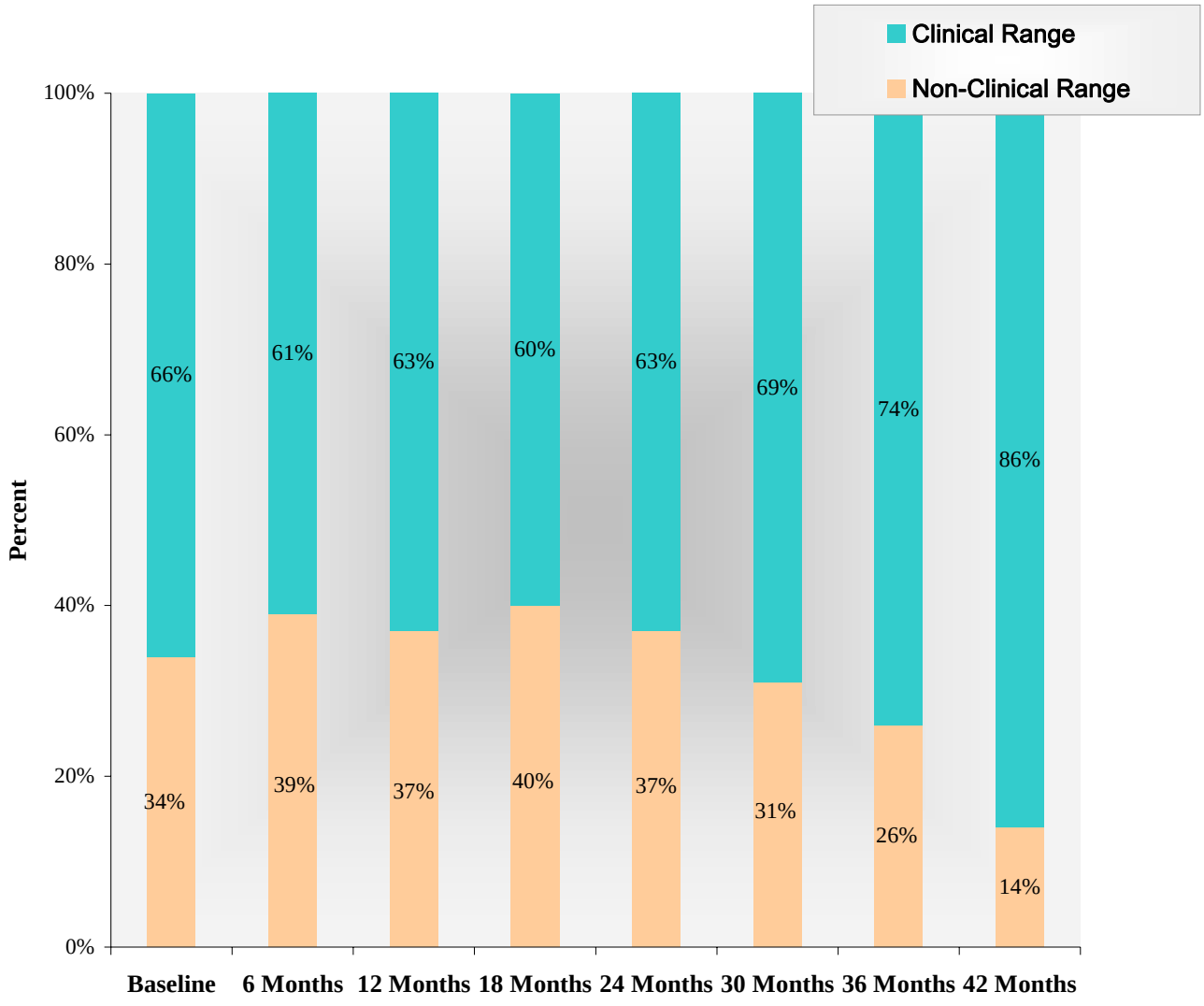
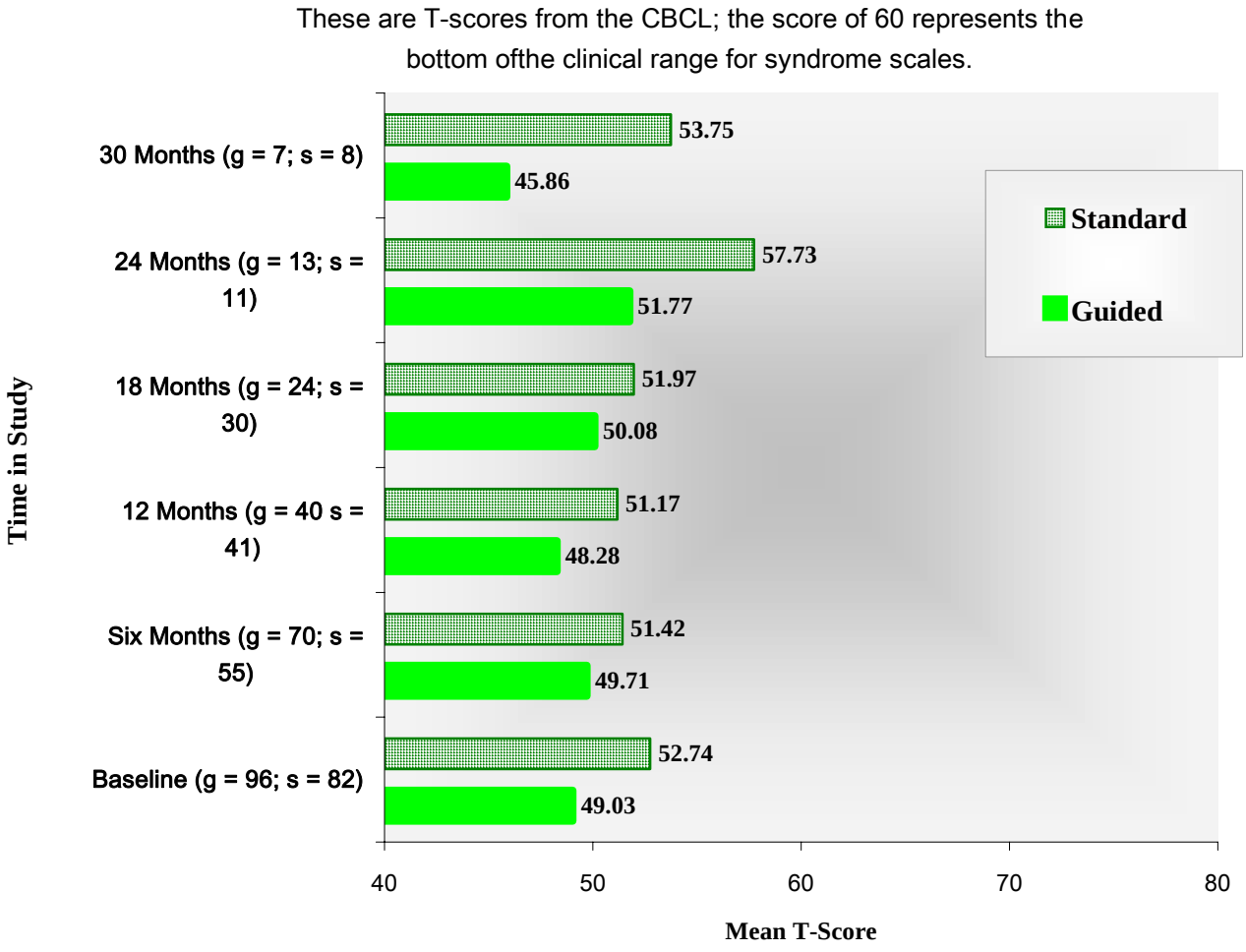


Chart 55

Total Problems Child Behaviors Younger Child Ages 1 - 5 Years
December 2004

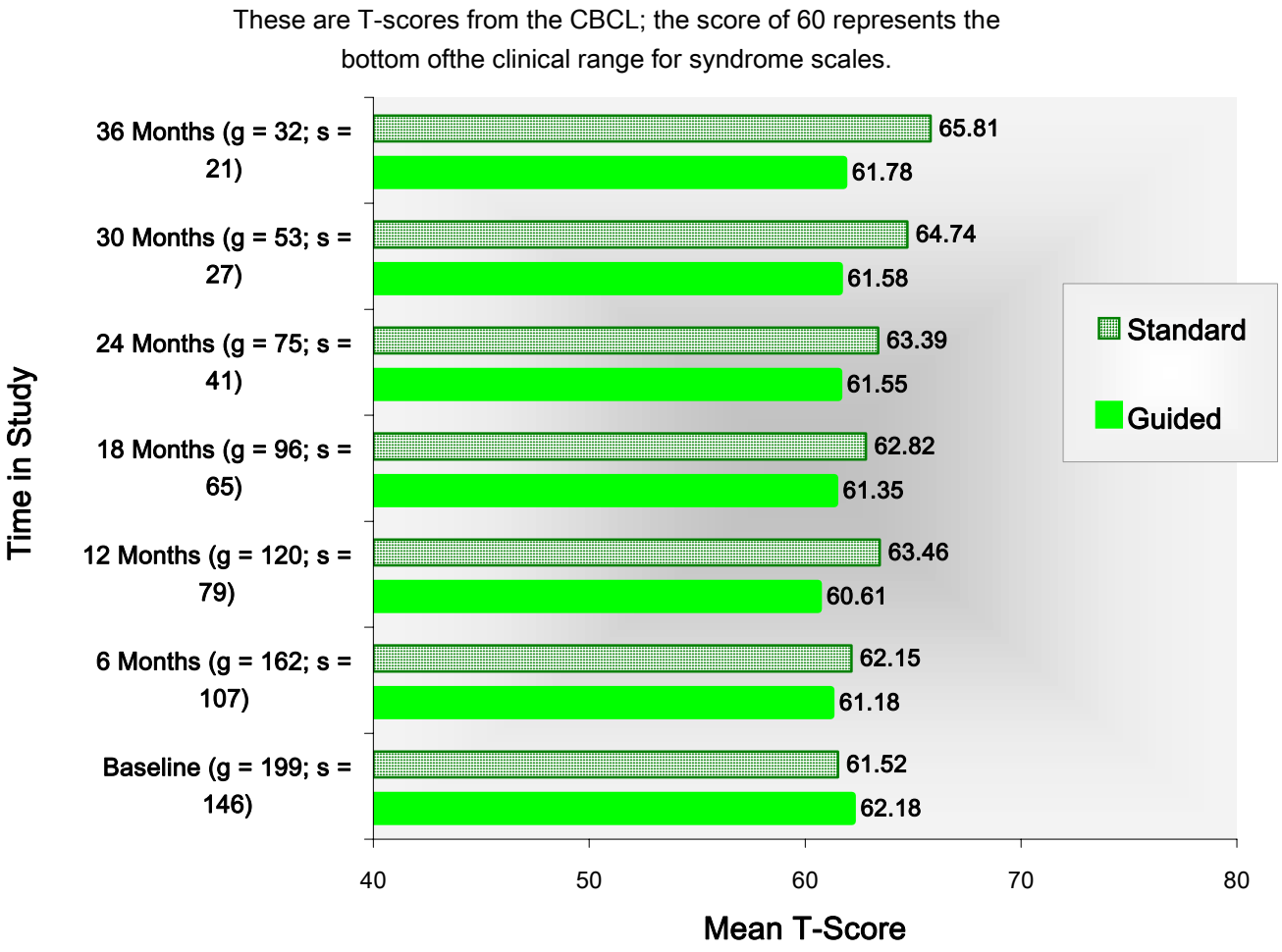


According to Achenbach et al (1991) the Total Problem score can be used as a basis for comparing problems in different groups and for assessing change as a function of time or intervention. The Total Problem score was computed by summing all problem items except for Sleep Problems. If a parent rated more than one problem for item 100 (Other Problems, only the item with the highest score is counted. There are 100 problem items on this section of the CBCL. Averages for these groups are below the clinical range.

There was no statistical difference over a 24 month period of time between the two groups on this outcome.

Chart 56

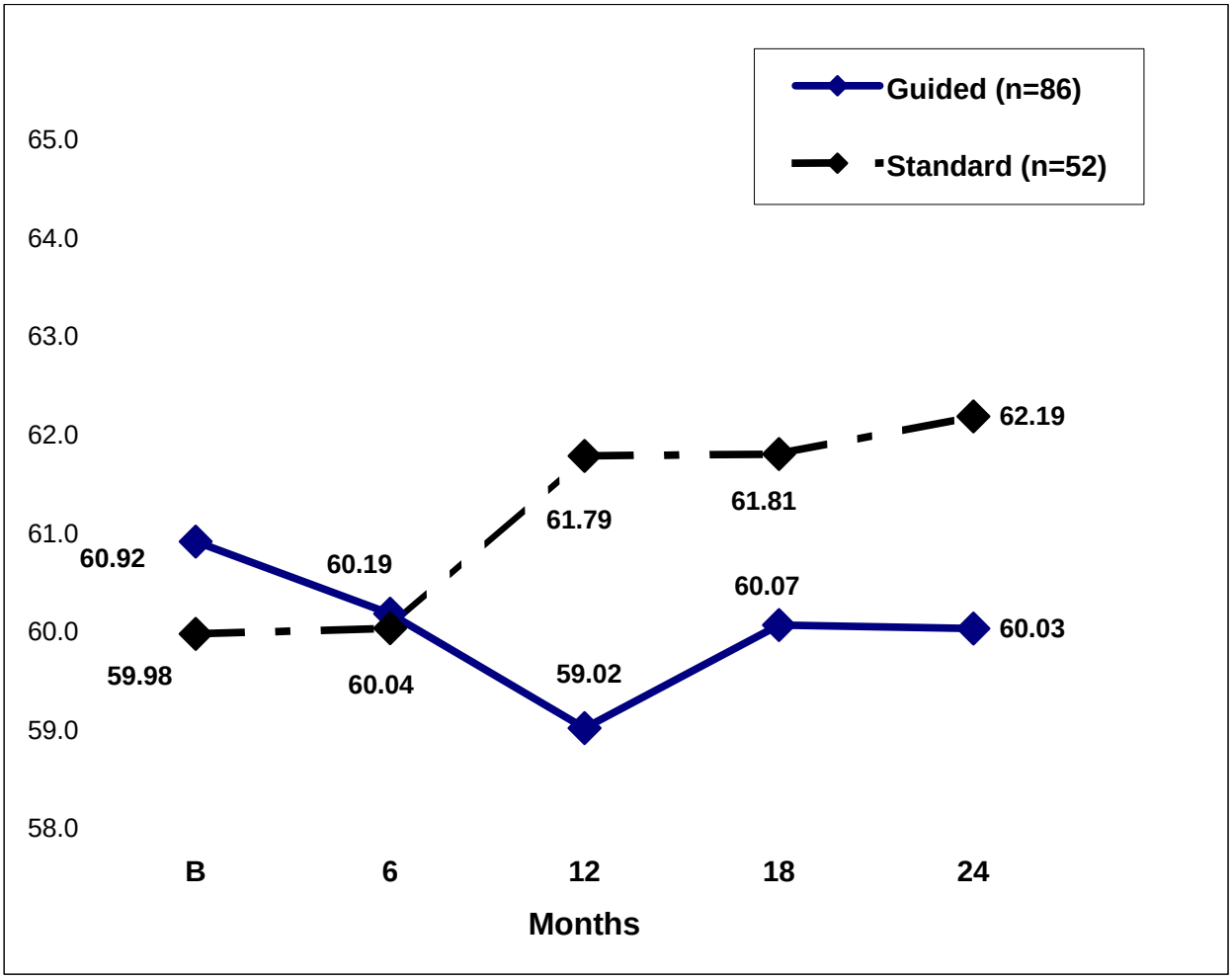
Total Problems Child Behaviors Ages 6 - 18
December 2004



For the Total Problems scale, these mean scores are at or above the cut-point (60) indicating a need for referral to clinical services. According to Achenbach et al (1991), the total problem score can be used as a basis for comparing problems in different groups and for assessing change as a function of time or intervention. The Total Problem score was computed by summing all problem items except items 2 (Allergy) and 4 (Asthma). If a parent rated more than one problem for item 113 (Other problems), only the item with highest score was counted. There were 113 problem items on this section of the CBCL.

There was no statistical difference over a 24 month period between the two groups on this outcome.

Graph 3
Total Problems CBCL Scores - All Ages Combined
December 2004

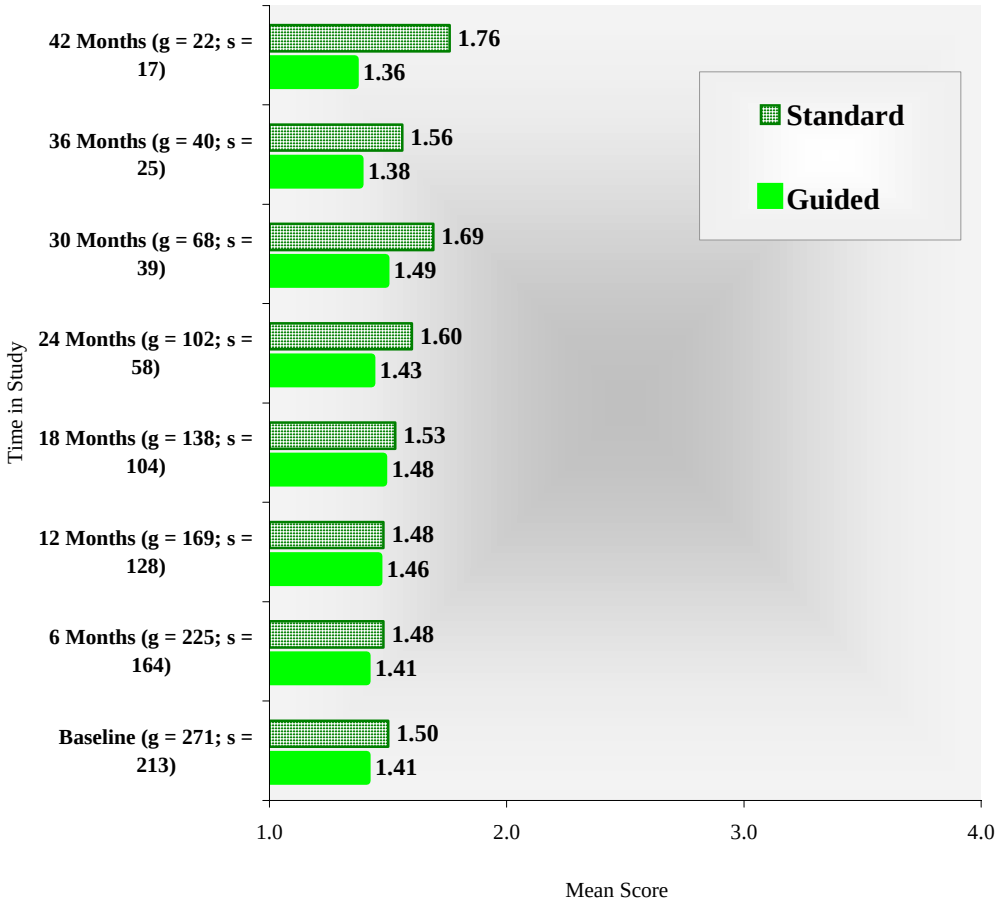


The graph above outlines the average scores of children over time, when data is combined from the 1.5 – 5 year-old, and the 6 – 18 year-old tables.

Repeated measures analysis finds a statistically significant difference between groups on this Total Problems measure for all ages combined; F (3.271, 138) 3.037 and p = .025. The Guided Services group had lower average Total Problem scores for a 24 month period compared to the Standard Services Group.

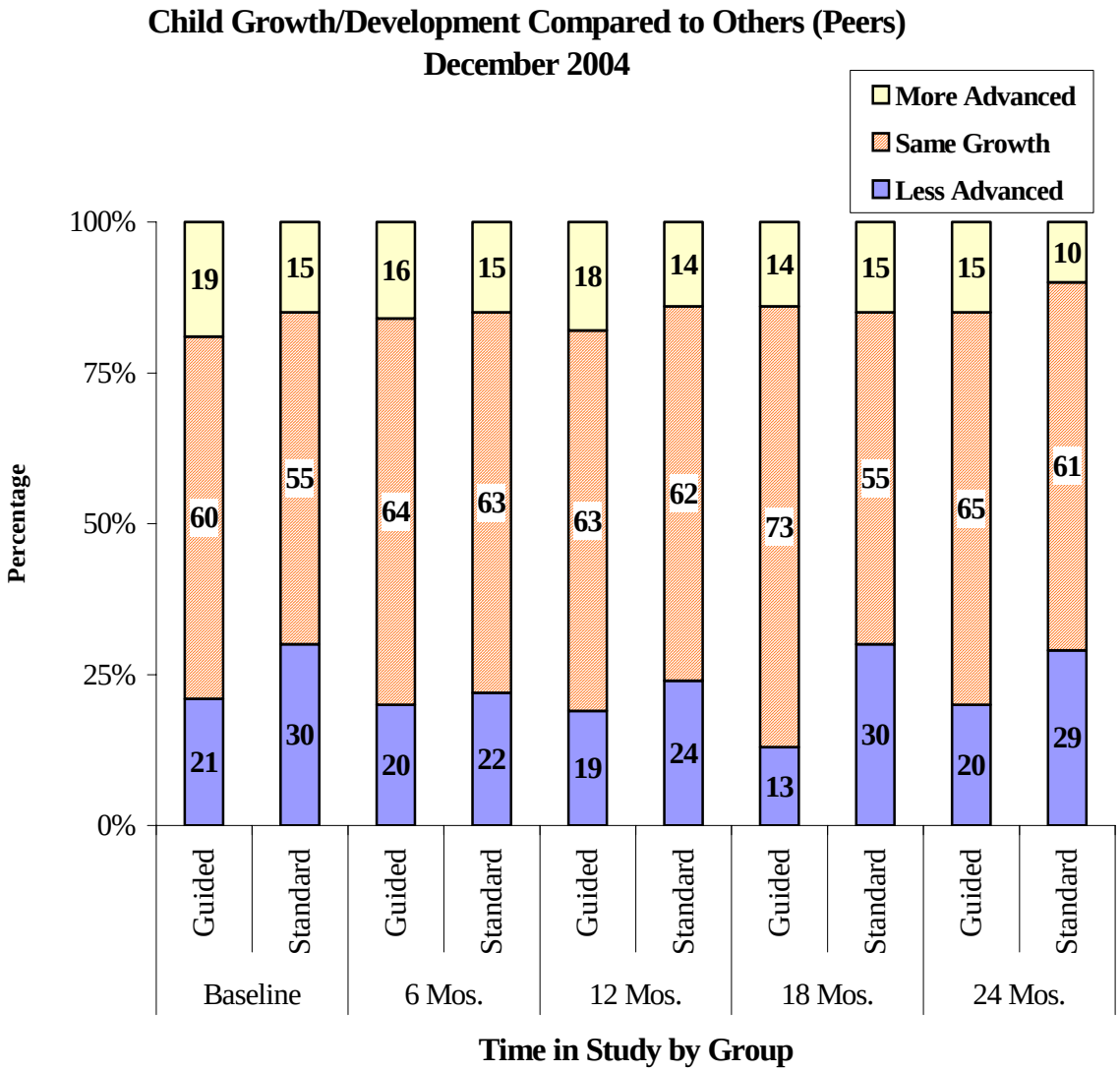
Chart 57

Child Overall Health
December 2004
1 = Excellent 4 = Poor



There was no statistical difference over a 24 month period between the two groups on this outcome. Caregivers in both groups rated their child's overall health as excellent to very good.

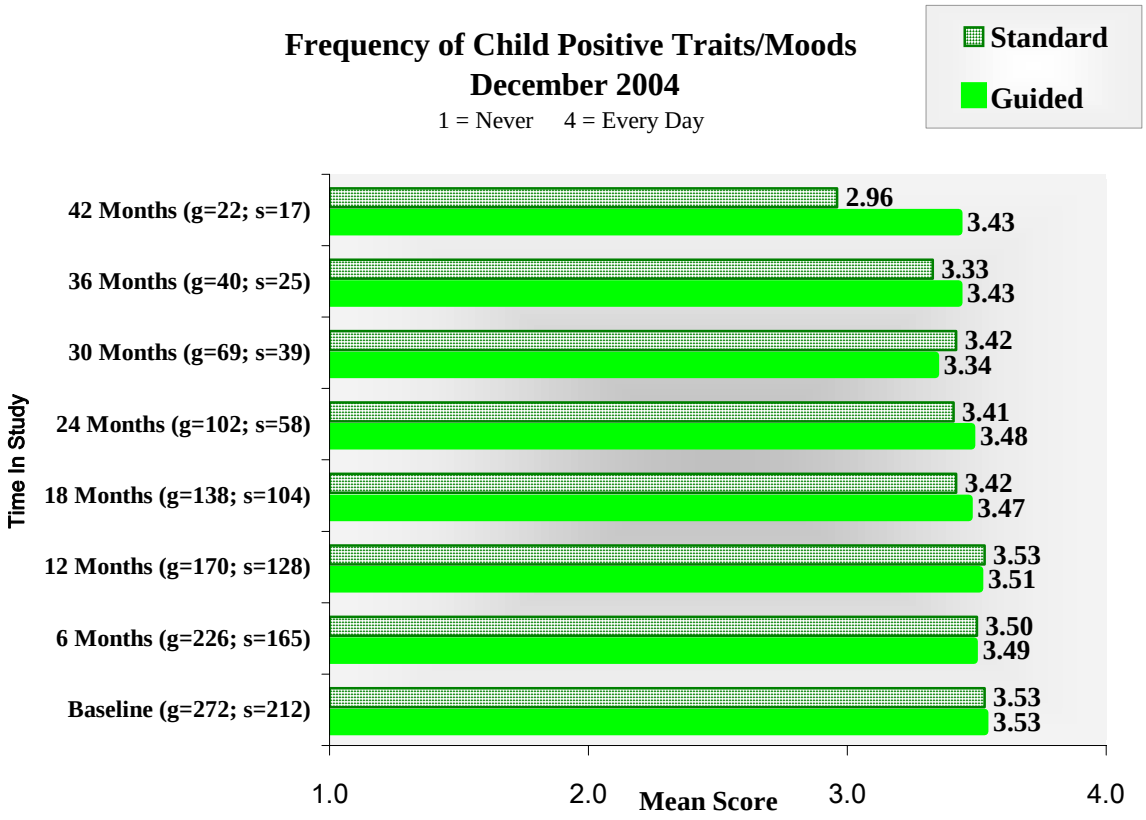
Chart 58



Parents were asked to rate their adopted child's overall physical growth and development compared to the child's peers at baseline and each six month period. Tests for significance resulted in no significant statistical differences between groups.

Parents in both groups appeared to rate their child's overall physical growth and development the same over time.

Chart 59

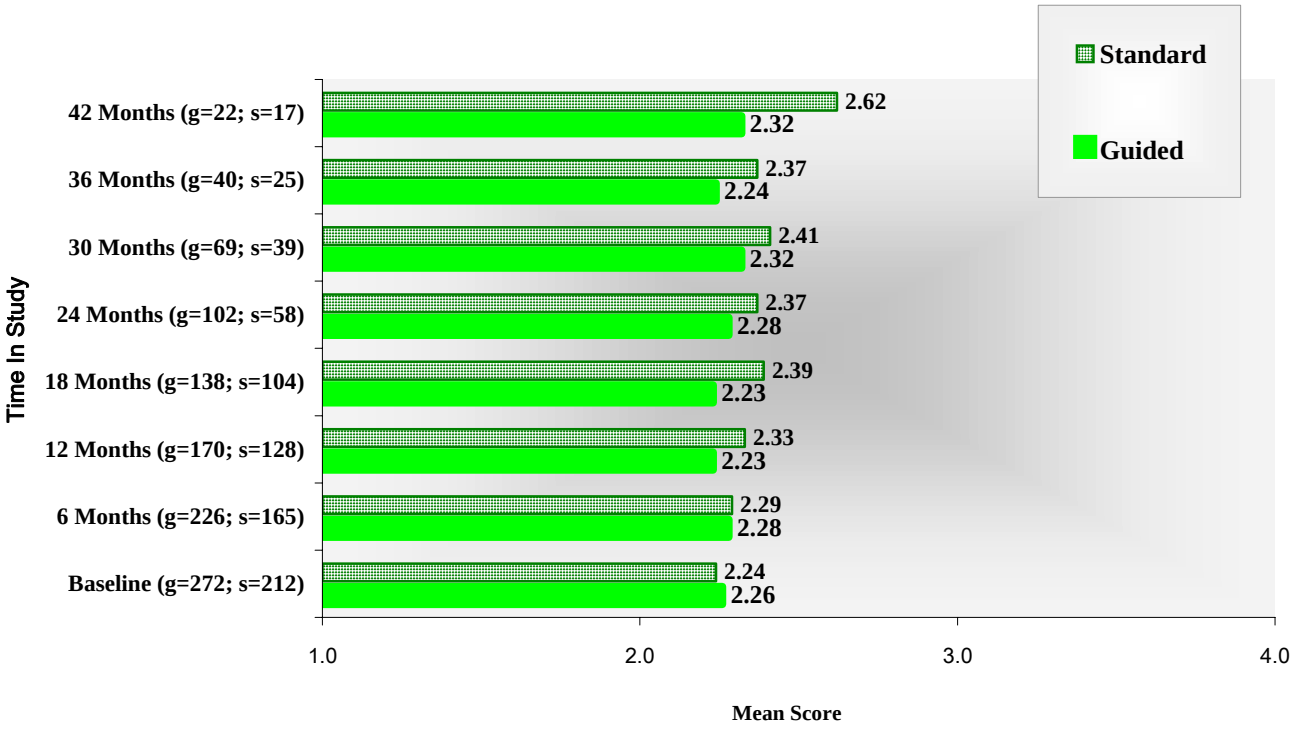


For this score there was no statistically significant difference between groups over a 24 month period. Caregivers were asked to estimate how often their child had demonstrated a particular trait/mood or behavior. Caregivers in both groups reported often to daily demonstrations of positive traits/moods. Positive traits/moods are: Pleasant to have around; Loving; Well-adjusted; and Cheerful.

Chart 60

Frequency of Child Negative Traits/Moods
December 2004

1 = Never 4 = Every Day

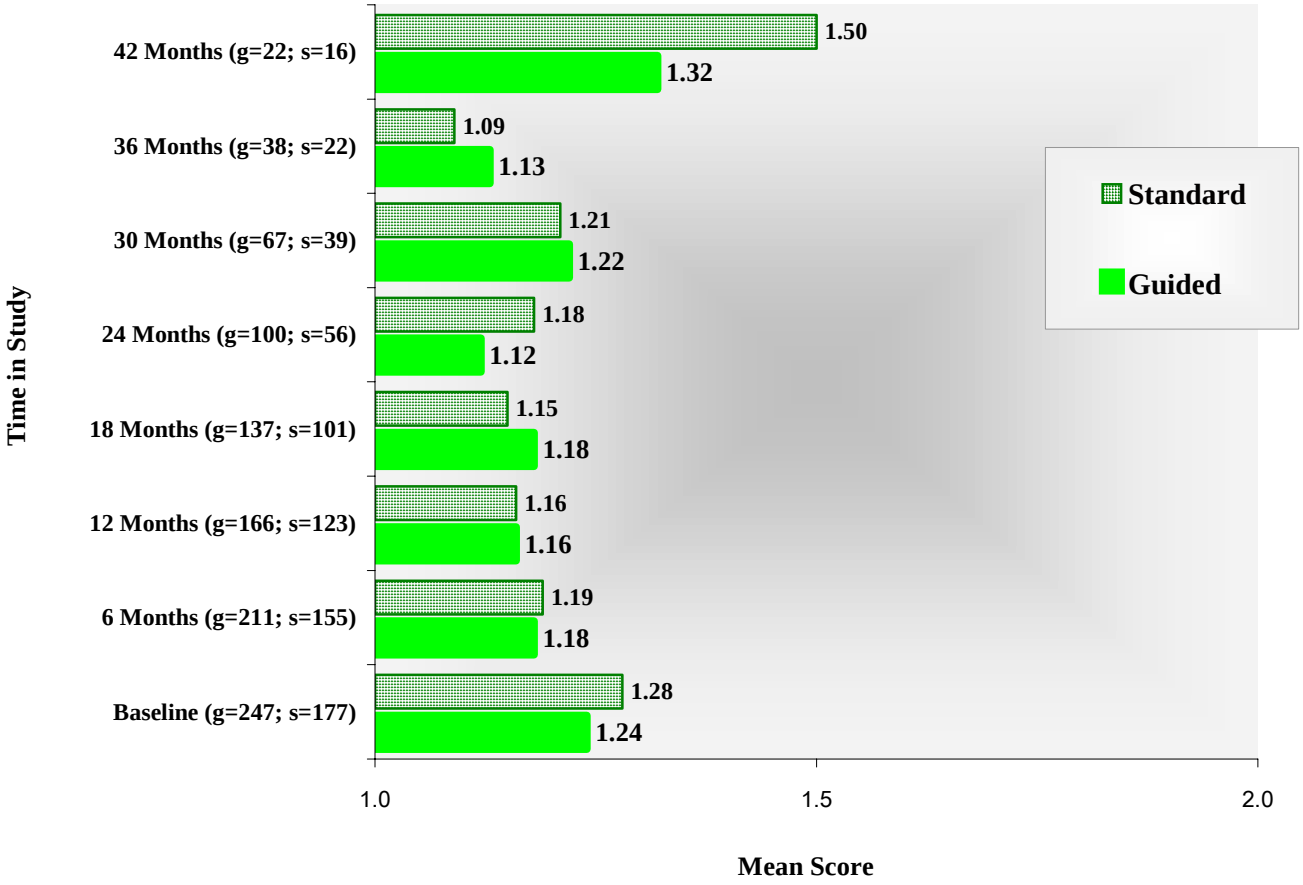


For this score there was no statistically significant difference between groups over a 24 month period. Caregivers were asked to estimate how often their child had demonstrated a particular trait/mood or behavior. Caregivers in both groups reported often to seldom demonstrations of negative traits/moods. Negative traits/moods are: Moody; Hostile or Aggressive; Jealous; and Destructive.

Chart 61

Caregiver Report on Child Satisfaction With Adoption
December 2004

1 = Very Satisfied 4 = Not at All Satisfied

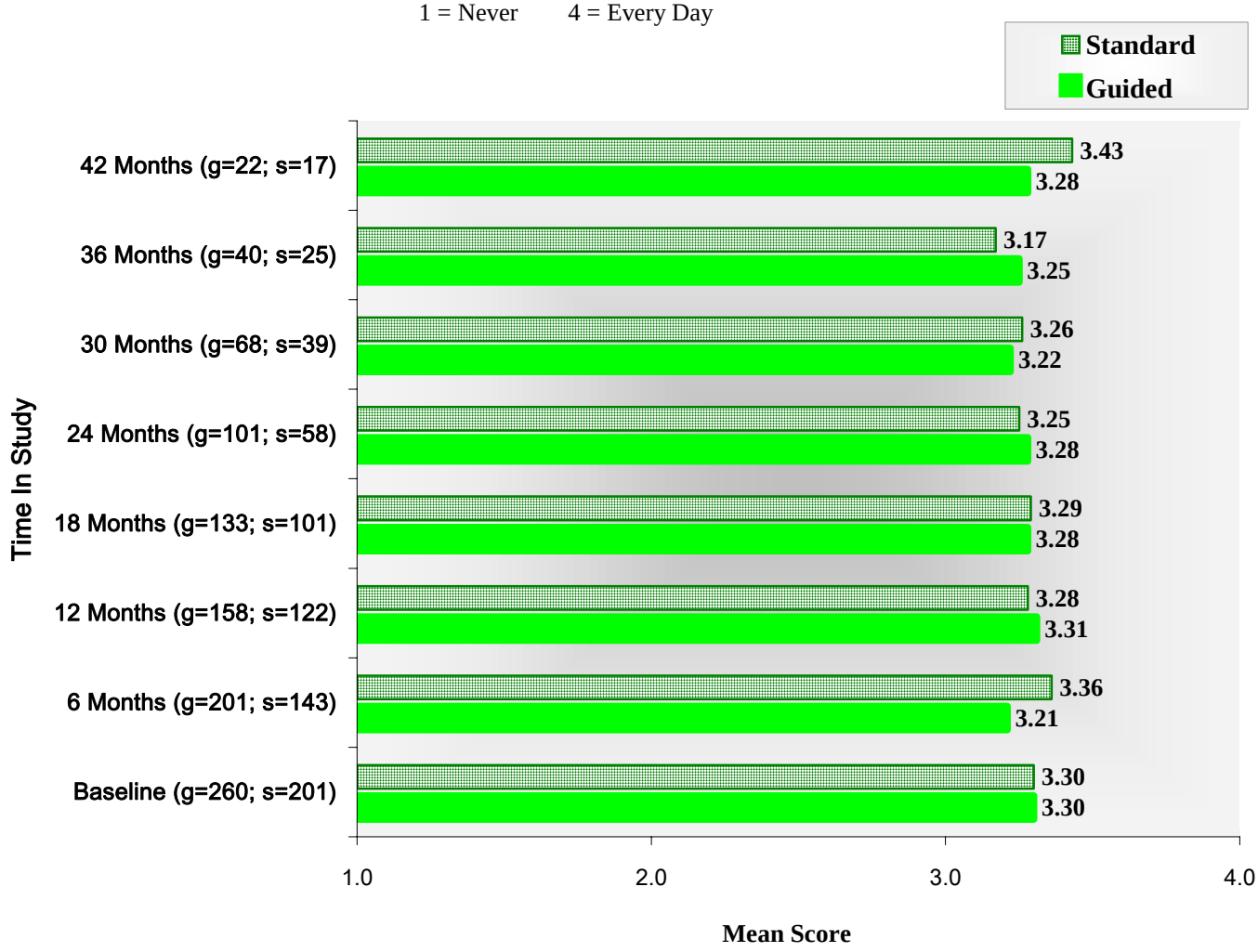


Caregivers from both groups reported that they believe their child(ren) were very satisfied with the adoption. For this result, there was no statistically significant difference between groups over period of 24 months.

Chart 62

Caregiver Report on Frequency of Child Positive Behaviors to Parent
December 2004

1 = Never 4 = Every Day



For this score there was no statistically significant difference between groups over period of 24 months. Caregivers were asked to estimate how often their child had acted a certain way toward the parent. Caregivers in both groups reported often to daily demonstrations of positive behaviors exhibited to them from their child(ren). Positive behaviors are: Said nice things; Helped you with housework; Showed that s/he liked having you around; Did things with you; Was thoughtful when you were tired; Kissed/hugged you; Comforted you; Made you feel loved; and Showed you that s/he needed you.

CHAPTER V
COST NEUTRALITY INFORMATION, MAINECARE AND GUIDED SERVICES TITLE IV-E COSTS

The evaluator worked cooperatively with DHHS and Casey Family Services Program staff in tracking costs associated with the implementation of MAGS. All the cost data was provided by, and reviewed for accuracy by, agency administrators at Casey Family Services and at the state DHHS. This chapter contains three major sections:

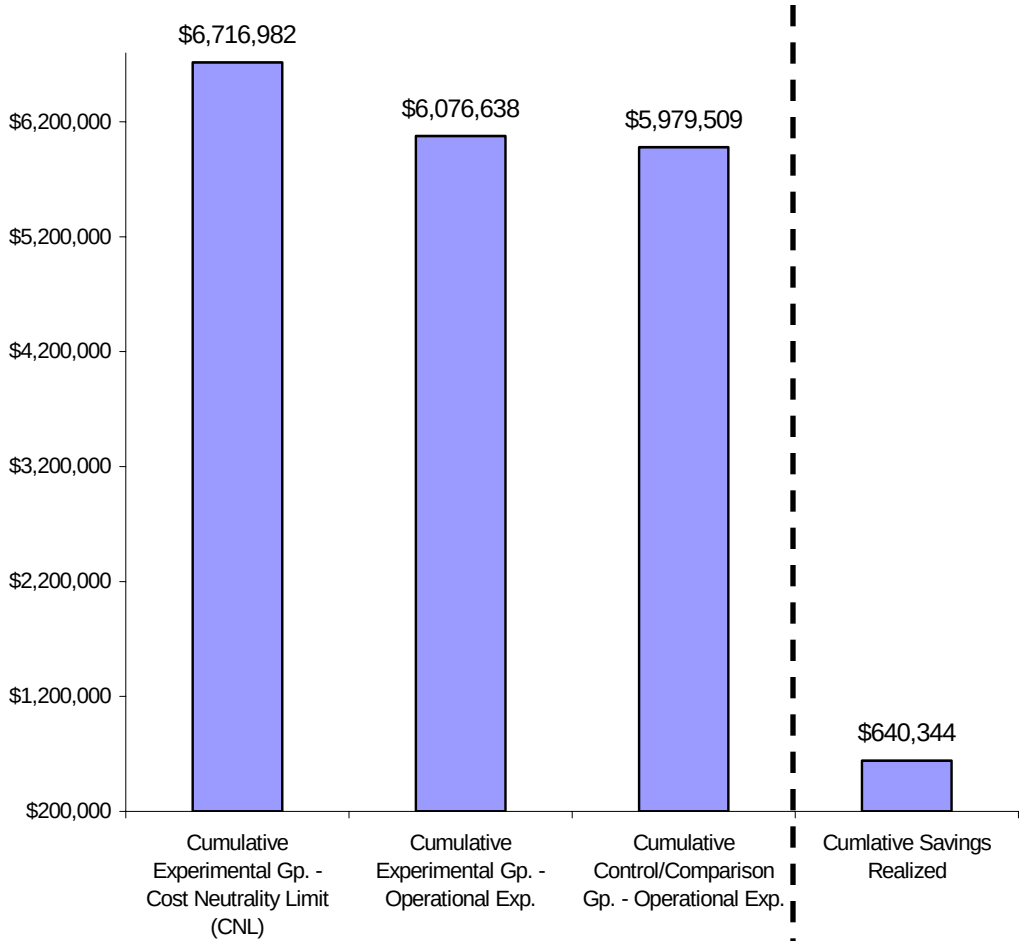
1. **Cost-Neutrality:** DHHS staff track Title IV-E costs associated with this Waiver project and report on cost-neutrality.

2. **Title IVE Costs – Concrete Services:** Evaluation staff collected information about the Title IV-E dollars provided by the state DHHS to MAGS families for concrete services.

3. **MaineCare (Medicaid) Costs:** Evaluation staff worked cooperatively with DHHS to monitor MaineCare (Medicaid) costs for all children in the study.

A. COST NEUTRALITY RESULTS

Chart 63
Title IV-E Foster Care & Adoption Demonstration Project
Cumulative Costs & Savings
December 2004

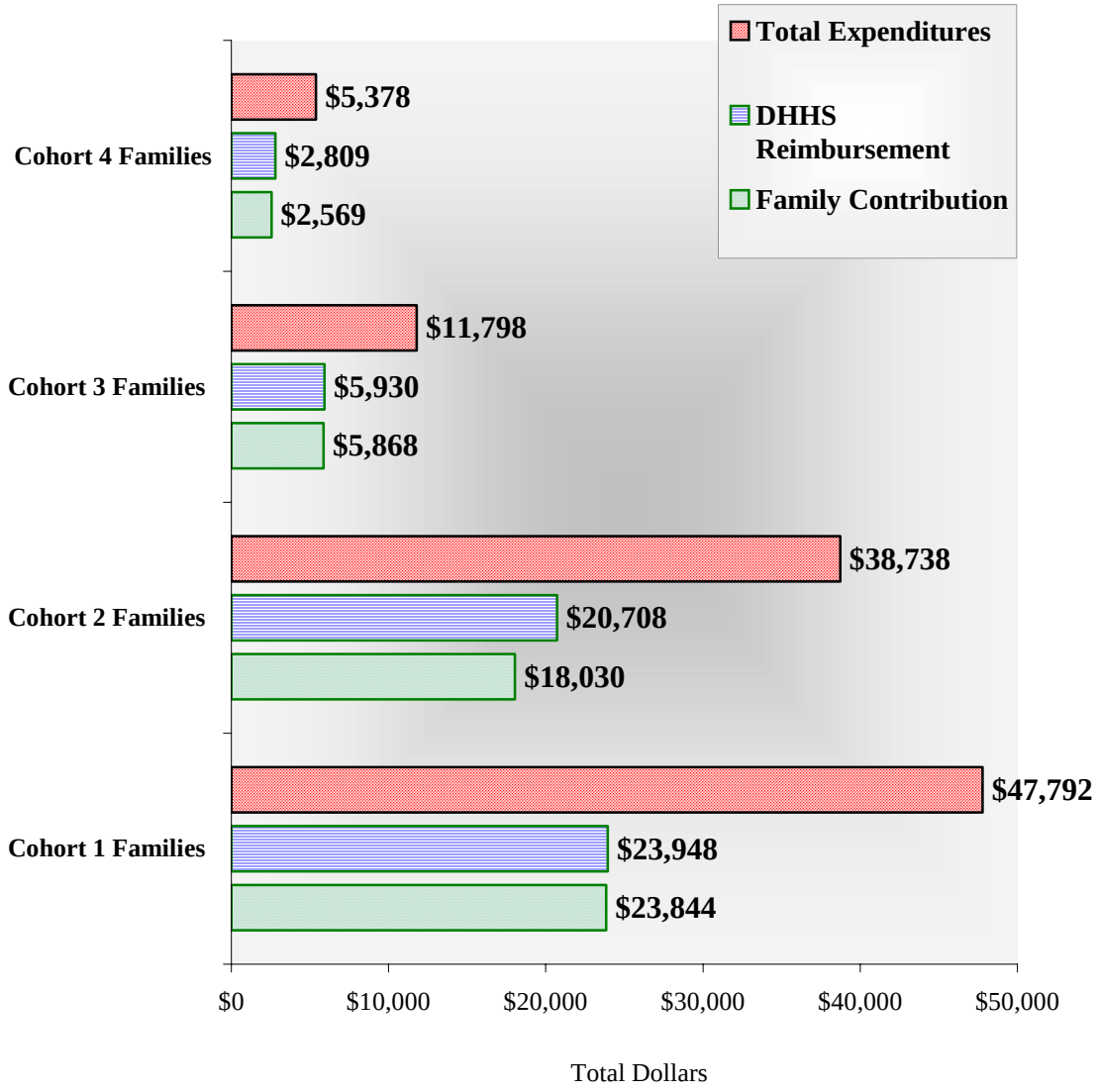


The figure above shows the cumulative savings realized over the period of this project; approximately $640,344. This project demonstrated a savings in that amount to the Federal/State Title IVE Program and thus was cost-neutral.

B. TITLE IV-EXPENDITURES – CONCRETE SERVICES

Chart 64

Guided Services Families: IVE Expenditures
December 2004



This chart, and the one following, tracks costs that are Title IV-E dollars provided only to Guided Services (E) families. These funds were for services of various types that are not paid for from current options such as MaineCare and/or private insurance carriers. These services included such activities as respite, educational activities and/or special therapeutic activities. The intent was for the family to share equally in the costs of these services. Requests were made by the family to MAGS/Casey Family Services social workers and then approved by the state DHHS adoption program manager on a case-by-case basis.

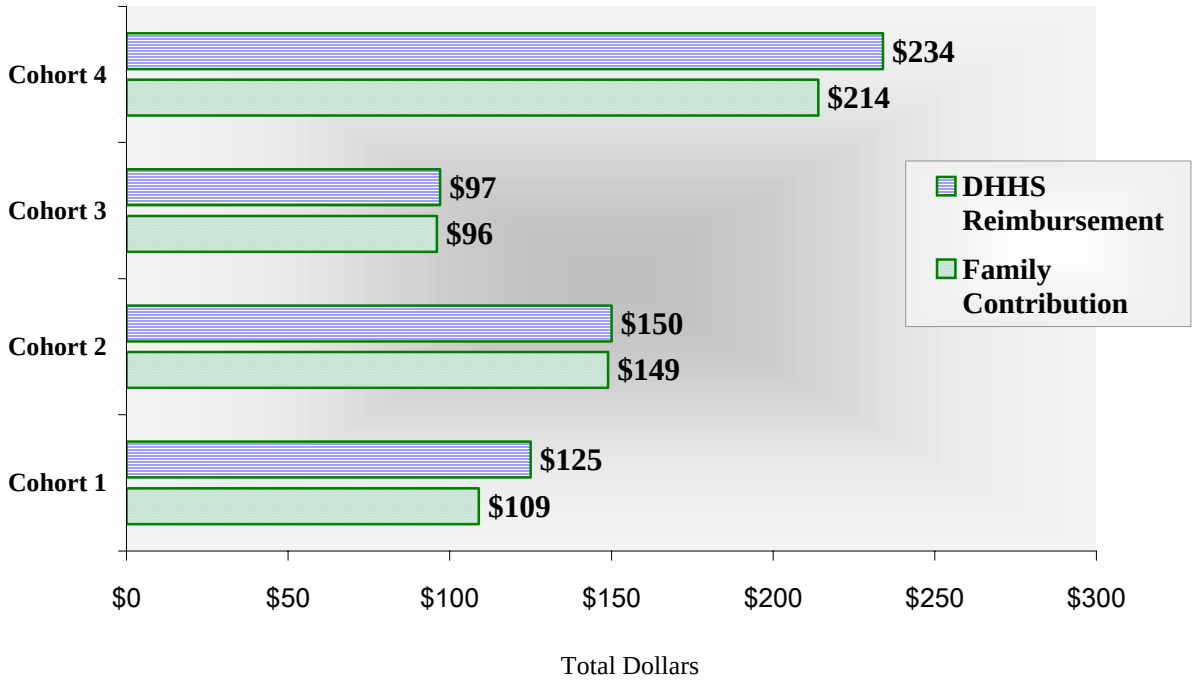
Cohort 1 (n=20) families were those families accessing these funds that entered the project in the first year, Cohort 2 (n=23) families entered in the second year and Cohort 3 (n=13) entered in third project year and Cohort 4 (n=9) entered in the fourth year. An additional eight families who had dropped out of the project also had requested funding and we did not keep or report on their data. Approximately 31% of Cohort 1 families had accessed this funding, 33% of Cohort 2, 19% of Cohort 3 families, and 14% of Cohort 4 families.

The types of activities paid for from these funds was varied; one arbitrary categorization of these activities was respite related services and all other.

- Cohort 1 Families: 19% Respite and 81% Other Types of Services
- Cohort 2 Families: 37% Respite and 63% Other Types of Services
- Cohort 3 Families: 23% Respite and 77% Other Types of Services
- Cohort 4 Families: 33% Respite and 66% Other Types of Service

Chart 65

Average per Family IV E Expenditures
December 2004



The chart above depicts average overall expenses per family. This data indicates that the intent of co-equal contributions from families and the Title IVE dollars appears to be evident; there were no statistical differences to report.

Looking closer at costs for types of expenses over the length of the study (4 years):

- There were a total of 439 requests for financial support from 73 families.
- 132 requests for Respite type services, at an average total (family and DHHS combined) cost of $261.00 per request.
- 307 requests for Other types of services, at an average total cost of $268.00.
- Average costs per activity were:
    - Family Contribution: $131.00
    - DHHS Contribution: $134.50
    - Total Combined: $266.00
- Minimum Contribution by Family = $0.00
- Minimum Contribution by DHHS = $12.50
- Maximum Contribution by Family = $1,550.00
- Maximum Contribution by DHHS = $1,550.00

C. MAINECARE (MEDICAID) COSTS

The evaluation staff at the University established a process with the state DHHS, Bureau of Medical Services to track MaineCare costs per child. Children were tracked by matching DHHS foster/adoptive program identification numbers to DHHS MaineCare identifiers. In this analysis, each service provided to a child was coded in the following manner: (1) Category of Service – a broad definition of service type, (2) Procedure – a more specific coding related to MaineCare regulations, (3) Diagnosis – physical or mental health, and (4) Provider – who or what agency provided that service. The MaineCare cost analysis focused primarily on exploration of between group differences overall and at the level of Category of Service. The general hypothesis for this analysis was that MaineCare costs for those children receiving the intervention, the Guided Services model, would be equal or less than MaineCare costs for those children in the Standard Services comparison group. The belief being that through the intervention children and their families receive effective services and support resulting in less need for services over time.

Families' Type Of Medical Coverage

At baseline, families were asked how the costs for their adoptive children's medical physical health needs, and medical mental/psychological health needs are covered. The following table outlines the percentage of families that relied on each type of coverage. Note: Percentages total more than 100% because some families used a combination of coverage methods.

Table 55
Paying/Coverage for Child's Medical Needs Percentage of Families Using Each Method
December 2004

Type of Coverage	Physical Needs	Mental Health Needs
MaineCare	92%*	84%*
Employer insurance/Union	10%	9%
Out-of-pocket	7%	2%
Private insurance	2%	1%
Other Method	5%	9%

At baseline, entry to the project, families reported receiving full MaineCare coverage for approximately 92% of their child's physical health care and 84% of their children's mental health care needs. The assumption was that the remaining 16% use some other form of payment/coverage in addition to MaineCare. Over time in the study, the percentage of families who reported receiving MaineCare coverage for medical needs varied.

Table 56
Paying/Coverage for Child's Medical Needs 12 – 36 Months: Percentage of Families Receiving MaineCare
December 2004

Type of Coverage	Physical Needs 12 months n=161	Mental Health Needs 12 months n=161	Physical Needs 24 months n=90	Mental Health Needs 24 months n=90	Physical Needs 36 months n=40	Mental Health Needs 36 months n=40
MaineCare	35%	31%	43%	38%	92%	82%

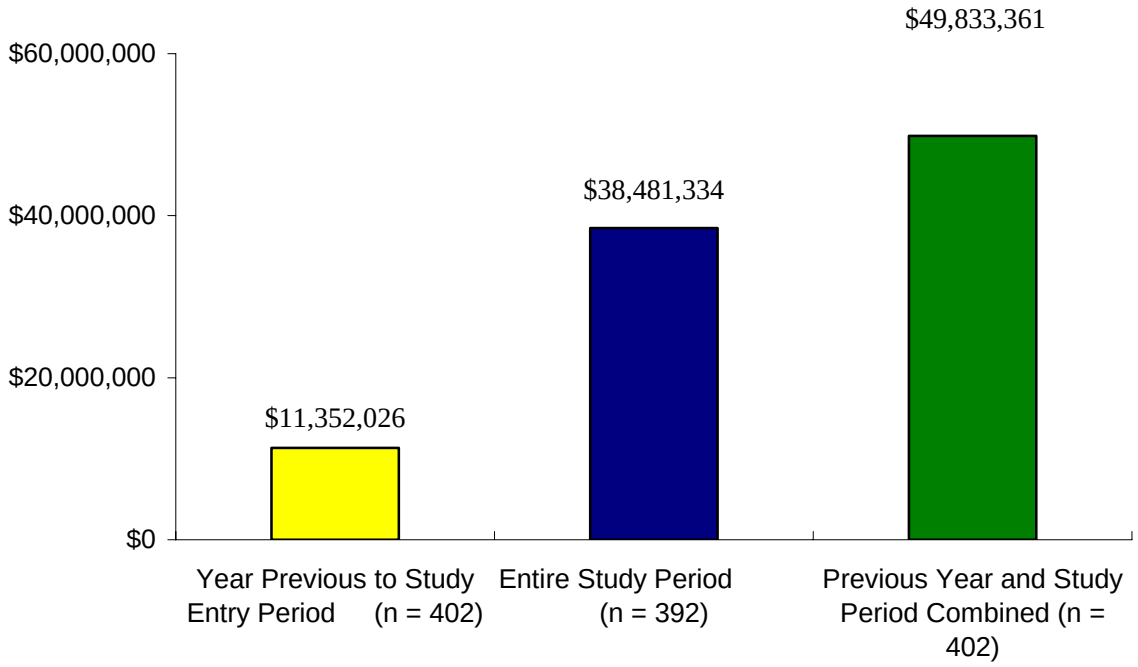
These results appeared to indicate that families do use MaineCare to pay for both physical and mental health services for their adopted child. Therefore, an analysis of MaineCare costs was one way to try to describe costs associated with supporting the needs of children adopted from the Maine child welfare system.

The data set for this MaineCare cost analysis had a total of 402 cases, children who were in the study at baseline; over time this number changed due to attrition. The average age of the children in this MaineCare data set was 8.8 or 9 years old; 52% were female and 48% male. Approximately 12% of these children were adopted by parents who were not Foster Parents at the time of adoption. What is important to note is that for the time period previous to study entry, *there were no statistically significant between group differences* on the variables of: Gender, Age, Length of Time in Home, Type of

Adoption and Time in Study. At least as measured on these variables, the process of random assignment appears to have created two similar groups.

Chart 66

TOTAL Amount MaineCare Costs
December 2004



The chart above presents the total amounts for all children, the chart that follows presents the median per child costs for the same time periods. The total amount spent on the study population, n = 392 children, for the study period 1999-2003 (four years), was $38, 481, 334. Due to the nature of these costs, with instances of just a few children having extremely high costs in one or two periods that skew the distribution of the data – most often due to physical medical care - the median amounts are a more accurate average to use in describing these costs. As this data is not normally distributed, in order to calculate between group differences the data was analyzed with non-parametric statistics and or transformed using a logarithmic procedure.

For the study period, the median amount per child costs to MaineCare was $22, 121 for four years.

Chart 67
Median Amount of All MaineCare Costs
MaineCare Costs
December 2004

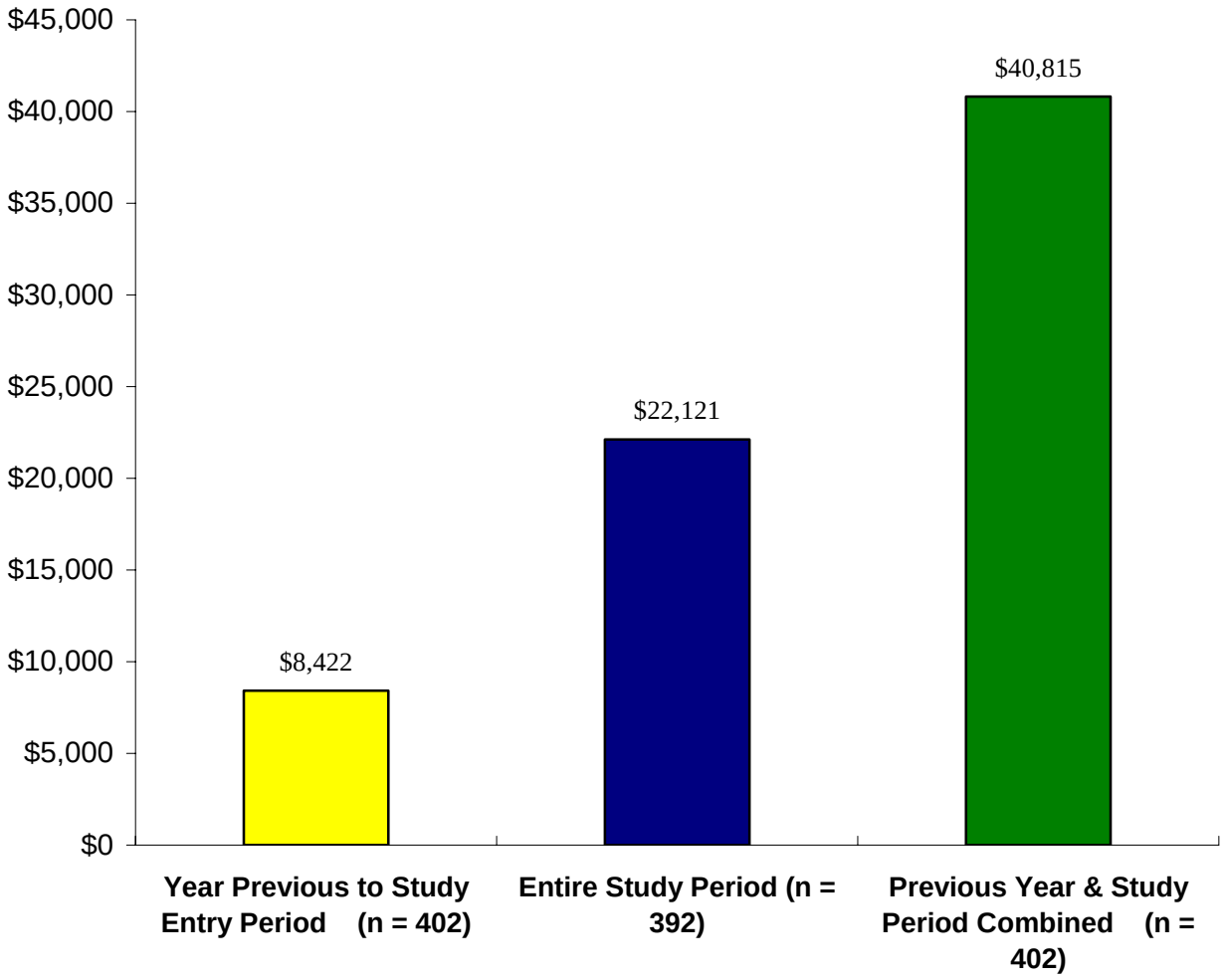
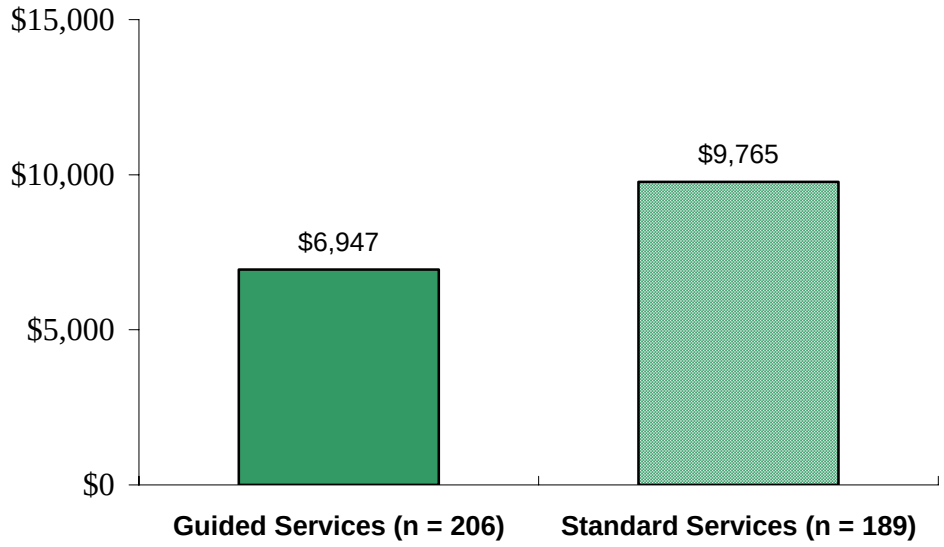
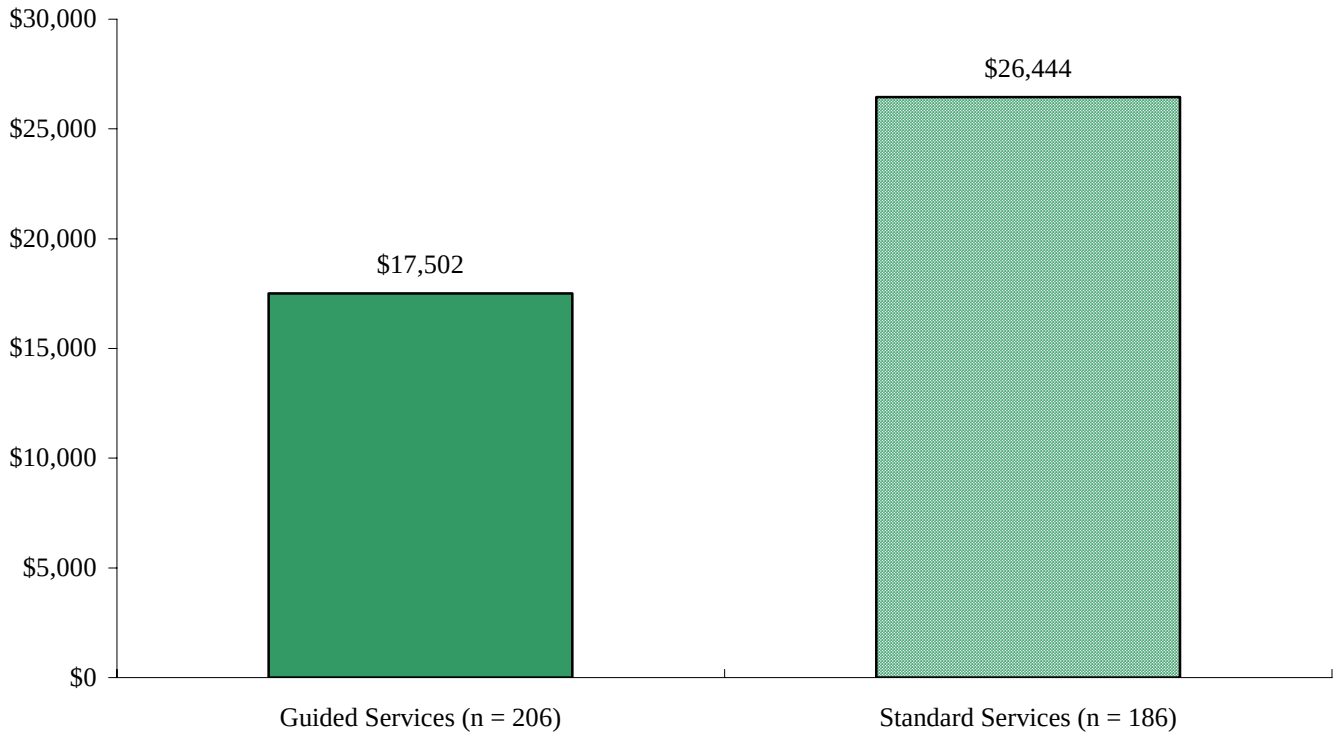


Chart 68
Median Per Child TOTAL MaineCare Costs -
Year Previous to Study Entry
December 2004



For the year previous to study entry, using both a parametric statistical test (t-test) and nonparametric statistical test (Mann-Whitney) there were no statistical group differences between those children in the Guided Services group and those in the Standard Services group (t-test p= .681 and Mann-Whitney p=.317). This result indicates that costs for both groups were similar before entering the study.

Chart 69
Median Per Child TOTAL MaineCare Costs - Entire Study Period
November 2004

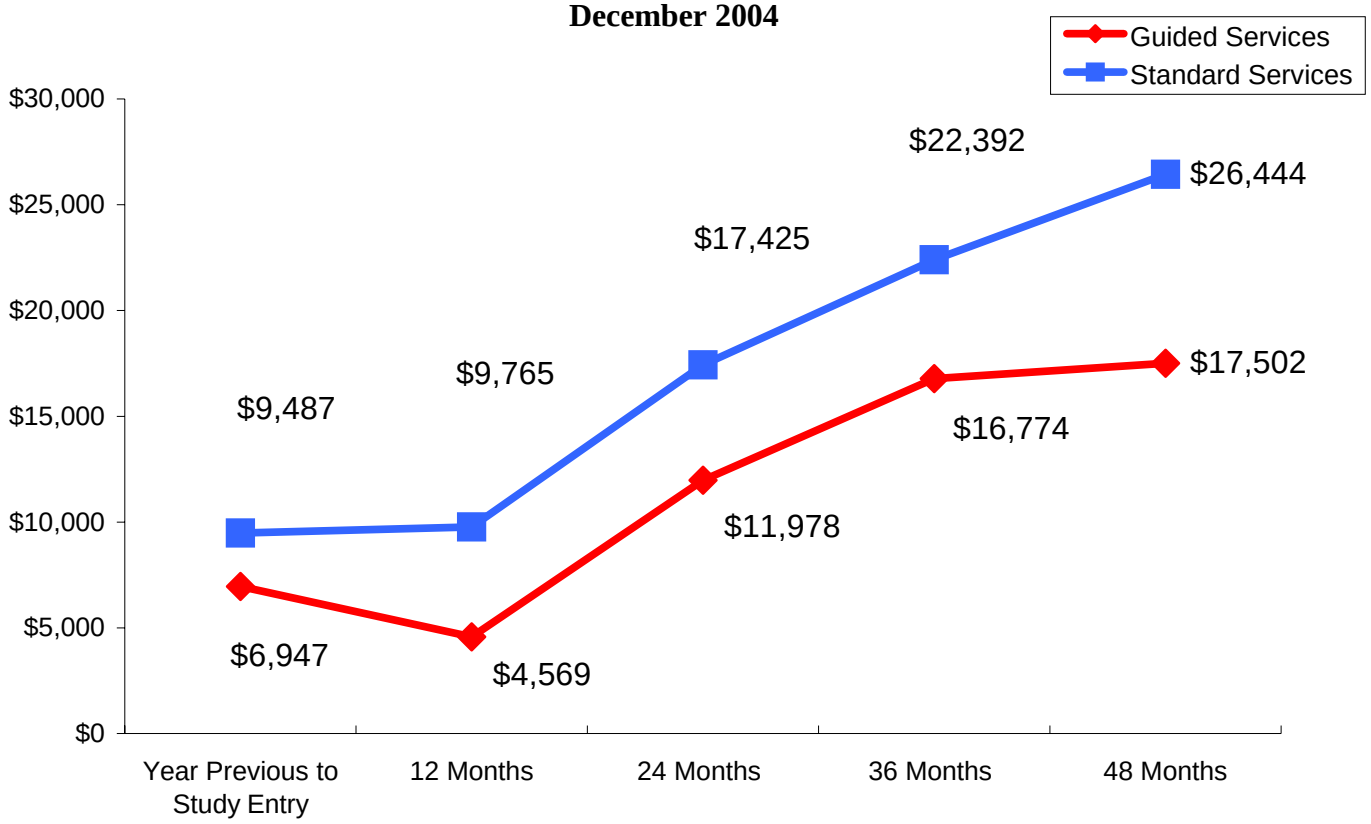


The chart above indicates differences between the groups during the four-year study period. As mentioned earlier, as this data is not normally distributed applying a nonparametric test, Mann-Whitney, does find a statistically significant difference between groups at p = .011. With the use of a transformation, the subsequent parametric test for group differences, Independent Samples t-test, resulted in a statistically significant difference at p=.016. These results indicate a statistically significant difference in MaineCare costs for the study period. Meaning that those children in the Guided Services group had lower costs overall than those children in the Standard Services group.

The average (median) difference in cost per child for the entire study period is approximately $8, 942.

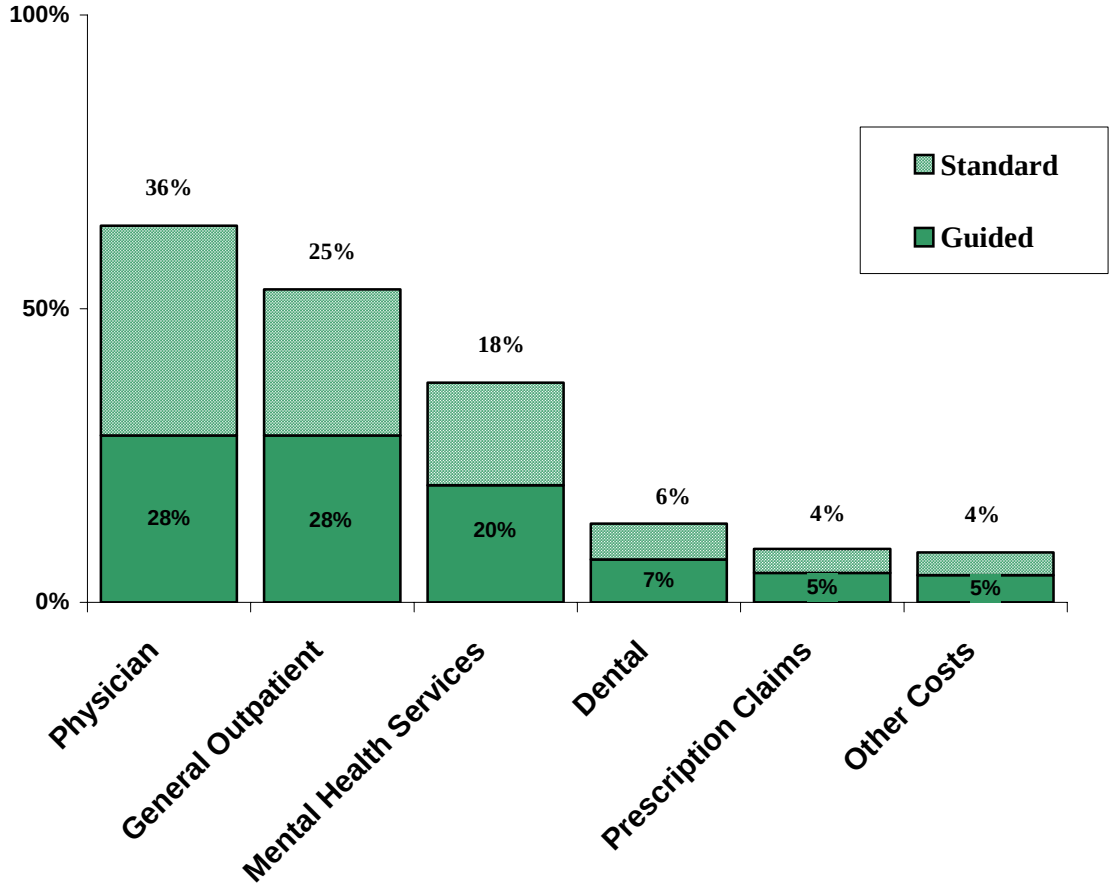
The following chart is provided for descriptive purposes showing the between group differences at each period of time, using the median as the average per child cost. Costs for both groups increase over time.

Graph 4
Median Per Child TOTAL MaineCare Costs
December 2004



MaineCare Category of Service codes were analyzed to identify those codes that were most frequently assigned for this population of adopted children. The following chart describes those most frequently used Categories of Service. Physician, General Outpatient and Mental Health Services were the most frequently used types of service codes.

Chart 70
Most Frequently Used Category of Services
December 2004

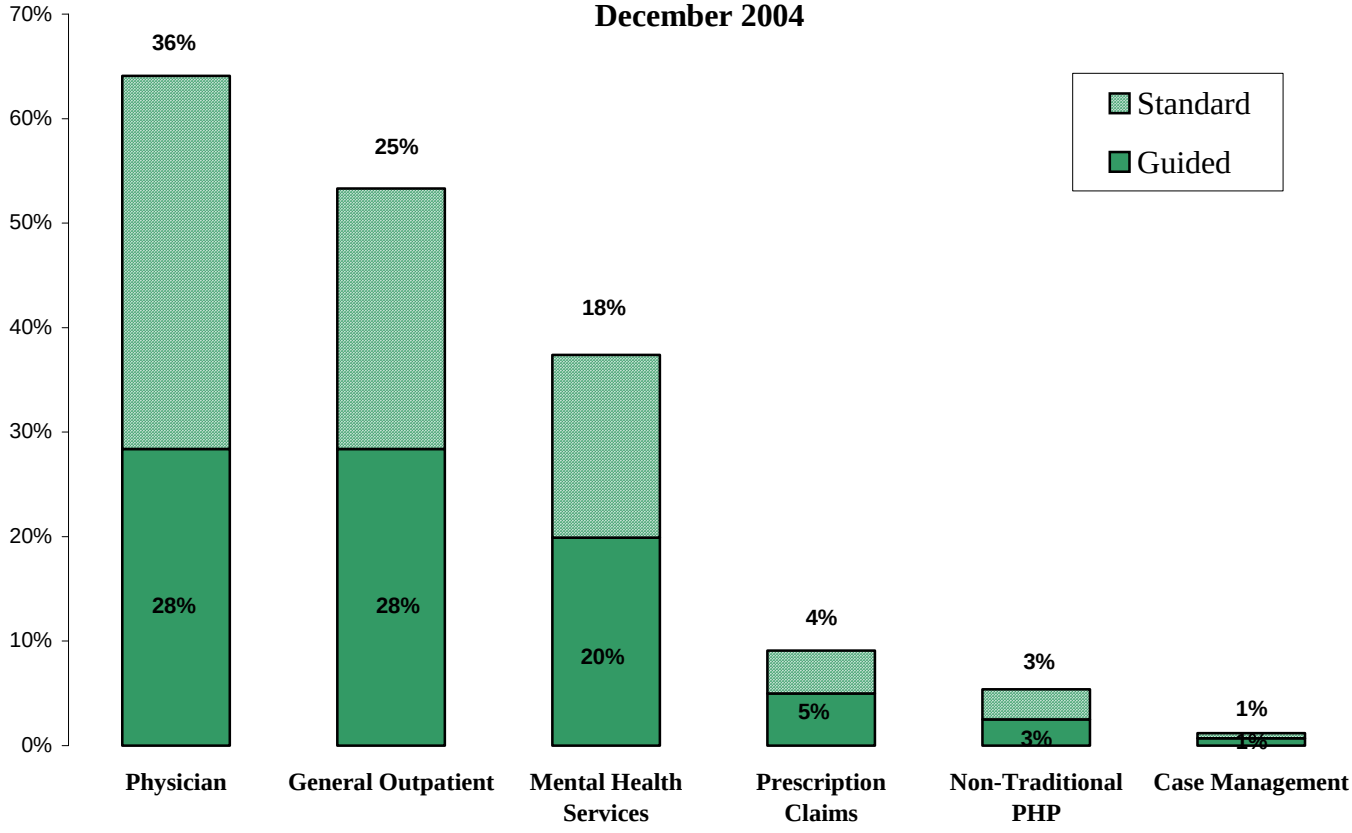


Then those codes were further refined to just those Category of Service codes thought to be most associated with needs that these children may experience and that may be influenced by this type of clinical case management intervention. These following codes account for over 85% of all the types of services provided to this population. The primary Category of Service codes selected are listed below and provided in the next chart:

- General Outpatient: Covered costs associated with outpatient services, including behavioral health.
- Physician: Recognized that for many families, physicians were involved with both physical and behavioral health treatments.
- Case Management: The specific type of service model.
- Mental Health Services: Therapeutic Services
- Non-Traditional PHP: Services for youth with significant behavioral health needs.
- Prescription Claims: Consistently at least a third of this population were using psychotropic medications; according to parent reports.

Note on the following chart that both groups used similar amounts of service with the exception of the Physician category of service code.

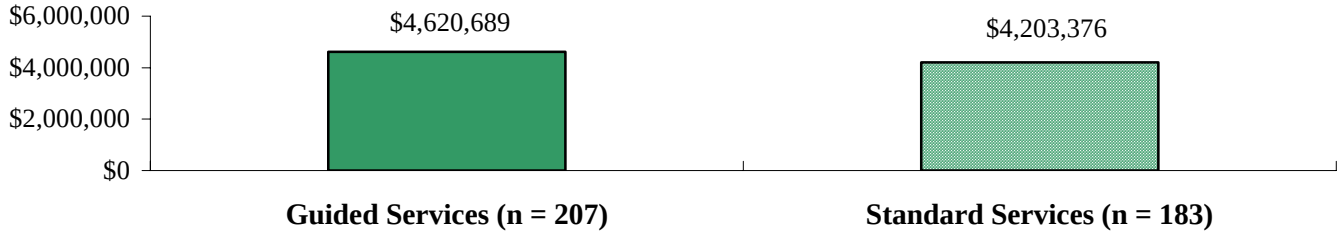
Chart 71
MAGS Related Categories of Service Frequencies
MaineCare Costs
December 2004



The charts below describes the total and median per child costs for just those MaineCare service categories thought to be most associated with the needs of this population and the purpose of the intervention. There was no statistical difference between groups at this previous year period, (t-test p = .886 and Mann-Whitney p = .103).

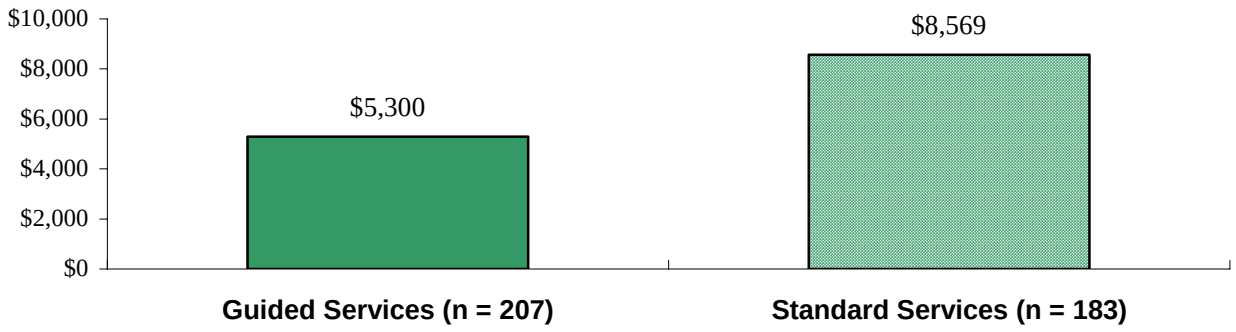
Due to a limited sample size, the study period analysis for the following charts was for a three-year period. Children were tracked for the first year in study (Year 1), second year in the study (Year 2), and third year in study (Year 3).

Chart 72
Previous Year Total Costs - Select Intervention Related MaineCare Category of Services
December 2004



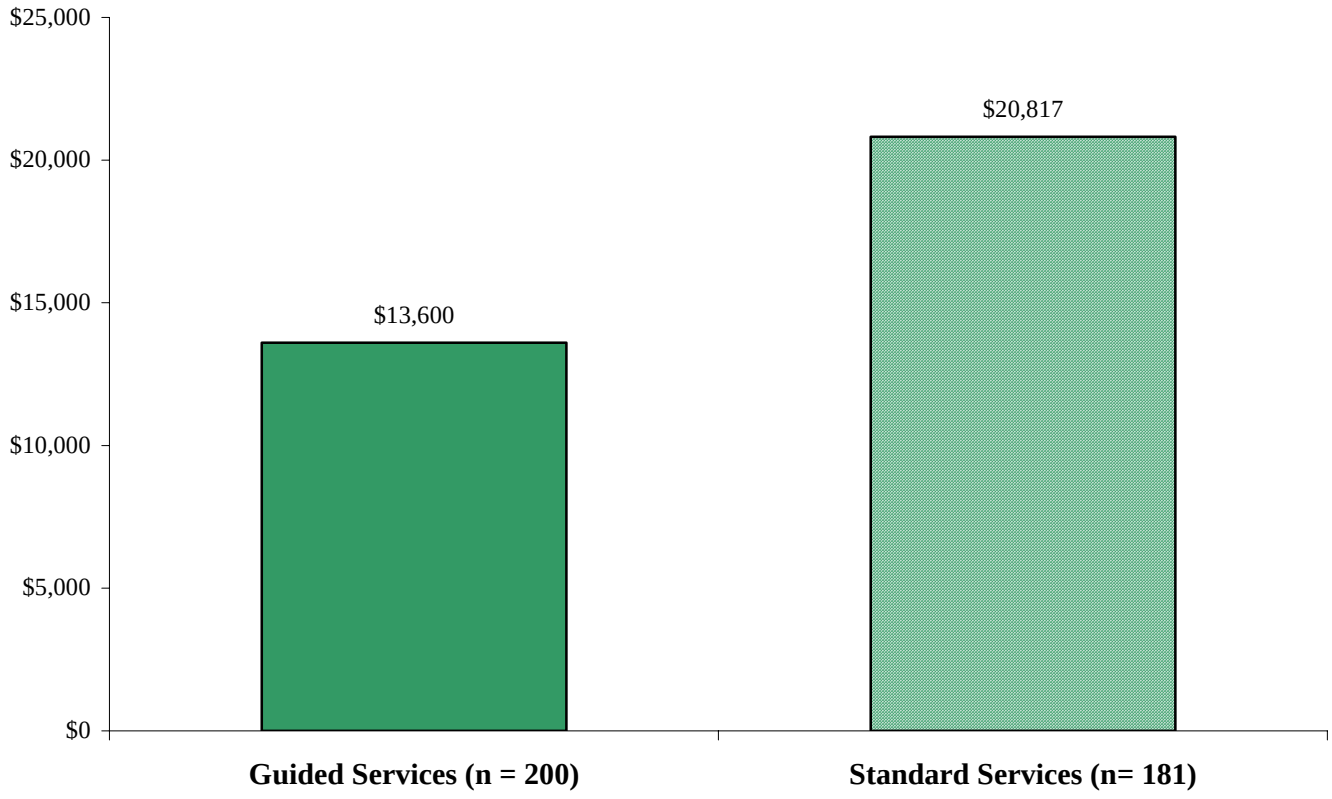
For the previous year to study entry, the total MaineCare costs for these related service categories was $8, 824, 065. This was approximately 78% of the amount for all MaineCare costs ($11, 352, 026) during the year previous to study entry.

Chart 73
Median Per Child Intervention Related MaineCare Cost
Previous Year to Study Entry
December 2004



The chart below illustrates costs for those in the study for this three year period of observation. These between group average differences were statistically significant using both parametric t-test ($p = .012$) and nonparametric Mann-Whitney tests ($p = .004$). These results indicate that similar to the results for all types of MaineCare costs, the Guided Services group had lower MaineCare costs than the Standard Services group on these select Related Service categories. The median average difference for these Related Service costs was approximately $7, 217 per child for the study period.

Chart 74
Median Per Child Related Services MaineCare Costs 3 Year Study Period
December 2004



The following chart describes the median per child costs over time for each group. After one year in the study, Guided Services median average costs were lower than those for Standard Services and continue in this trend. What is interesting to note is that different from the earlier chart describing all MaineCare costs, these related service costs seem not to exhibit an increase over time.

Graph 5
Median Per Child Related Services MaineCare Costs
December 2004

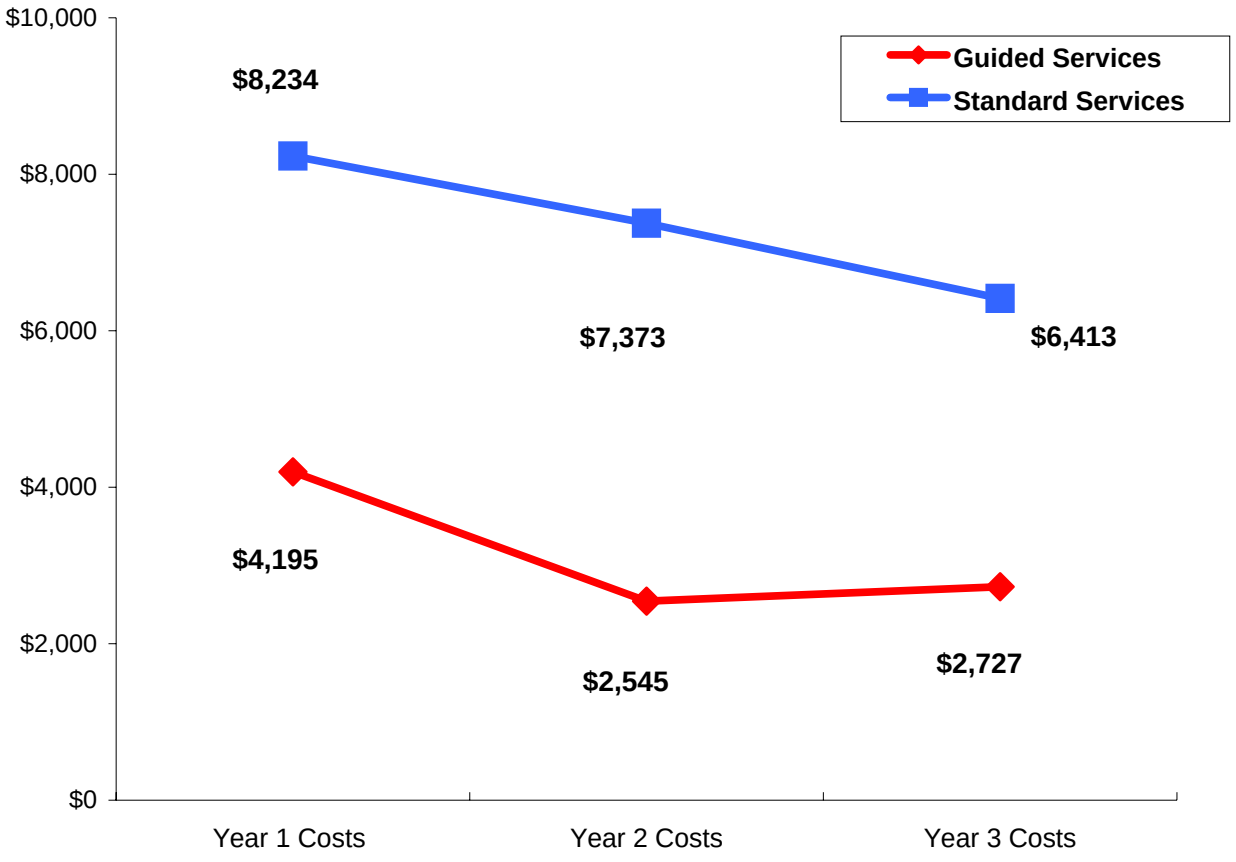
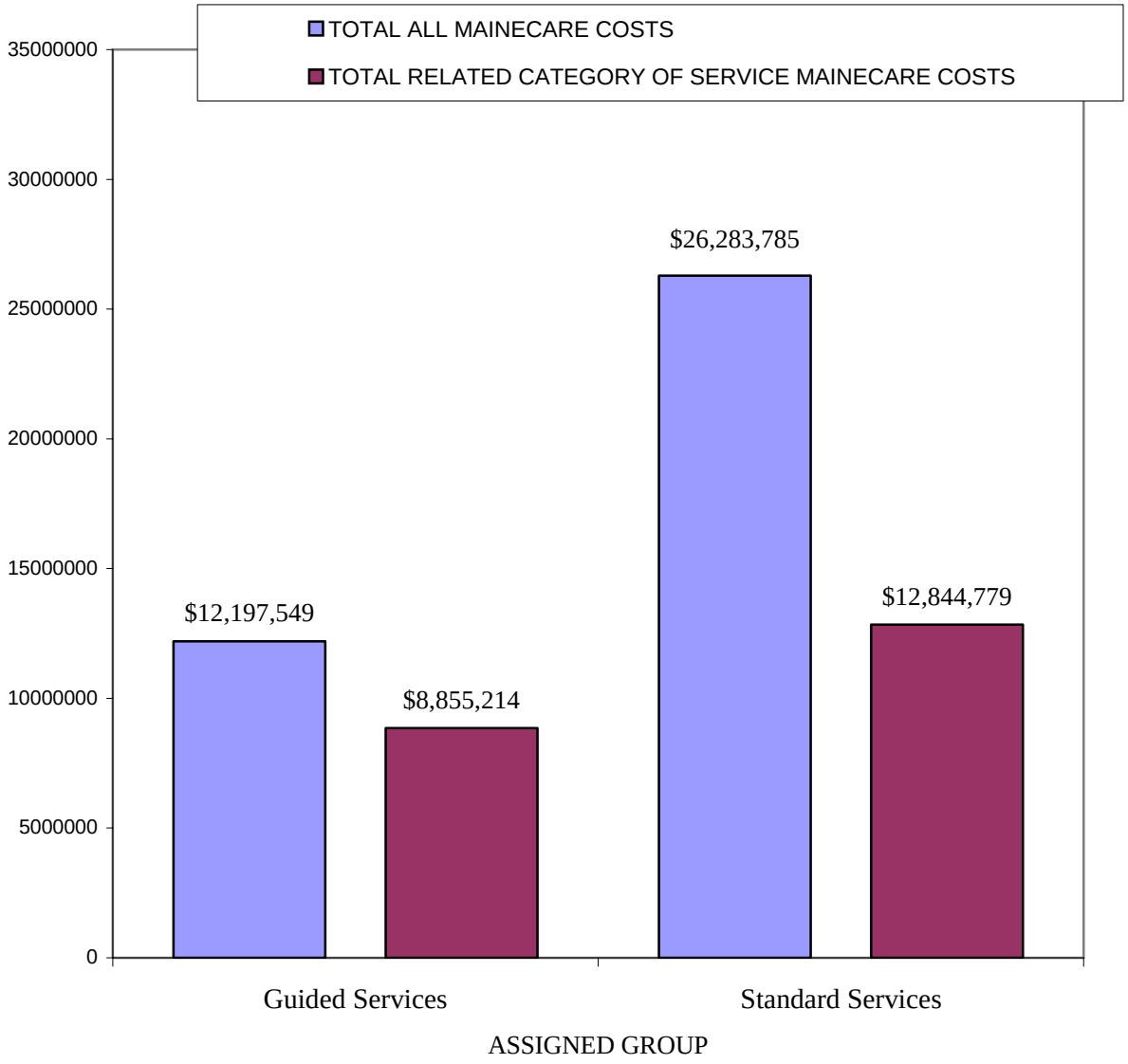


Chart 75
MAGS MaineCare Costs
December 2004



COST FINDINGS:

- Total amount of MaineCare dollars spent on study population, n=392 children, for the study period 1999-2003 (four-years), was $38, 481, 334.
- Total amount of MaineCare dollars spent on Related Services for the same period, those cost categories most related to what the intervention is thought to effect, was $21, 699, 993. These related cost categories accounted for over 85% of all cost categories for the study population.
- The Guided Services group, the group that received the intervention, had a total savings to MaineCare of $14, 086, 236 over a four-year period in comparison to the Standard Services group that did not get the intervention.
- The Guided Services group costs were 32% of all MaineCare costs and the Standard Services group costs were 68% of all MaineCare costs; for a difference of 36%.
- Analyzing just the most related cost categories; the Guided Services group had a savings to MaineCare of $3, 989, 565 for a four-year period.
- The Guided Services group costs were 41% of the total Related Service Category MaineCare costs and the Standard Services group costs were 59% of those costs; for a difference of 18%.
- The difference in cost between groups was statistically significant for both the total costs analysis and the related services only analysis.

CHAPTER VI - CONCLUSION

The Maine Adoption Guides project concluded as of March 31, 2004. Four and a half years of data collection provided us with extensive in-depth information about the needs of adopted children and families.

A critical finding from this study was the level of need for behavioral health services for many of these children. Using the Child Behavior Checklist (Achenbach, 1991) as a measure of functioning, findings indicate that anywhere from 45% to 68% of older children (age 6 – 18 years old) in this study were considered in need of clinical mental health services. This provided evidence in favor of having post-adoption services and supports available to families for their children adopted from the state child welfare system, especially for those older children who may have spent time languishing in the state foster care system.

In addition, it is clearly evident that a majority of the older children in the study were scoring in need of clinical services and parents were most often not seeking clinical services/supports for these children. This finding was critical in that these service gaps were evident within the first six months of children being in the study and therefore were likely to also be present at the time of legalization. Therefore, there was a concern in terms of whether or not the foster parent and/or state agency adoption caseworker were identifying these needs and responding to these needs in support of the child.

Caregivers appeared to feel positive about the adoption process and rated the level of attachment of child to family and family to child as positive. Ratings of overall communication with the child and overall quality of home life were also positive. The parenting styles reported, Authoritative, and degree of family Cohesion and Adaptability were all results in favor of healthy family functioning. Overall, the majority of the families were reporting positive experiences with their adoption of a child from foster care. This is certainly good news and needs to be shared widely with prospective adoptive parents.

Caregivers were also asked about their own health and well-being. The majority of respondents in this study were female and identified as the mother to the adopted child. While reporting positively on the adoption as a whole, approximately two years after legalization of the adoption, approximately 32% of all parents reported that adoption-related parenting stress had a negative impact on their health. The percentage grew over time during the course of the study. Post-adoption services need to provide specific supports for parents for their own health and well-being.

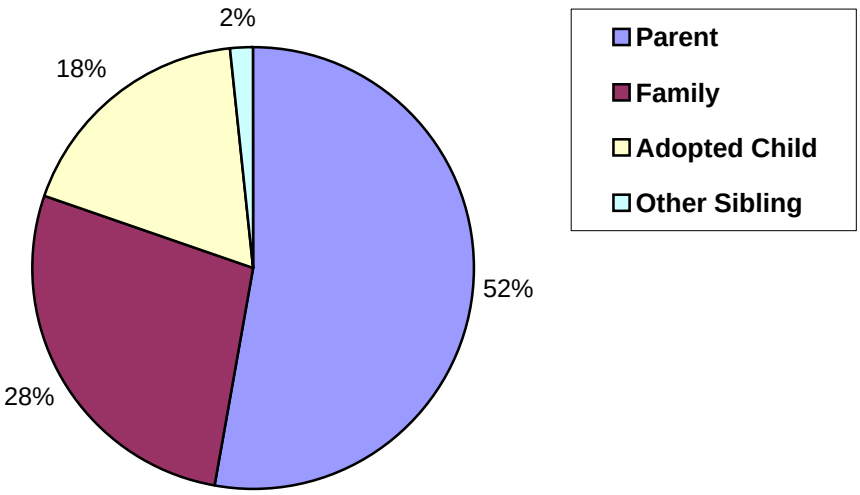
Another key finding was that the Guided Services model appeared to be significantly more family-centered than the other types of case management services provided to the Standard Services group. This finding provided evidence in support of the intervention being implemented with fidelity to this philosophical approach. This is a significant finding in that traditionally child welfare services are child centered and often parents report feeling blamed for problems they experience with their adoptive child.

Following the lead of the parent and considering the family as a whole has worked well in this particular program. There were no other statistically significant between group differences on other family level outcomes.

The primary recipient of post-adoption services was the parent. The most common service provided to families from the MAGS social worker was Parent Education and Support: approximately 25 percent of all the types of services provided. Other frequently provided services were Building/Maintaining Relationships, Collateral Contacts, Individual Child Therapy, and Adult Group Therapy. The amount of time spent providing services varied depending on the type of service. The average number of minutes for all services in general was 48 minutes per service.

Overall, MAGS Casey social workers provided an average of 170 services per family for those families in the study for four years, or approximately 43 service contacts per year. Considering all families in the Guided Services group, the amount of time (minutes) spent working with each family differed—ranging from 15 minutes to 486 hours. Families were most frequently provided services through telephone contacts and in-home visits. Seventy-six percent of services provided did not require any travel time. Seven percent involved between 15 – 60 minutes of travel and 12% required between one and two hours of travel. Five percent required more than two hours of travel. The majority of services provided were telephone contacts. In addition, no travel time was required for in-office visits or documentation.

Chart 76
Service Recipients as Reported by MAGS Social Worker
December 2004



Findings at the child level, outcomes for children, were limited to just two in favor of the Guided Services model. For all children in the study, the children in the Guided Services group had fewer problems with functioning compared to the Standard Services group, as measured by the Total Problems scale of the CBCL (Achenbach, 1991). While this finding was encouraging in terms of support for this type of clinical case management, it was discouraging to also report that both groups on this measure scored in the clinical range. In addition, on all the child functioning measures, there was no evidence for a trend towards improved functioning. Another finding in favor of the Guided Services group was that parents reported more often that they trusted their child compared to parents in the Standard Services group. This finding was interesting and somewhat hard to interpret. The proposition was that parents in the Guided Services group were more informed about their child's behaviors, may have felt more able to manage or co-exist with those behaviors, and therefore were more able to trust their child. This was only supposition about a rather unique finding. All other well-being, functioning outcomes at the child level resulted in no statistical difference between the groups.

Findings related to costs were in support of this approach to post-adoption services. When looking at Medicaid (MaineCare) costs, results showed that there were no statistical differences between Guided and Standard children in the year previous to the study. However, examining the total MaineCare costs during the study period, there was a significant difference between groups—children in the Guided services group had lower costs overall than children in the Standard services group. This result was found when analyzing all MaineCare costs together, and also when examining just intervention-related costs. This was a significant finding, considering that the Guided services model included as much service time as a family wanted—families were free to decide their amount of contact with a MAGS social worker, and therefore, could make daily contact if they desired. Yet, MaineCare costs show that the children in the Guided services group had fewer costs than Standard services children. In addition, the cost analysis for cost neutrality – examining whether Guided Services group state/federal Title IVE costs were the same as or less than the Standard Services group over time - also proved in favor of the intervention.

This cost analysis appeared to indicate that this clinical case management model, through which any member of the family received informal and formal supports at anytime, at home or in an office setting, from a Master's level clinical social worker, did result in less cost to the state/federal Medicaid and Title IVE programs.

In conclusion, the finding is – the Maine Adoption Guides post-adoption services model provided to children and families *the same or better services and supports, families got what they asked for the way they wanted it, and all for less cost to the taxpayer.* This intervention model appears to have been designed and implemented to meet needs expressed by these adoptive families, this is an important and positive finding. Statistical group differences were few and were in favor of the Guided Services model. The philosophical intent of providing services in a family-driven framework was

evident. The partnership between the Casey Family Services agency and the state DHHS adoption program functioned in support of this project. Both agencies demonstrated willingness to collaborate and work through a uniquely difficult process with families at various stages of engagement.

Our recommendation of a model for post-adoption services includes:

- ❖ Clinical Case Management Provided to Families by a Master's Level, Adoption Competent Clinician
- ❖ Training Program
- ❖ Outcome Monitoring / Quality Assurance Procedures

1. Clinical Case Management Component:
   - Master's Level Clinician: Provide both therapeutic and traditional case management services.
   - Flexible, Home Based Service Delivery
   - Family Driven Focus: Relational Focus (Parent and Child)
   - Case Management includes Access to Limited Resources for Concrete Services
   - Utilize Targeted Case Management MaineCare funding mechanism with a Family Level Rate billed monthly (Re-define TCM policies to make specific for post-adoption model)
     - Community Based Agencies Providing Post-Adoption Services participate in development, implementation of Parent Support Groups and use of Respite Services
     - Concrete services available for critical needs

2. Training Program:
   - Continue with Basic (ASAP) Adoption Awareness/Education Programs
   - Implement New Cross-Disciplinary Competency Training Modules
   - Develop, Implement and Evaluate an 'Adoption Competency Certification Program' through partnerships with University and other Trainers

3. Monitoring/QA:
   - Review TCM Quality Assurance policies, Relevance to Model
   - Performance Based Contracting Strategy to 'Purchase' Specific Approach to Case Management for Post-Adoption Services
   - Set of Outcome Indicators for Post-Adopt Clinical Case Management Model
   - QA Monitoring System

Despite lack of statistical evidence in favor of the intervention on the majority of the outcomes measured, a focus needs to remain on the fact that there was a substantial need for behavioral health services and supports for the majority of children who were adopted from the state child welfare system. In fact, in 2004 the state DHHS office conducted a survey of all parents receiving adoption subsidy across the state and *over 400 families* indicated an interest in receiving post-adoption services. The services and supports that were provided to these MAGS families were comprehensive, family centered and provided at less cost to the taxpayer.

In the midst of caring for children with substantial needs, caregivers reported overall positive satisfaction with the adoption process, their services received from state DHHS staff, and with the supports they received from the Guided Services social workers. These findings are a testament to the grace exhibited by these parents. Their lives create families that result in better communities for all of us…they are the ties that bind.